SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 January 2026

Day 1
Tuesday, 20 January 2026

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10:02

Opening Remarks

THE CHAIR: Good morning and welcome, both to those here in the hearing room in Edinburgh and those following proceedings on the new YouTube feed. Can I extend a particular welcome to those-- I can see at least one core participant who is attending in person in the hearing room. I would wish to acknowledge that engagement.

Now, the Scottish Hospitals Inquiry has finished its hearing of evidence from witnesses and consideration of documents. As I have been reminded, we have heard, I think, 186 witnesses, and we have considered many documents over a period of hearings extending to – I think I'm right in saying – 29 weeks.

Now, these hearings have been in a number of sessions, which we have designated Glasgow 1, Glasgow 2, Glasgow 3, and Glasgow 4. Glasgow 1 was in 2021 when we heard from some patients and family members who had very direct experience of the-- particularly, the Children's hospital in Glasgow, Glasgow 2 hearing was in June 2023, Glasgow 3 was a hearing over 12 weeks, with a break of a week, from August until November 2024, and in 2025 we have had the three parts of the Glasgow 4 hearing in May, then in August, and then between September and October.

So the Inquiry has heard the evidence. What I have invited legal representatives to do during the four days of this week is to, in oral submission, draw my attention to what they consider to be the important aspects of that evidence and the important issues which that evidence gives rise to. It will allow legal representatives to respond to what has previously been provided to the Inquiry by way of closing statements.

Following the end of the third part of Glasgow 4, I invited core participants to provide closing statements, and all core participants have done so in writing by way of their legal representatives. I've considered all these written statements, and I'm very grateful for them. They have been helpful.

As I say, today is an opportunity-- today and following days is an opportunity for legal representatives to draw attention to important aspects of their written statements, and the written closing statements of other core participants. It also provides me with the opportunity to ask questions. Counsel to the Inquiry, Mr Connal, today, and Mr Mackintosh on Friday, will also have the opportunity to make oral closing

statements.

With that by way of introduction, can I turn to Mr Connal and invite him to address the Inquiry?

Closing submissions by Mr Connal

MR CONNAL: Thank you, my Lord. It's not quite the final curtain, but the final oral hearing has at last arrived. Quite a significant milestone, I might suggest. In the words of the song, it has been a long and winding road. Some might argue slightly unnecessarily long, unnecessarily winding.

As this will be, in all probability, the last occasion in which I will address your Lordship in a public session, I'm going to take the indulgence of offering a couple of thanks. One is this: I'd like to express the thanks of Counsel to the Inquiry, to the much wider Inquiry team, many of whom have been effectively invisible to the public because they don't participate in the public sessions directly. But without them, those of us who perform on this stage would simply have been unable to achieve what we have managed to achieve, so our thanks go to them.

I would also like to extend my thanks to core participants for their cooperation during the Inquiry, which has allowed us to move forward much more smoothly than might otherwise have been the case. My thanks even extend to NSS, who have borne, with considerable good humour, the occasional mild grumbles on our part when they picked us up on matters of fine detail in one statement or another, but thanks to all the CPs.

Now, as my Lord has said, my role today is to respond, as it were, where necessary, to the written closing submissions by the various core participants who have made them. I'll endeavour to do so broadly in the order in which they are either scheduled or originally intended to speak in this final session. Many of these submissions are lengthy and detailed, and I have absolutely no intention of dealing with every point they make – otherwise, no one else will get a chance to speak this week at all – but that is not intended in any way to decry the effort that has been put into these well-presented and argued submissions.

There is, as my Lord is aware, a written response that has picked up a lot of the detailed points that were made by the core participants, and that has been reduced, I think, and circulated, and I----

THE CHAIR: Just to clarify that point, particularly with a view to people following our proceedings, I think – and correct me if I'm wrong about this – this is

a reference to a document prepared by Counsel to the Inquiry picking up on errors, points of detail, which core participants' legal representatives have very helpfully picked up on, drawn to a counsel's attention. These have been addressed and a, as it were, response has been provided.

MR CONNAL: That is exactly correct, my Lord.

THE CHAIR: Right.

MR CONNAL: The points picked up range from errors in discussion right through, at the other extreme, to incorrect footnote notation, and it was thought undesirable to take up time in today's final session by dealing with these matters orally, so that has been produced. Now, it's possible, just by the nature of things, that there may be minor areas where I duplicate what is said there, but hopefully these will be at a minimum.

So, that said, I turn then to the closing submissions by the core participants, and I start – and they are to be the next speakers – with that for NHSGGC. I may have a little more to say about this one than some of the others, perhaps for a variety of reasons, including what they describe as their unique position in this Inquiry, and I'll try to refer to the paragraph numbers as I go.

I think the first thing I should say about that submission is that it would be wrong to do anything other than recognise and welcome what I would suggest is a very significant change of approach which appears in this written document, I think the first written document from NHSGGC which contains that change of approach. So, that is the right thing to do. I welcome that change of approach.

Now, I am aware that the next question that a number of parties will raise is, "Well, is it real?" It's said to be a change of approach on a whole range of fronts. Is that a real change, or is something merely evident on paper? That will be a question which my Lord will have to address in due course.

I am conscious that the publication of the NHSGGC response has drawn comment in the press and elsewhere. Perhaps oddly, that comment is almost entirely focused on their position on infection link – that's almost the only thing that most of the coverage mentions – and I suggest, with all due respect, that there are other areas – some of which I will pick up, but not all – where significant things are said by the Board which are worth looking at.

For instance, their position on whistleblowing is important, just to pick one. There are significant statements accepting failures right through the

process of the design and building of the new hospital expressed in plain terms. All of these are, I would suggest, worthy of attention.

I don't suppose I can leave it without noting that the word "humility" appears in this submission I think almost for the first time. This is an interesting phrase in the context of an organisation which has been described by some as "an organisation which always knows best" or which "wants to go its own way", but "humility" now seems to be said to be an appropriate label for its approach. The other thing I suppose it's difficult to leave without saying is this, it's just perhaps a little disappointing that this change of position did not come a lot earlier.

The other thing I need to say is this, that we are told there was a change. We were, I think, first told about this in the oral evidence by the current chief executive, Professor Gardner. I suggest we do not yet know how, why, or when: How was that change decided upon? Why was it decided upon? When was it decided upon? There are hints, but I don't think we really know that, and I suspect that many of the parties to the Inquiry would find it helpful to understand that process as part of the process of being convinced by what is said to be a changed position.

My Lord, if I can now turn to the terms of the closing submissions for the Board themselves, and I'll simply pick up a number of paragraphs. If I start just by noting paragraph 1.3, which is perhaps one that I note, particularly as one of Counsel to the Inquiry, that NHSGGC agrees with our assessment of the evidence, other than as set out specifically in the submissions they have lodged. My Lord will recall there was a very substantial assessment of evidence contained in the submissions that we put in.

Having noted that, I then turn to section 3, which is the position of NHSGGC. I think it's fair that I should immediately welcome statements made, particularly in paragraphs 3.1 and 3.3, where, for instance, in 3.1, NHSGGC say that:

> "… its management of issues investigated by the Inquiry fell well below what patients, families, clinicians, and staff should expect."

3.3 says similar things. So I very much welcome the approach taken there, that acknowledgement of points that have otherwise been contested, and I suggest contested by witnesses who either were or are employees of NHSGGC, but this is now the Board position.

In paragraph 3.2, perhaps in contrast, the general assertion is made that:

> "… all [their staff], at all times, did what they considered was best for patients, acting in good faith [and were] committed to patient safety [above] all else."

Now, for our part, we find that statement rather more difficult to accept. I'm not going to go back into the story of communications but that's an area where there were issues about that commitment.

There are-- I'm trying to think of another example. Changing the direction of an IMT so that it focuses on exculpating the building. Is that consistent? Pushing the "nothing to see here" approach. Is that consistent? Even – and it's not within our remit – "not everything said in the investigation into the complaints of A&E consultants suggested that patient safety was the main objective". So that paragraph, I suggest, is not correct.

Now, if I just move to 3.4, the only point I want to make there, and this may turn out to be simply a misreading, in 3.4 there's discussion of the building project, and about two-thirds of the way down it's said:

"NHSGGC accepts there were failings at handover and commissioning for which it must accept some responsibility."

Now, I just raise the question – and I'm afraid some of the points I make do amount to questions – as to whether that should be read as meaning that NHSGGC do not accept any responsibility for anything prior to handover? Now, it would seem a little odd if it was to be that, because there are other parts of the submission which seem to accept failings at an earlier stage, but that phraseology in 3.4 seems to point in a particular direction.

THE CHAIR: I mean this is not your language, it's the helpers' language. How do you understand the word "commissioning"?

MR CONNAL: Well, I take that, my Lord, because it says "handover and commissioning", to be a general, rather than a technical, phrase to reflect the processes taken to move the building from one which was a shell to one which was working and ready for the occupation of patients.

THE CHAIR: Yes.

MR CONNAL: I think that's the way I would have viewed the words "handover and commissioning".

THE CHAIR: I think the expression used to describe that, at least on some occasions, is "operational commissioning". Is that an acceptable way of describing it?

MR CONNAL: That would be near to my understanding of this phrase; the

period after the Board, as it were, gets its hands on the building for the first time and then the process by which checks are made or not made, as we've heard in the evidence.

My Lord, if I then move to 3.6. Now, I suggest that deals with two issues. One is NHSGGC – and I'll come back to that – and the other is NHS Assure, which of course is a new body born, as we understand it, largely out of the issues at the new Glasgow hospital.

Now, my position on that is quite simple. It's not difficult in my submission to see that the creation and indeed operation, since its creation of NHS Assure, is a significant step designed to assist with some of the issues that we have been considering. We had detailed evidence on what they were doing, what they were hoping to do, all the various steps that they were taking. So, in a sense, we have the vouching for that.

The question – and I'm sorry to have another question again – that I have is this. Why can this Inquiry be assured that NHSGGC has developed and improved? It's not immediately clear from the material that I have seen why that should simply be accepted, but perhaps my understanding is flawed.

Now, when I come to my next point, my Lord, I'm going to take my Lord on a little tour.

THE CHAIR: Just before we do that.

MR CONNAL: Sorry.

THE CHAIR: I mean, again, I appreciate this is not your document. What is being said here and what is the relevance of NHS Assure-- which, as I think you've said, was only established in 2021? Do you understand what's being said here?

MR CONNAL: Well, my Lord, part of my difficulty is that when I listened to Professor Gardner I got a little lost about "journeys" and "unpacking" and "arriving at the destination" and other such management-type phrases which were obviously intended to indicate something. This paragraph I think suggests that there has been a process of improvement which has come to if not a conclusion, but is well advanced in picking up a lot of the failings which are identified elsewhere in these submissions.

I think the challenge may be that, in part because the change of approach by NHSGGC came when it did, it's not entirely obvious to me why one should just be assured now, immediately, that all is well in the Board, however one takes the current chief executive's statements on these matters. I think that the problem is the word "assured". How are we to be assured, to take the start of that paragraph?

Now, in fairness, they do say they continue to learn and so on and so forth. So I'm not suggesting they've set out a journey which is completed. They haven't finished "unpacking" yet, but that's the nearest I can come to an understanding of that paragraph.

What I was going to go on to do, if I may, my Lord, is go on a little journey on a topic. My Lord may recall the evidence of the previous chief executive, Ms Grant, on what the approach of the Board was-- Sorry, on what her approach was to the conclusion of the Case Note Review that there was infection link in a significant number of cases. Her evidence on that point extended over a substantial number of pages of transcript.

Counsel to the Inquiry have suggested that it would at least be open to your Lordship to conclude that the then chief executive, and possibly other senior officers, decided that they did not accept the Case Note Review conclusion on infection link, but also decided that they would not say so, notwithstanding the apology that was issued and the other processes that were ongoing. That they would not say so because of the fact they were still in what I'll just call "special measures", or the fact that it might upset parents and so on, and no doubt it would have done, had the Case Note Review come out and said, "There's infection link," and GGC come out and said, "Well, we entirely reject that."

THE CHAIR: Ms Grant did not say that in terms.

MR CONNAL: No, she did not. I'm not sure we know, but the matter is discussed quite fully in our submissions, and it had occurred to us that we might hear from NHSGGC clearly what the position was at that time.

Now, Professor Brown says he wasn't told anything about it, but we're looking at the position of the Executive. So, I thought I might find that explanation in paragraph 3.9 where there's discussion of the position of NHSGGC evolving, but I don't. Just for my Lord's note, I've looked at other paragraphs. If I can just jump ahead for a moment. If my Lord sees paragraph 4.4, it said:

> "NHSGGC has accepted and has acted upon both the conclusions and the recommendations of the CNR Overview Report. [Their] position on the CNR is set out in more detail in paras 13.11–13.12."

Well, we know what they've done now. The question is what they did then. The other place I looked was 5.9, so if I just go there, all that is said there is:

> " ... it is not accepted that NHSGGC was any way disingenuous or dishonest as to its position on the CNR. This position is

addressed more fully [elsewhere]."

Well, that's a general claim, but nothing further is provided. There's reference to it, I think, briefly in paragraph 9.1 where there's discussion about "cover-ups". So, I thought, gleefully, I may say, that I would find the answer in paragraphs 13.11 and 13.12. Unfortunately, I don't. All that's said in 13.11-- There's a discussion of the CNR; there's a claim in the third line that NHSGGC hasn't changed its position.

I'm not sure whether that's a statement of the technically correct – in the sense that if the Board was never told, and thought it was accepted, and the Executive had a different view, that's not a Board view, that's an Executive view – or not, but I don't find anywhere there any explanation to indicate why it was, apparently, that there was a different view of the CNR which led to the view on the CNR which, as we know, was ultimately expressed. We've dealt with that very fully in our submissions and, in my respectful submission, we haven't had a reply.

THE CHAIR: Remind me, have we seen a Board minute dealing with the question as to whether the-- well, dealing with the CNR?

MR CONNAL: Not that's particularly helpful to us, no. I mean, we have the evidence of the chairman of the board----

THE CHAIR: Yes.

MR CONNAL: -- Professor Brown that said, "Well, as far as I was concerned, everything was accepted."

THE CHAIR: Mm-hmm. He was quite clear about that.

MR CONNAL: That, at least, was not what the then Chief Executive, Miss Grant, was saying, because she was asked any number of times, "Did you accept the infection link conclusions?" and gave a variety of answers.

THE CHAIR: Mm-hmm.

MR CONNAL: We've dealt with that very fully, indeed suggested-- I mean, we have gone so far as to suggest that if a decision was taken that the infection link was not accepted, but nevertheless the apology was made and patients and parents were told various things, that would be a very significant event. So, I had hoped that we might get the answer to that, but it appears not. So I apologise for going slightly out of order in the way I'm going through these submissions.

THE CHAIR: Well, you started this by saying you were going on a journey. Now, what was the purpose of this journey?

MR CONNAL: Well, the purpose of this journey is essentially-- and I'm not sure I'm very keen on adopting the

journey analogy, but nevertheless, I'll take that.

THE CHAIR: Well, if it is the wrong analogy fine, but you chose to do that.

MR CONNAL: Yes. The----

THE CHAIR: If it's the wrong analogy, fine, but----

MR CONNAL: The purpose of the journey was to try to illustrate that a clear statement of what the position of the then chief executive and senior officers of the Board was on the CNR at the time is not discussed in these submissions. Part of my reason for that – for raising it – is that a very significant potential criticism was made in submissions by Counsel to the Inquiry to the effect that if the position was that that was not accepted, then allowing the Board to think it was, allowing at least the chairman to think it was, allowing patients to think the apology was all-encompassing, and so on, could well have been misleading, to say the least.

Now, my Lord, if I can get off the journey and go back into the text. If I go, now, briefly to 4.3 in the submissions. I'm going to come back to 4.3 at a later stage, very briefly, but I just noticed that that paragraph, which contains the now-much-quoted acceptance by NHSGGC on the balance of probabilities that there's a causal connection between infections and the hospital, starts – and, in my respectful submission, perhaps slightly unfortunately starts – with "there is no definite link between infections and the water system". Now, it may simply be that that is an expression about scientific absolute certainty, and one should read it as no more significant than that but, no doubt, if my understanding is incorrect, I can be told.

THE CHAIR: Well, I have to confess, if it's not that-- In other words, if it is not saying – which, after all, is what the CNR said – that one cannot be absolutely definite in a scientific sense-- if it doesn't mean that, then I don't know what it does mean.

MR CONNAL: No, I suppose the position that we took was that, in circumstances where the second part of that paragraph – the acceptance on balance of probabilities – was clearly going to be of major interest, I just wondered why the paragraph started by emphasising the question of no definite link, but I can't take the point any further, my Lord.

What I can do is go to the next paragraph, 4.4, and ask this question. That paragraph says-- Sorry, I'm in the wrong paragraph. In 4.5:

> "[The Board] accepts that its previous criticisms of Dr Inkster and the 'whistleblowers' were neither helpful nor fair."

Question: when was that decided, because that also, I would suggest, is a significant change of position? Again, we don't quite know how that was reached, because-- I mean, it's not necessarily unfair to say, "Well, who was it that decided that the very critical approach adopted to the whistleblowers almost throughout this Inquiry, should be so adopted?" Presumably, it must have been the chief executive, Ms Grant, but I don't know. Somebody must have decided that, and now it's accepted that this was wrong – in fact, unfair.

THE CHAIR: Well, it doesn't say it's wrong.

MR CONNAL: No.

THE CHAIR: It says it's "neither helpful nor fair".

MR CONNAL: Well, it doesn't use the word "wrong" ----

THE CHAIR: It doesn't use the word "wrong".

MR CONNAL: -- but if the criticisms are not fair, then -- And I note the next sentence says--

THE CHAIR: In the context of an Inquiry, is the word "helpful" perhaps significant?

MR CONNAL: Well, it may be, my Lord, because the Inquiry can only proceed on the material placed before it, and if a party adopts an approach which it now accepts wasn't helpful, then that makes our task – your task – significant----

THE CHAIR: Does it not go a bit further? An Inquiry is obliged to respond to the material that is put before it.

MR CONNAL: Well, indeed, and that's why I mentioned the change of approach --

THE CHAIR: Mm-hmm.

MR CONNAL: -- because a particular approach has been adopted, and I suggest that must have been a deliberate approach; it must have been instructed by somebody. Now, at this stage, we're being told these criticisms were "neither helpful nor fair", and they are withdrawn, and indeed apologised for, and then there are other comments on whistleblowing.

My Lord, can I just move to one or two issues that might be focused more on the construction side of the project? In paragraph 5.11, there are a number of statements there: "a lack of appropriate inhouse expertise and of sufficiently rigorous scrutiny [and so on]". Then there's mention of the organisation Capita. Capita are not a core participant, but did give evidence, and it's suggested there that Capita were appointed named supervisors within the NEC3 contract. That is correct. It says:

"... and were responsible for checking and providing assurance to

NHSGGC that the building was delivered in line with the agreed contract."

Now, our position on that is that there was evidence from Mr Redmond of Capita – and for my Lord's notes, the bit I'm talking about is in our submissions at paragraph 1569 – that they were not called upon to carry out the assurance role, their instructions being phrased as "if called upon", and then as a series of things. Now, I don't – and the fault may be mine – recollect any contradiction to that statement. No one produced anything "calling upon them" to do that role. So, I question whether the statement in 5.11, if it intends to contradict that, is covered by the evidence.

My Lord, if I can move on, 6.9 contains some very helpful comments, for instance, that parties who have migrated into a new hospital shouldn't have to migrate out of them – whatever Mr Calderwood said; there "should not have been a need to decant a ... unit", and so on. It's just notable, perhaps, that, in 6.9, the Board don't pick up any question of any contribution by anyone from NHSGGC, specifying what was required or operating in the project team or any of these issues. They make very fair points, but they don't identify any issues which are directly related to their teams.

THE CHAIR: Sorry, can I just take a moment here? As you say:

"... it should not be the case that clinicians, and patients, moving from older hospitals should have lower quality facilities ..."

That seems uncontroversial.

"... to the ones they left which negatively impact on patient care."

Right. So, from the word "However" to the end of that paragraph seems entirely uncontroversial.

MR CONNAL: Well, indeed, and I welcome the acknowledgement.

THE CHAIR: Right. Do you know what the first two sentences mean:

"A design and build form of contract is a design process requiring the appropriate responsive resources at the required time to iteratively develop the design."

Well, I suppose that might be so.

MR CONNAL: Well, that might be so. I mean, I-- Then the next sentence----

THE CHAIR: And then, the next sentence --

MR CONNAL: -- talks about "failure to have adequate resources".

THE CHAIR:

"... failure to have adequate resources available at key stages meant not everything that was requested could be provided."

MR CONNAL: Well, I'm not sure I follow that. I mean, I took the first sentence to be probably a pointer towards the fact that, when matters were being designed, neither the project team nor anyone assisting them was in a position to pick up and develop some of the questions and queries which might otherwise have arisen over the specification of different areas.

Now, here it's expressed as "resources". I'm not sure it's ever been a question of, you know, "Was there enough money in the pot?", but I think that's probably what that is a hint to, and perhaps I'm simply pointing out that there's no real acknowledgement of any failings on the part of anyone in the Board in these areas.

THE CHAIR: It's not really any detail.

MR CONNAL: No. No, it--

THE CHAIR: Right.

MR CONNAL: Sorry----

THE CHAIR: (Inaudible 10:45:08), Mr Connal.

MR CONNAL: If I can go to paragraph starting at 6.12, running into 6.13, 6.14. I needn't go through these, but my Lord will remember a number of the NHSGGC witnesses were reluctant to accept there was really any problem, or any problem they were aware of or should have been in existence, about resourcing, but one will find in .12, .13 and .14 of this section broad acceptance, as I understand it, by the Board that things were not done as they should have been done in terms of resourcing and response to requests for resources, and I welcome that.

THE CHAIR: The paragraph offers an obvious example, the-- I think it's an obvious example to illustrate the hospital opened too soon. Am I right in thinking that the Multiplex position on the absence of HEPA filters in the filtered casings, the explanation for that is that they were told to omit them, or as is my recollection faulty?

MR CONNAL: That is an interesting section because, as I understand it, the Multiplex position is that the specification produced by their ventilation designers simply provided for the casings; that's what they provided. However, it's also fair to note that when the context of the absent filters was discussed with them very urgently, shortly after the hospital was handed over, no one seems to have taken a contractual point and declined to provide and supply the filters. There was some challenge about getting them very quickly, but it was done.

THE CHAIR: Mm-hmm.

MR CONNAL: So whatever their position may have been on the contract,

they don't seem to have stood on that point on the day.

THE CHAIR: My point is a very minor one. It's just that I wonder if that's the most obvious example.

MR CONNAL: Well, I would suggest not, my Lord. There are some very general acceptances of failures on the part of the Board in these paragraphs, and my suggestion is that these have rather wider implications than simply the HEPA filters. I mean, one gets to the end of that section, and it almost ends with a section, "They did not resource or manage the project properly." You can't get much more general than that. They ought to have done.

My Lord, moving on, I got a little puzzled, I have to say, about the phases that were set out in these submissions. We have Phase 1, "Pre-2015 before hand over," "2015 to 2025," and then Phase 3, which appears on page 14 of the submissions, "Phase 3 - 2025 onwards." Now, I confess, having read the submissions, I'm not entirely clear why 2025 onwards is a phase at all, but I suppose it comes back to this question that I raised earlier, "When did the Board decide to change direction, and how do we know?" and indeed, "Has anyone ever discussed why the previous direction was unsatisfactory?" I haven't seen anything, but, again, maybe I'm not looking in the right place. So just a general point there.

My Lord, can I touch on section 7, which is whistleblowing?

THE CHAIR: Right. I mean, just to follow this, the-- What the Inquiry is being offered in paragraph 6.7 is looking at three time periods, and I suppose contrasting-- in the first two of the time periods, commenting, I think broadly speaking, critically on GGC's performance and contrasting that with the future.

MR CONNAL: Yes, right, but of course we need to bear in mind that the apparent change of position of NHSGGC on a variety of issues – change of tone and everything else – only really first emerged in the oral evidence of Professor Gardner, which is very late on in this process.

My Lord, others will want to say things about whistleblowers, which starts at 7.1. I only have a few comments. The inference from this general section is that, "Well, things were very difficult and unprecedented and challenging," and so on and so forth, and that is somehow offered as an explanation. My submission is this: that being under pressure in difficult circumstances might be precisely when it is important to treat whistleblowers properly, because when difficulties arise, that's when people are likely to be taking these steps.

Also, just to say, and I'll come back to this, that if the approach until very recently by NHSGGC to the whistleblowers is not acceptable, it's not clear to me why those who didn't treat them acceptably cannot be properly criticised.

Now, the answer to that seems to be near the end of 7.1, that nobody should be criticised, and they are all experts in their field dealing with serious and unprecedented situations. Well, I've dealt with the serious and unprecedented situations, and I suggest that expertise is not really the issue here at all. If people haven't behaved properly, as they ought to have done, surely it is right that they should be criticised.

The other slightly surprising feature, given what the Inquiry now knows about whistleblowing as an issue in public service, is that 7.4, near the foot of page 15, seems to be part of the excuse for the Board's behaviour, that whistleblowing was in its infancy within NHSGGC. Now, that struck me as a slightly odd excuse to proffer. Issues over the treatment of whistleblowers have been around for some time.

THE CHAIR: I was a little puzzled by that, because I think there's a GGC policy document, or framework document, dated in 2013.

MR CONNAL: Well, indeed. There have been other iterations of the-- but it doesn't----

THE CHAIR: It's not as if it's-- Well, anyway.

MR CONNAL: It's not a new topic, and all I'm suggesting is that it's precisely when you get the approaches that were adopted to Drs Peters and Inkster in 2015, and Dr Redding in 2017-- and they were raising questions, they weren't getting these questions dealt with-- that's when you get the issues arising. So to say, "Oh, well, the first NHS Scotland whistleblowing standards were only introduced in April 2021," doesn't really answer the question. Beyond that, I'll leave whistleblowing. Others will talk about that, no doubt. I do note – and my Lord will have read in paragraph 8.1, page 16 – that points raised by Sir Robert Francis in his report to the Inquiry, both as principal and also with application of NHSGGC, are accepted, so there's no challenge there.

The Board turns again to no deliberate concealment of information, and I've largely dealt with that, and I've dealt with the example of the approach to the CNR earlier, so I won't repeat that. I'll move to a different topic, paragraph 10, "Relationship with ARHAI." Now, it says in paragraph 10.1:

"The relationships between NHSGGC IPCT and ARHAI became

challenging ..."

Question: why? What was done or not done that should have been done? We don't know, and that is an area where there's been a lot of work to try to make progress, but unless we have acceptance and identification of things that were not done properly, it may be more difficult to be confident in the future, given the now infamous SBAR that Professor Gardner sent without comment in the not-that-recent past----

THE CHAIR: Well, bear in mind we have a broader audience, some of whom are very well informed, some of whom will be less well informed. Now, that's a reference the SBAR dated, I think, in November 2024 in the name of the Infection Prevention----

MR CONNAL: Control team, which made a series of criticisms of various people, including experts instructed by this Inquiry, and suggested they were sensationalising points and so on and so forth. That was sent by the chief executive to, if I-- I think I'm right saying the Scottish Government, or-- I don't know.

THE CHAIR: Ms Lamb.

MR CONNAL: Yes, Ms Lamb of the Scottish Government, and it was sent without any comment, although, in oral evidence, Professor Gardner said, "Oh, well, [she] didn't think the tone or content was appropriate," and clearly had forgotten to mention that when she sent that on. But I simply make the point that unless there's some acknowledgement of what was done incorrectly, it's perhaps more difficult to be as confident as we would like to be that this relationship will in fact move forward.

THE CHAIR: Well, I was going to ask you, what is the point you make? The Infection Prevention and Control team expressed their views in this document----

MR CONNAL: The chief executive says----

THE CHAIR: -- last November.

MR CONNAL: -- it was inappropriate.

THE CHAIR: Chief executive says it was an inappropriate way of expressing things. Now, what do you take from that?

MR CONNAL: Well, from time to time, we've been dealing with people who are no longer in post. We're not dealing with that here. You have an existing team. A number of the senior people involved in Infection Prevention and Control are still in post at NHSGGC and expressed these unguarded – perhaps I might be polite – views in that SBAR. So, you have a chief executive that said that wasn't appropriate, either in tone or content. So you then have quite a challenging situation.

Now, I'm not suggesting that ARHAI and the Board are not going to make efforts to deal with this, but unless one openly acknowledges what was wrong, one might find it more difficult to actually get to the final positive result in that relationship. This submission simply says, "Well, relations became challenging."

THE CHAIR: Right, but in fairness to Professor Gardner, she recognises that that should not have been said----

MR CONNAL: Yes.

THE CHAIR: -- and she also gave a fair bit of evidence of the work that she hopes will be done to ensure that people get on better.

MR CONNAL: Yes. Yes, she does. I don't dispute that. My Lord, only a few more points about the Board's position, hopefully. Paragraph 11 is headed, "The hospital is safe." All I say here is two things: first of all, I acknowledge that the position adopted by Counsel to the Inquiry on the use of the term "safety" has developed as the Inquiry has progressed. I need say no more about that. It's dealt with very fully.

But we've made a number of suggestions for recommendations and I'll just instance, for my Lord's notes, those in paragraphs 1888 and 1889 of our closing submissions, which focus on what should be in the full business case, filling

of water and so on and so forth, and no one has challenged these. So, we acknowledge that the position has moved on.

THE CHAIR: Right, so you're referring me to the Glasgow 4 Closing Statement and paragraphs 188 and 189?

MR CONNAL: 1888. 1888 and 1889.

THE CHAIR: Sorry, 1888?

MR CONNAL: Correct.

THE CHAIR: And 1889?

MR CONNAL: Correct.

THE CHAIR: Thank you.

MR CONNAL: Let me go to another paragraph, "Changing Governance", paragraph 12.2. In and of itself it's an interesting paragraph: witnesses thought responsibility lay elsewhere, no one took responsibility, and so on. Pretty damning criticism.

But one of the notable things about the Board's position is that all of the failures that they accept, all of the things that were not done that should have been done, or not done properly, or done inappropriately, or no instance of bad behaviour, appears to have been done by any individual at all. No one is criticised. It's all just, "Well, people were doing their best in good faith." In my respectful submission, that is close to being an untenable position.

These submissions we're looking at

at the moment are replete with apologies for things that weren't done properly or not done at all. These things were all the responsibility of individuals. It rather reminds me, my Lord, of the almost comical exchanges early on in the Inquiry where people said, "Well, who told you this incorrect information about validation?" And the answer came, "The Project team". "Well, yes, but it must have been an individual who told you that information which was incorrect," and people were very reluctant to identify individuals.

Just as a general comment on these submissions, it's our position that adopting a line under which no one is responsible for anything is not a tenable approach given what we're being told.

THE CHAIR: I wonder if I can be more specific. On this issue of attribution of personal responsibility, can we look at paragraph 3.7 of the GGC's closing statement?

MR CONNAL: 3.7, my Lord?

THE CHAIR: 3 .7.

MR CONNAL: Yes.

THE CHAIR: The full paragraph is:

> "QEUH/RHC is a critically important hospital in Scotland and in the United Kingdom. It is essential that patients, families and the public can have full confidence in it. There is considerable public interest in the report and recommendations of this Inquiry. Public perception of QEUH/RHC has undoubtedly been negatively influenced by the incidents that have been investigated by the Inquiry."

Now, it's the last two sentences that I'm particularly interested in your comment on:

> "It is critical that the public can see, through the work of the Inquiry, that people have been held to account. Where criticism is due, it is right that it be made robustly."

Now, what's your comment on that?

MR CONNAL: Well, I have two comments. Firstly, that insofar as the phrase "hold to account" was examined during oral evidence in the Inquiry, it was difficult to ascertain any real content to it. It seemed to be somebody might be spoken to, but that was about the sum and substance of it. So the phrase in itself may be misleading. The public might think that "holding to account" means "where appropriate". I stress "where appropriate". There may be consequences if there is a failure, a significant failure, something done inappropriately. So I don't place great credence in the phrase "hold to account".

But even if I leave that aside, the implication of these sentences is that it ought to be possible to identify and

criticise those who contributed to failures. The general impression I have from the remainder of the submission is that, at least wearing the NHSGGC hat, there is a reluctance to do that because everybody was behaving in good faith. I'm not even sure "good faith" is the right phrase.

THE CHAIR: Well, I may come to your reluctance point, but if we just look at these two sentences:

> "It is critical that the public can see, through the work of the Inquiry, that people have been held to account. Where criticism is due, it is right that it be made robustly."

Now, do you agree with it?

MR CONNAL: Yes.

THE CHAIR: Right.

MR CONNAL: Yes, I do. The point is that if you say-- Let me take an example. If you say the Project team didn't do something very well, that doesn't really tell the public anything very much, because they say, "Well, who are they? Was it one person or more people? Was it a committee decision? What was it?" So, I would agree that the public ought to see that, if there is failure, if things have not been done, that people – and by that I assume is meant individual people, not a collective responsibility – have been held to account.

Now it may be that the Board says, "Well, we're taking all the blame on our shoulders. We're the collective, and you can blame us collectively," and that I suspect is the broad line that appears in these submissions, but I don't disagree with the proposition that people should be held to account.

THE CHAIR: Can I take you to paragraph 7.1?

MR CONNAL: My Lord.

THE CHAIR: You, I think, have already looked at this.

MR CONNAL: Yes.

THE CHAIR: Taking up the paragraph beginning:

> "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."

Now, these individuals are named in 7.1.

MR CONNAL: Yes.

THE CHAIR: Now, do you see any tension between what is said in that sentence and what we've looked at in paragraph 3.7?

MR CONNAL: Well, I do, because if there is-- I mean, particularly against a background where there is now a general acceptance that the treatment of the whistleblowers was unfair. If there is appropriate criticism of someone who

participated in that process, then in my submission there's nothing wrong with challenging them over that.

I think the point that I was making about that paragraph is the fact that there were tensions, far from being an excuse should not be treated as one at all. And secondly, it's nothing to do with the expertise of these individuals, because we're talking about treatment of whistleblowers. It's not whether they have expertise in some topic.

So I do see a tension, but I return to my general theme that the line taken in these submissions seems to be to say nobody can be blamed for anything, or ought to be blamed for anything. Yes, people should be held to account, but actually when we pick them all up, we say "Don't do it".

(After a pause) And if one even just reads the start of the next paragraph 7.2, my Lord, just to go to where my Lord was:

> "… NHSGGC's treatment of the whistleblowers fell far below the standard expected. They were not adequately supported. They were not treated as they ought to have been."

Now, if they were not treated as they ought to have been, that must have been by somebody. (After a pause) I think otherwise I'm likely to reiterate things I've said earlier, my Lord.

A little peculiarity, my Lord, if I can just identify it. 12.3, page 20, this is under the general section about governance. The issue is the issue of the Board basically being ill-equipped to handle a process. 12.3:

> "The issue was particularly acute when it came to receiving advice on design of the hospital. There was little expertise within the board …"

Well, that might suggest, "go get some".

> "The board was accepting of what it was told during the design and construction phase. It was reliant on the Technical team …"

Now, those who have not watched the entirety of this Inquiry will be aware that a debate arose about the use of the phrase "the Technical team" because there was at one point what was described as a "shadow team of sub-consultants" covering a variety of areas of expertise, including ventilation, and they were, as a matter of deliberate choice, stood down early in 2010, if I'm remembering correctly.

THE CHAIR: Well, the contract was signed on 18 December 2009, and Currie & Brown, who prior to that date had managed a team of sub-consultants where their duties were significantly

limited, from about-- Is it January, February, March?

MR CONNAL: January/February 2010.

THE CHAIR: Of 2010?

MR CONNAL: Yes. I think that the decision was communicated through the appropriate chain in and around that time. So during the design and construction phase, or at least most of it, so after early 2010, the Technical team, as I think is suggested by other submissions that you have, my Lord, basically, as previously understood, that team did not exist.

THE CHAIR: This is really a question for others, but there's maybe just a little ambiguity as to what is meant by "the Board". What do you understand? I mean, is it the Board as represented by the Project team, or is it the members of the Health Board?

MR CONNAL: Well, I think it's used possibly in more than one sense because this paragraph starts by saying:

> "There was little expertise within the board to cope with a project of this magnitude."

Now, that could apply to the Board collectively, for reasons we've discussed, but also to the Project team.

THE CHAIR: Well, wait a minute. When you use the words "the Board collectively", are you meaning the 40,000 employees of Greater Glasgow Health Board?

MR CONNAL: No, I'm meaning the Board in the sense of the corporate group which runs the NHSGGC, the Statutory Board, as it were.

THE CHAIR: Yes, I mean the people on the Health Board?

MR CONNAL: On the Health Board, yes. So, "little expertise... to cope with a project of this magnitude" could apply to the Health Board, the people on the Health Board, for reasons we've heard about, but it could also apply to those in the project team because, as my Lord will have heard, many witnesses talked about, "Oh, this was a matter for the Board; this would be approved by the Board; somebody in the Board approved it," when they actually meant a representative, usually of the project team.

Then:

> "The Board was accepting of what it was told during the design and construction phase."

Mainly, that must be the project team, I think, because the statutory Board wasn't told very much.

THE CHAIR: Mm-hmm.

MR CONNAL: I'm not sure I can sub-analyse that----

THE CHAIR: No. I mean----

MR CONNAL: -- too much.

THE CHAIR: -- it's not really a

matter for you, but the Board was poorly advised, but lacked the expertise to challenge that advice, and the Board is now in an entirely different place. Does that help or not?

MR CONNAL: Well, I still think it relates to a number of different uses of "the Board" in evidence. It just strikes me as slightly odd that we started this conversation by saying the Board was reliant on the Technical team, when we've had endless discussions about how the originally named technical team, i.e. the sub-consultants appointed by Currie & Brown were, in the main, not in play after early 2010.

Now, my Lord, just looking, briefly, on the same page, 12.5, 12.6, two things, just so we're clear. 12.5 talks about being in line with the NHS Scotland Blueprint for Good Governance, and my Lord will recall that that was actually co-authored by Professor Brown, who of course was in the chair.

THE CHAIR: Sorry, my fault entirely-- Yes, we're now on 12.5.

MR CONNAL: 12.5, yes.

THE CHAIR: All right.

MR CONNAL: That blueprint was, I think, co-authored by Professor Brown, who was actually in the chair during at least some of the difficulties that we have discussed in this Inquiry. So, how valuable it is to, you know, rely on that as

part of the explanation for change, I'm not entirely sure but, more significantly, these issues – all the blueprint, and so on and so forth – all predate two things: first of all, Professor Gardner's witness statement to this Inquiry, which was 25 September 2025, in which no indication of a change of position was recorded and, secondly then, her oral evidence on 9 October 2025, which did indicate change. Now----

THE CHAIR: Right. I think you're moving between two points here----

MR CONNAL: I am.

THE CHAIR: -- Mr Connal. First of all, let's start with the paragraph:

> "The Board and its Standing Committees have clearly defined and documented roles and responsibilities. In line with the NHS Scotland Blueprint for Good Governance, NHSGGC has an integrated approach to governance across clinical areas, performance management, staff."

Now, the reference to the "Blueprint" is a document which I think is in two editions, or rather the original edition has been revised. Although it's a document directed not simply at Greater Glasgow Health Board, it happens to have been authored by Professor Brown, who has a particular expertise in this area. Now, can you remember the date of the original

document? I think it may be 2017, but I may be wrong. If you can't, it won't---

MR CONNAL: I can't just immediately recollect.

THE CHAIR: Right.

MR CONNAL: I think I was making no more point about that than, these statements are no doubt correct, but where do they take us in being assured that the position of the Board, which was heading in a particular direction until Professor Gardner spoke, has changed.

THE CHAIR: Right. Now that's the second point that I think you were making----

MR CONNAL: The first point is----

THE CHAIR: -- which is specific to what one sees on one hand – or, at least, I think this is what you're saying to me – in Professor Gardner's witness statement dating from August of last year?

MR CONNAL: September, my Lord. 25 September.

THE CHAIR: 25 September 2025.

MR CONNAL: 25 September was a witness statement which showed no indication of a change of position on anything. It contained some very general material. Most of the material that we'd been discussing actually emerged for the first time in her oral evidence on 9 October. My points – they're only twofold: firstly, I question what value reliance on the Blueprint has, since it was

around for some time during the difficulties and the acknowledged failings that we've been discussing and, secondly and perhaps more significantly, these paragraphs appear to be designed to support the proposition of change, but all of these things were in place well before Professor Gardner came here and told us of the bright new world that she was promising. It rather looks as if they're trying to say, "Oh, well, if you go back, you can find X, Y, and Z to support that," but if it was there, it didn't seem to have had any impact.

THE CHAIR: Right. Now – and one can check this proposition – Professor Gardner provided a witness statement which, as I recollect, she will have authored.

MR CONNAL: Yes.

THE CHAIR: I mean, is that right?

MR CONNAL: Well, one assumes so.

THE CHAIR: I mean, as opposed to something the Inquiry produced.

MR CONNAL: Correct.

THE CHAIR: Now, you say the date of that was-- Did you say 23 September?

MR CONNAL: My note says 25 September.

THE CHAIR: 25 September. Now Professor Gardner gave evidence on 9 October----

MR CONNAL: Correct.

THE CHAIR: -- so you are pointing to the possibility of-- what?

MR CONNAL: Well, if I go back-- I mean, there was originally a question as to whether Professor Gardner was going to give evidence at all. That was then arranged. A witness statement was requested and produced. That witness statement-- I forget all of the contents, but it contained various material, but nothing indicating any significant change of position – on anything – by the Board. So, whether one wants to describe it as anodyne, but certainly not critical. Then, on 9 October, we got, for the first time, material about changing of position.

So, the question is, when did that change happen? Now, on the face of it, if the intent was to help the Inquiry, one would have expected, if there was a change, to see it mentioned in the witness statement because, broadly speaking, subject to questions, the witness statements might be expected to cover the things the witness wants to say. So, is the change something which happened between 25 September and 9 October? It doesn't seem to be something that arises earlier. If I can, I'll leave that point, my Lord.

A few more. 13.8 – I simply note this, given that it's controversial in some other submissions, I'm assuming it's quoted for a reason – says:

> "Dr Agrawal [who my Lord will remember was one of the HAD experts] accepted that conformity with SHTM 03-01 [i.e. the Scottish guidance on hospital ventilation] can reduce airborne transmission in line with the Inquiry panel."

I simply note that that's an acceptance that appears in this submission, presumably advisedly, and it's helpful because it accords with the line that Counsel to the Inquiry take. However, when we come to 13.9, just immediately following that, which deals with the instruction of these experts by NHSGGC, my Lord will see the second sentence, "The purpose of the HAD report is to assist the Inquiry ..."

Well, one could get into endless argument about that, but I'll not do so. Then it says:

> "... and provide detail on the wider management of infection risk".

Now, what I suggest is that, if my Lord looks, in due course, at the letters of instruction sent by NHSGGC to these experts, suggesting that details of wider management of infection risk was the topic on which they were to assist is not correct. In fact, they were given very little information about wider management of infection risk.

THE CHAIR: Sorry. Your point is

that the letter of instruction doesn't mention management of infection risk?

MR CONNAL: It doesn't seem to be the aim of the report at all.

THE CHAIR: Well, does it mention it?

MR CONNAL: Not that I can recall, my Lord. The point, just while I have it in my head-- I promised to return to 4.3, and this may be important. 4.3 was the paragraph in which the Board accepted, on the balance of probabilities, there's a causal connection between infections and hospital environment. The question is, over what period is that accepted?

THE CHAIR: Well, there seems to be a disconnect between paragraph 4.2 and paragraph 4.3.

MR CONNAL: Yes. I mean, perhaps wrongly, I had assumed on first reading that the acceptance of infection risk – infection link – covered the period from, let's say, 2016 through until 2019, perhaps 2020, which appears to be what 4.2 says, but there are indications that 2018 is the end date to which the concession applies.

THE CHAIR: Is there any explanation why 2018 appears in paragraph 4.3?

MR CONNAL: No. It may simply be that I'm not reading these paragraphs correctly, but if it was the case that the Board was restricting its concession to a period between 2016 and 2018, then I suspect my Lord would need to know why that was and on what basis.

THE CHAIR: Yes, it's obviously an important paragraph.

MR CONNAL: Because, you know, it specifically says-- Just so those watching are aware of what this says, in paragraph 4.3 it says:

> "NHSGGC accepts ... that it is more likely than not that a material proportion of the additional environmentally relevant [infections] in the paediatric haemato-oncology population between 2016 and 2018 had a connection to the state of the hospital water system."

If that is the case, then I suspect it would be helpful to know the evidential basis for that potentially important restriction.

My Lord, 13.11 makes a statement:

> "The [Case Note Review] did not consider other infection mitigations ..."

Now, we know that the Case Note Review team had the entire patient journey, cleaning records, water and environment testing. I wonder whether that is a fair statement.

THE CHAIR: Well, just-- Sorry, which paragraph were you looking at?

MR CONNAL: 13.11. It's just a question of whether it's fair to criticise the

CNR for not considering other infection mitigations, given the whole of the material that that body had.

THE CHAIR: Well, the CNR did a number of things, but what we're talking about at the moment is the consideration of the 86 paediatric cases, and the CNR was specifically tasked with four questions, three of which, essentially-- the first three essentially were whether they could identify a link between the physical environment and the particular group of cases that had been identified for them. Now, what does infection mitigation have to do with that?

MR CONNAL: Well, I'm not sure, except it sounds like a criticism.

THE CHAIR: Oh, it clearly sounds like a criticism----

MR CONNAL: That criticism----

THE CHAIR: -- but can you give it any content of meaning?

MR CONNAL: Well, given what we were told about the steps that the CNR body took to find out about, if you like, the patient journey and everything relating to it, and all the information that they had, I don't know what it's referring to, if it is a criticism.

THE CHAIR: Well----

MR CONNAL: It's simply because we're now in a situation where the Board broadly accepts what the CNR broadly accepted, probably, which is an infection link. I'm not quite sure what the point being made here is. Just to finish that section, in the next paragraph, there's the statement:

> "If the instruction of the HAD authors to comment on the CNR has caused patients or families any upset then that is a matter of extreme regret. That was not the intention."

I suppose my comment there is that, given the apology that patients received after the CNR report was issued indicating probable and possible links to the environment, it's perhaps disappointing that we don't have any acknowledgment here that any decision to challenge, to take a different view, was not communicated-- I don't think was ever communicated to patients and parents until they found it mentioned in papers in this Inquiry.

My Lord, the next section deals with communications. That's a very well-trodden path, and I don't particularly want to re-walk it. This is another attempt, I suggest, by NHSGGC to set a test and then say the test is not met. It's linked to their previous statement, "There was no cover-up." Well, "cover-up" suggests an organised and definite attempt to hide things, perhaps by an organisation, but that's not a phrase that, I don't think, Counsel to the Inquiry have used, but Counsel to the Inquiry have suggested

that, at various points, statements were made which were not accurate, and known to be not accurate.

I would suggest this, my Lord, to try and get closer to the heart of it: in paragraph 14.3, in the middle of that paragraph, the Board says that its communication style was at times defensive – now, "defensive" means defensive of its position – "defensive," and, "this approach was unhelpful."

That's not much of a jump from that to a more popular phrase, which is "spin", designed to put the Board in the best light in the circumstances. It's a matter of disappointment that that's not now accepted. I don't want to go back over matters that have been discussed endlessly previously, but my Lord will remember what was being done in Ward 2A as an opportunity for an upgrade.

Now, that's nothing more, in my respectful submission, than a phrase deliberately selected for image reasons. This is not saying that, "This has had to be ripped apart because it wasn't built properly for whatever reason." This is, "Oh, well, we're taking the opportunity to upgrade the ventilation," and that point-- before you get to the question of whether anyone has been misled about the position on the CNR, or the change of position on the CNR, or indeed the new position on the CNR, all of which have changed.

My Lord, I'm coming to my conclusion on the Board. It might be sensible for us to finish that, if I may, before----

THE CHAIR: Yes----

MR CONNAL: -- we arise----

THE CHAIR: Yes, there is a sort of legitimate expectation of coffee.

MR CONNAL: Indeed so, and I wouldn't want to disappoint anyone's legitimate expectations, lest I get detailed submissions from someone, perhaps on the Government side, about what the definition of "legitimate expectation" is, but I'm close to finishing what I want to say----

THE CHAIR: Right.

MR CONNAL: -- about GGC, and I might just do that briefly, if I may, my Lord. If I go to paragraph 15.2, under the heading of, "Looking Forward," what I say is this: that lots of the participants in this Inquiry are going to be looking for real, concrete evidence that things have changed, and they will be reluctant, I suspect, to accept that any paper produced by Professor Gardner, however well-intentioned, amounts to concrete evidence that anything will actually change, or has actually changed.

Now, I've dealt with the fact that we don't much material to show where this change came from, what the debate was

about it, or anything else, but part of the concern is not eased, I have to say, my Lord, by the fact that the Board has recently written, as my Lord is certainly aware, to Dr Peters, Dr Inkster, and----

THE CHAIR: Sorry, you said the Board has written to----?

MR CONNAL: Yes. Well, I take it these are letters instructed----

THE CHAIR: Well, these-- you're referring to three letters----

MR CONNAL: Letters from Professor Gardner.

THE CHAIR: -- signed by Professor Gardner.

MR CONNAL: Yes, yes, signed by her as chief executive of the Board. So, Professor Gardner has written to Dr Peters, Dr Redding and Dr Inkster just very, very recently –13 January, I think in all cases – suggesting a meeting.

Now, I think it's probably for others than me to comment in any detail on these letters, but my first reaction to them was that they read a little like the kind of letter that one's Human Resources department might have drafted when somebody needs to be brought in for a "little chat with the boss", and they can bring a friend if they want----

THE CHAIR: Well, with respect, Mr Connal, am I going to be assisted by your impression of a letter, which I think I'll be given an opportunity to read?

MR CONNAL: The main point, my Lord, is there are some things don't appear in this letter. The most important one is the word, "apology." There's an offer of a meeting to discuss various things but, given where we are now, on 13 January, to write to these participants whose treatment is now accepted to have been inappropriate without even mentioning apology, an acknowledgement of failure, or even an offer to listen to them rather than enter a wider discussion, may not be a helpful indication of where we're going.

Now, perhaps my understanding of these letters is incorrect, but I suspect those acting for the recipients will want to address you on them in any event.

THE CHAIR: Well, I don't recollect Professor Gardner using the word, "apology," in her evidence.

MR CONNAL: I think she probably apologised, but-- If I remember rightly, my Lord, I think she apologised in her evidence, but said it couldn't be a Board apology because the apology hadn't been approved by the Board as a collective, but that was purely my recollection.

THE CHAIR: I think she said she was sorry.

MR CONNAL: Well----

THE CHAIR: "I'm sorry that individuals did not feel listened to by the organisation, or were treated in a way

that allowed them to feel empowered to be able to be harnessed into a solution, and were not afforded that opportunity."

MR CONNAL: Well, I may be wrong in paraphrasing that as an attempt to make an apology by somebody who is accustomed to using management speak. The word, "sorry," is at least an indication that that was the intention.

THE CHAIR: Right. So, I'd be wrong to have been listening to Professor Gardner, understood her as someone who only came into post in February of 2025, as being unable to apologise-- I mean, she said in terms that she didn't feel able to apologise on behalf of the Board, and one can understand that, so I would be wrong to interpret that as just an expression of regret that these things happened?

MR CONNAL: I think it can be interpreted in a variety of ways, but it can equally be interpreted as a statement by somebody who hasn't gone through the processes that she may think are necessary before she, as a spokesperson, can give a formal apology.

THE CHAIR: Mm-hmm.

MR CONNAL: Maybe we find the formal apology in the submissions that we've been looking it, but certainly letters suggesting a meeting don't mention an apology.

Also, oddly enough, all these three letters – bearing in mind that Dr Peters is still in employment, Dr Redding has retired, and Dr Inkster is now employed by somebody else – they're all written in exactly the same terms, which is slightly odd. Anyway, I'll leave that for others to deal with. I've really nothing much more to say. There's a recommendation from NHSGGC, which I simply note in paragraph 16.2. 16.5 talks about----

THE CHAIR: Now, help me with this: my recollection is that there was reference to a-- what I understood to be a reporting template which----

MR CONNAL: Yes.

THE CHAIR: -- has been adopted by GGC recently, and my understanding is that that recommendation is for a more general adoption of the template. Now, my recollection, which may be wrong, was that I asked Professor Gardner if we could get more detail about that? Now, has that----

MR CONNAL: I don't believe----

THE CHAIR: -- arrived, to your knowledge?

MR CONNAL: I don't think so, but----

THE CHAIR: All right, okay.

MR CONNAL: -- my understanding may be faulty on that.

THE CHAIR: No doubt it will be provided.

MR CONNAL: Yes, but my Lord is

right. The recommendation is essentially that the Board has produced a new form of reporting on various things and suggested that all boards should do that----

THE CHAIR: Yes.

MR CONNAL: -- and I have nothing myself to add which is of any value. 16.5 is a recommendation for facilitated discussion and mediation during whistleblowing. The only comment I make on that is that I worry a little about whether this is driving back to the point that the whistleblowers objected to, which was focusing on personal relationship-building rather than what is the substantive point we're trying make and what are you doing about it?

Really, I finish, my Lord, just by saying this. I've said that many people involved in the Inquiry will want to be convinced that change has happened. One of the ways of assisting the understanding of what is happening might be to explain to us who decided on the change, what discussion took place, debate, perhaps, and how it was all done, and whether the whole Board participated in that. That might assist in public confidence that, at the very least, there has been a full discussion on the matter, we've looked at all the issues, and this is the conclusion. Beyond that, I have nothing further to add on NHSGGC.

THE CHAIR: Right, but you propose to make submissions in relation to other closing statements?

MR CONNAL: I do, my Lord. I have a little bit to say about a couple of the construction participants, if I can put it that way. I have much less to say, for a variety of reasons, not least of which is-- about some of the others, because in some cases I take the view that you might be best to read the submissions undistracted by anything I might add to them. So I have a little bit to say about Currie & Brown and TÜV and much less to say about anyone else.

THE CHAIR: Well, we have in the past taken a coffee break about this time. Can I ask people to be back for five past twelve?

(<u>Short break</u>)

THE CHAIR: Mr Connal.

MR CONNAL: My Lord, I'm going to leave NHSGGC now and turn to some of those involved in the construction process and start by dealing with Currie & Brown and TÜV SÜD, who are, for most of our purposes, Wallace Whittle and ZBP.

The first thing to say is that each of these participants advance arguments in their closing statements which are not in line with those made by us, Counsel to

the Inquiry. That's not necessarily unexpected, but we don't propose to depart from our position as set out in our submissions.

The other point to make is that these parties paint conflicting pictures about ventilation design. Now, I'm paraphrasing slightly but, at the one end, one has an argument that ventilation design is solely down to ZBP, the specialist designers – it's their job; they have to design it; they have to get it right – and, at the other extreme, a view that the Board, NHSGGC, had to specify every detail, and any detail not so specified would simply not be delivered. So, you have two very different views of how the ventilation design of a project like this should proceed.

Our position is that, while we acknowledge – and we cover this in our submissions – that a clinical output specification should be as helpful as possible, we suggest that an approach nearer to that proposed by the lead consultant and architect, Emma White, should be adopted. In other words, recognising that a clinical output specification is likely to be a variable content document, depending on who prepared it, what their expertise is and so on, and it is then for the specialist designer, using their skill and expertise and referring to guidance, to design what is required.

THE CHAIR: Just help me with this. You've introduced the notion of conflicting pictures in relation to ventilation design. Is that specific to this contract or are you making a more general statement?

MR CONNAL: It can only be specific to this contract----

THE CHAIR: Right.

MR CONNAL: -- because the submissions that parties make relate to this particular contract.

THE CHAIR: Right. Now, I have to be conscious that it's no part of my function to interpret the contract, but you're providing me with your understanding of the contract in order to give me a context----

MR CONNAL: And the way in which --

THE CHAIR: -- in which to consider what else you have to say.

MR CONNAL: Yes. The way in which I suggest the contract should have operated, and I do suggest that the approach that we adopt broadly accords with evidence given by Mr Pardy of ZBP. I just give you examples of that from our submissions at paragraphs 437 and 1556.

THE CHAIR: Right. Could you give me his paragraphs again----?

MR CONNAL: 4-3-7, four hundred and thirty----

THE CHAIR: 1037----

MR CONNAL: No, sorry.

THE CHAIR: No, my fault entirely.

MR CONNAL: Four hundred and thirty-seven, 4-3-7.

THE CHAIR: 437.

MR CONNAL: And 1556.

THE CHAIR: 1556, n the G4----

MR CONNAL: Submissions.

THE CHAIR: -- submissions.

MR CONNAL: Yes. Just to avoid going into it, my Lord will be aware that the submissions made by Counsel to the Inquiry maintain the view that providing air changes in accordance with the guidance in SHTM 03-01 does have a value which includes – I've used the word "safety" dilution for safety purposes. But that crops up from time to time, and I'd have to repeat it a lot.

THE CHAIR: Just give me that again. "Providing the air change rate according to"----

MR CONNAL: "SHTM 03-01 does have a value which includes safety."

THE CHAIR: I mean, you use the word, "have a value." Would "objective" be----

MR CONNAL: Yes----

THE CHAIR: I mean, that's----

MR CONNAL: Yes, yes.

THE CHAIR: Okay.

MR CONNAL: Now, the other thing I tried to do, my Lord, was to see whether I could provide a helpful analogy, because one of the issues that keeps cropping up is, "What function signing off drawings and documents is?" I confess, having made this effort, I'm not actually sure that making it has proved worthwhile, because, ultimately, there are contract provisions in this contract which say what they say.

The nearest I came to one – and I will offer it only for what little assistance it may have – is that imagine a knowledgeable client who wants a house built: he's had several houses built; he knows a bit about it; he – and I'm using "he"; I should say "he or she" – knows where he wants the rooms, that he wants doors that open onto the garden, so on and so forth; he instructs a builder; he/builder designs his house, but wants the client to sign off on the design, which the client then does. Fine.

What then happens if the wall of the house, which faces the weather, the prevailing wind, promptly leaks because the materials are not adequate to exclude the Scottish weather? The client does not plan to get a house which leaks, plus a right to sue somebody. He wanted a house that didn't leak and, arguably, the responsibility to provide that rested with the designer, even if the design was signed off. But the problem with that analogy and any other I could give, my

Lord, is that my Lord will say, “Yes, that’s right. But let’s look at what the provisions and the contracts say about how the design process was to operate,” and we have that in our submissions.

So, I don’t take that any further, which leads me to the submissions by Currie & Brown. Now, I should be able to move through these reasonably quickly. One of the topics dealt with is whether the definition of the areas to which-- what I’ll call the “ventilation derogation”, the provision to depart from the six air changes an hour in guidance, whether that area was clearly defined. We submit, “No.” My Lord should therefore be aware that in paragraph 7.1 of the submissions by Currie & Brown, they say that it was clear to what parts of the hospital that change should be applied. It’s just a difference of view which we don’t accept.

THE CHAIR: Well, Currie & Brown don’t seem to recognise it as being a difference of view. It’s common ground and a matter of record that the ventilation and derogation did not apply to isolation rooms or specialist wards.

MR CONNAL: Yes.

THE CHAIR: So there is a difference of view.

MR CONNAL: There is a difference of view. The difference simply, my Lord, is that we accept that by carrying out an exercise of looking at a number of different locations, it’s possible to come to a view as to where the derogation should be applied. But we have suggested in our submissions that, really, that should have been made simple and patent somewhere, rather than requiring that exercise to take place. Of course, as Currie & Brown go on to point out, the challenge is that the derogation was then in fact applied in areas which on their definition it should not have been applied to.

My Lord, there’s some discussion from time to time here and elsewhere on the status of SHTM 03-01.

THE CHAIR: Only if you have the reference, Counsel to the Inquiry’s position on that point is made in which paragraphs?

MR CONNAL: I’m afraid I don’t have a note of----

THE CHAIR: Very well.

MR CONNAL: -- that paragraph----

THE CHAIR: I mean, I can find it.

MR CONNAL: -- but, my Lord, there’s a section of the submission in which we deal with possible interpretations, we look at the different interpretations, and then we indicate what we think on balance is the correct one, and we suggest it would’ve been far easier if somebody had said, “Well, let’s just get it clear. Where are we applying

this? Where are we not applying it?" and written that down.

My Lord, again just to illustrate a point that's going to crop up in these documents repeatedly, in paragraph 16.2 of Currie & Brown's submissions, they say SHTM 03-01 is non-mandatory guidance. Now, my Lord, I don't want to get into the debate about whether it should be treated as effectively mandatory and so on, which has been had elsewhere and also by a number of the witnesses, but of course the point was that it was intended, at least prior to the contract signature, to be a compulsory document to follow. In fact, it still appeared in a list of documents of compulsory guidance, subject, of course, to what had been agreed. I'm simply illustrating that that debate is still live.

Now, the approach that is adopted by Currie & Brown leads them to the conclusion that the whole issue of the ventilation derogation is a red herring, and that's set out at paragraph 37. We do not agree, and we remind my Lord that the ZBP strategy paper which accompanied it was not, shall we say, "viewed favourably" by any of the witnesses of expertise who subsequently looked at, whether instructed by this Inquiry or by NHSGGC, and we still don't really know why it appeared at the very last minute.

THE CHAIR: All right. Just reflecting on paragraph 37. (Pause for reading) Now, I take it that is proceeding on the basis that the ventilation derogation had no application to specialist ventilation areas.

MR CONNAL: That must be the case, but essentially, my Lord, the Currie & Brown position is, "It was only guidance. There was nothing wrong from departing from it in the circumstances of the case. The air change rate is only for comfort, and there's no evidence that it's actually caused damage to patients," and these are set out in some detail on the preceding paragraphs.

THE CHAIR: But, at risk of repeating the question, the premise is that the derogation only related to general wards?

MR CONNAL: Yes.

THE CHAIR: Right.

MR CONNAL: Which of course brings up different questions as to what, "Were they all generals wards, or not?" but, in any event, that is the premise indeed.

In paragraph 50, Currie & Brown take issue with our description, or our criticism, of Mr Pardy for saying that the air change provision was unnecessary. Now, I don't have the paragraph reference, but it was put to Mr Pardy that that was perhaps an unfortunate phrase

to apply to a long-standing UK requirement for six air changes an hour in general rooms-- was to dismiss it as "unnecessary," and I thought he accepted that that was perhaps an unfortunate use of the word, but that was all that we were seeking to make with that point.

My Lord, the other issue that emerges in these submissions is of course the role of Currie & Brown, not only at the time when the contract discussions were taking place shortly before the contract was signed, but also more generally. There was a debate – My Lord will perhaps recall – as to whether Currie & Brown should have done a bit more than they actually did. I illustrate that by looking at paragraph 63, where the writer says:

> "Currie & Brown was entitled to assume [leave the bit in brackets] ... that Mr Seabourne and Mr Moir complied with their own internal reporting obligations (which were [outwith their] knowledge) ..."

Now, I make two points about that. First of all, it's been broadly accepted that making assumptions is a very risky thing to do in a construction project. Secondly, I say this: if you're assisting with project management, particularly in the context of a part of the process which is under pressure of time, is it really unreasonable to suggest that you should check-- not that you should do these things, but you should check they've been done as part of the job that you're doing?

THE CHAIR: I apologise if you've already told me this. The reference to, "entitled to assume," is addressing criticism of what, criticism of Currie & Brown?

MR CONNAL: Well, it's referring to, at that point, the question of who should have told someone further up the tree than Mr Seabourne about the derogation, and----

THE CHAIR: Right, simply the passing of the information----

MR CONNAL: Passing of the information, and the point I'm simply making-- It's probably best actually illustrated by a later paragraph. It's paragraphs 65 and 66. Now, my Lord will recall that there was at one point a statement in these contractual exchanges suggesting that IPC sign off was to be obtained. Now, just take that as a premise for the moment.

There is no suggestion from where I sit that it was then the job of Mr Hall or anyone in Currie & Brown to go away, find an IPC specialist, engage in exchanges and obtain that information, because he wouldn't necessarily know where to go. I agree to that extent. But if you're under this pressure of time and someone has said "IPC sign-off is

required", is it not part of the project manager's job to say, "Alan, remember you were to get IPC sign-off? Have you got that? Can I tick that box? Has it been done? Have you got it in writing?" Whatever the point is.

So this is where there's a debate, I think, as to whether the Currie & Brown approach of saying, "Anything to do with anyone else in GGC is nothing to do with us. We just stay well clear of that. We're only looking at the actual project itself."

THE CHAIR: We're looking at a few days in December of 2009?

MR CONNAL: Correct.

THE CHAIR: At that time, Currie & Brown are providing the fuller service?

MR CONNAL: Yes. Well, they continued to provide project management services after that date. What they don't do is provide the list of sub-consultants. I have to say, if one looks at paragraph 65 of the submissions, where it was suggested, I think, on our part that Currie & Brown were perhaps downplaying their role and they're saying, "No, no, they're not downplaying it, they're merely explaining it, " and then it says:

"… the relevant questions in oral evidence proceeded on the incorrect premise that Currie & Brown had some kind of technical input into advising on that decision."

Well, I'm not sure that they did, but my point is simply, if you're assisting with project management, in order to be of assistance, is it really unreasonable to suggest if something was supposed to be done that you check with your people you're working with? We'd make no point beyond that.

THE CHAIR: Well, it might not be unreasonable to expect people to behave in a particular way, but in the context of a commercial project subject to contract, is Currie & Brown not entitled to say, "Well, we were obliged to do what we were obliged to do, but that obligation did not go the distance of essentially supervising Mr Seabourne."

MR CONNAL: If one takes on a role which contains a general statement, such as "project management", I'm not sure one is entitled to be as hard-nosed as that. "Supervising Mr Seabourne" would be the wrong phrase, but if you're assisting in the process of getting this to conclusion, which they seem to have been in some way, then is it really reasonable to say, "Well, yes, we saw this reference to IPC, but we just ignored that completely. We left that to somebody else. We didn't even ask," and in my submission that is pushing their envelope in the wrong direction.

My Lord, I have a few more points just to make. My Lord will have seen in the submissions from Counsel to the

Inquiry that we made the suggestion that the ventilation derogation should have been highlighted in some way. That's a matter for my Lord.

THE CHAIR: Well, am I competent to? I mean, is it enough for me to think, "Well, it would have been a good idea if it had been highlighted in some other way"? I mean, I think it's probably in the TÜV SÜD submission expressed with some energy that the documentation of the air change rate was in precisely the place that someone who knew about contracts would expect it to be.

MR CONNAL: Yes, and we make a different submission ----

THE CHAIR: Well, are we entitled as-- Do we really have the decision-making tools to say, "Well, it would have been a good idea if-- in the context of-- I suppose there is the qualification: there is, "This is a contract subject to an obligation to cooperate," whatever that may mean, but should I not be a little bit careful about second-guessing people who should be assumed to know what they were doing? I appreciate the assumption isn't perhaps an equal assumption but----

MR CONNAL: Well, I accept, my Lord, that this is an issue on which views differ, bearing in mind that-- and I think the point I was going to make was that our position, our submission to you, is that this derogation was quite different in scale and effect from the large number in paragraph 67.1, "… hundreds of items (clarifications, responses to queries …" and so on that were in that log.

If that is right, and if on the face of the contract that parties were about to sign the guidance is still specified as compulsory, you know, it's not subject only to what's written somewhere else, it may be that those who were most closely involved at the time say, "Well, what's the problem? It was in the log. It's in with hundreds of other things, but you'd find it somewhere if you knew where to look." But for a change of that kind, and we've seen the consequence, of course, that it was never, for instance, drawn to Scottish Ministers' attention, it is our submission that that was not an adequate recording of something of that significance.

THE CHAIR: You say it was not drawn to Scottish Ministers' attention. It wasn't really drawn to anybody's attention.

MR CONNAL: No, and that's the challenge because that minor query----

THE CHAIR: I apologise. That has to be qualified by looking perhaps a little bit more carefully at what Mr Seabourne said happened, but I don't think we identified anyone else who admitted to having become aware of it at or about the time.

MR CONNAL: No. I think the evidence, my Lord, was that nobody apparently knew about it, as a matter of fact, other than possibly Mr Calderwood, very late on, who said he may have had it mentioned to him, but it didn't really dawn as significant. The answer may depend, my Lord-- The thrust of the Currie & Brown position is, "This was a perfectly good suggestion, had no real effect, it's not a big deal. You can leave it with a hundred of other things in the log somewhere, that's fine. The people who are working on it know where to find it."

The alternative view is this was a significant decision with significant ramifications for any number of hundreds of rooms, departure from what was apparently intended to be compulsory guidance and so on and so forth, and a quite different type of change to the hundreds of other queries in that log. The fact that there were hundreds of other things in the log in a sense makes the point.

THE CHAIR: It's not very relevant to what you're saying at the moment – you've just characterised the Currie & Brown position – but would I be right in thinking that when Mr Calderwood did learn about it – and if I'm wrong about this, please tell me – and when he understood that it had to do with the maximum temperature variant, he thought it was quite a good idea?

MR CONNAL: Well, almost----

THE CHAIR: I mean, by that time, decisions had been made, buildings had been built, but----

MR CONNAL: Well, that may be. I have to say, my Lord----

THE CHAIR: I may be wrong in my recollection.

MR CONNAL: No, it was something along those lines. Both Currie & Brown, from their perspective, and TÜV SÜD, from theirs, make something of things said by Mr Calderwood, and I, for my part, wearing my hat, question whether selecting Mr Calderwood as the best historian on matters of technical detail is really very helpful.

One perhaps picks this up on the next point. In paragraph 74, Currie & Brown say that in our submissions we state that:

> "Mr Calderwood's oral evidence was that he worked on the basis that 'the technical advisors would have approved' the Ventilation Derogation."

Then they criticise the use of the phrase "approved", because they say, "Well, it wasn't for the advisors to approve anything, it was for their Board to approve it." All I say is, if you're listening to a layman – and there's only one team of experts on the plot, and that was

Wallace Whittle – is it really a fair criticism to say, "Well, I'm assuming the experts approved this"? I would suggest not.

THE CHAIR: Right. It's really just a point about use of language?

MR CONNAL: Yes.

THE CHAIR: Yes.

MR CONNAL: I suspect Mr Calderwood was not at the time engaging in a careful analysis of the contractual structures in place and the communication routes that were in place.

My Lord, if I move on, if I may, to 75.4, that paragraph deals with the issue which arose in the oral evidence of Mr Hall, where he suggested that the agreement of the ventilation derogation was in some way provisional and could have been changed later.

Now, all we have said in our submissions is this, that there is no suggestion of consideration of this agreement as provisional anywhere in any of the documentation at the time, or in any of the witness statements from anyone. But all we are saying is probably made less important because, as we understand Mr Seabourne's evidence, he said, "No one thought about that. That wasn't an issue that was discussed or debated. We weren't thinking about that." If they weren't thinking about it, it may or may not be a correct analysis of the way things might have happened, but no one was thinking about it as something provisional to fix later, and we say no more than that.

THE CHAIR: Sorry, my fault. Counsel to the Inquiry-- Certainly, when Mr Seabourne gave his evidence, he threw into the mix that the ventilation derogation which was agreed to pre-contract could have been revisited, although I think it was accepted that that might give rise to a compensation event.

MR CONNAL: I think that may have been Mr Hall's evidence and then Mr Seabourne touched on it, my Lord.

THE CHAIR: Now, the point that Counsel to the Inquiry make is, "Well, no doubt you can vary a construction contract at cost," or at saving I suppose, but what Counsel to the Inquiry are saying, which is being responded to, is that, "Well, there is no evidence that anyone applied their mind, subsequent to-- well, even either in December 2009 or subsequent to that, to such a change.

MR CONNAL: Correct.

THE CHAIR: Yes.

MR CONNAL: That is all we're saying. So it's interesting, but it doesn't take us very far. If we come back to the question of the application of the ventilation derogation, in paragraph 79, Currie & Brown criticise Counsel to the Inquiry for dismissing "the 'question' of

which rooms [it] applied to as 'largely an academic issue'" and they say:

> "... the real question is how that solution came to be applied much more widely than intended and agreed."

Now, we do accept that the question of how it came to be applied more widely is something we deal with, and the only difference between us and Currie & Brown, I suggest, is that we say that the lack of precision on its application in writing at the time may have played a part in how it came to be applied more widely.

THE CHAIR: But I suppose you'd have to accept that there's an element of speculation there.

MR CONNAL: Yes. My Lord, paragraph 90 sets out one of the paragraphs dealing with the changing role of Currie & Brown, and says, well:

> "Currie & Brown ceased to be a 'technical advisor' and ceased to have a Technical team to call upon ... Any reference to [them having a Technical team after that time was incorrect]."

We agree. It's still a bit mysterious why so many people thought there was still a technical team, but we don't really know. It does suggest some failure to communicate the change, and I suspect there is broad consensus that the job of communicating that change should have been in the hands of the person who instructed the change, in effect the Project team.

THE CHAIR: I think I got a feeling that the very presence of Mr Hall sort of seemed to have a reassuring quality.

MR CONNAL: Well, that's quite possible, my Lord. The difficulty is that there's a little bit of wrangling in these submissions over, "Well, remember the context", and when you come to TÜV SÜD, they say, "Oh, we only advised Currie & Brown. We didn't advise anybody else."

Well, leave aside whether that's accurate, but we know the structure: Currie & Brown were-- I've been criticised for calling it "lead consultants", but they were the consultants at the top of the pyramid of sub-consultants who worked to them, and clearly Mr Hall may have been the route for communications, but maybe he engendered confidence, I don't know.

Just to pick up my Lord, I started by mentioning the different views on the employers' requirements, and so on. Paragraph 101 is the nearest I can get to a summary of the Currie & Brown position:

> "The Employers' Requirements ... were, by their nature, not intended to be fully prescriptive and detailed design specifications; it was for the

design and build contractor (Multiplex) to develop the detailed design after the award ... in order to meet the GGC's requirements."

That's broadly the position that Currie & Brown say: it's for the designer to use their expertise.

The only other things I want to say in passing-- My Lord, if one looks at paragraph 107, there's a quotation – I think, from our submissions – at the top of page 36, just before the start of 108:

"Whilst Currie & Brown were clearly important part of the process and might have been the communication vehicle for escalation if so instructed, the ultimate responsibility for escalation of changes to the [Employers' Requirements] must lie with the project team and Mr Seabourne."

One might have thought that was unexceptionable, but Currie & Brown challenged that, and one sees that at 108.4:

"Currie & Brown disagrees with the conclusion ... that it was 'clearly an important part of the process' and 'might have been'"----

THE CHAIR: Sorry, just so that I'm following --

MR CONNAL: Yes. The part of our submissions criticised is at the top of page 36.

THE CHAIR: Yes, and the word "escalation" in that context is informal escalation----

MR CONNAL: Has to be----

THE CHAIR: -- advising----

MR CONNAL: -- of the change that was being made on ventilation.

THE CHAIR: Right. I mean, you don't seem to implicate Currie & Brown in any respect.

MR CONNAL: Well, all we've done is describe them as an important part of the process, where they were clearly one of the few people who were participating in these discussions. I don't think that's an exceptional phrase, and then I say, well, if they'd been instructed to escalate, they might have been capable of doing that. And that --

THE CHAIR: Is this really revisiting the point that we looked at some time ago – about paragraph 60 or so – about Currie & Brown saying, "Well, it wasn't our job to do Mr Seabourne's job"?

MR CONNAL: Yes.

THE CHAIR: Okay.

MR CONNAL: The only other point that I want to make before I leave Currie & Brown is that the one thing one doesn't really find in these submissions is a discussion of the signing off of apparently significant numbers of drawings and so forth by Mr Hall on an unqualified basis – by which I mean without saying, "Please

note: I'm signing this only in relation to clinical functionality, or whatever."

THE CHAIR: Right, so your point there is that we find Mr Hall's signature on drawings from time to time. Now, in contractual terms, the signature could have only any meaning if he had been delegated----

MR CONNAL: Yes.

THE CHAIR: -- possibly informally, the authority to do that by Mr Seabourne.

MR CONNAL: Mr Seabourne or Mr Moir, my Lord.

THE CHAIR: Or Mr Moir----

MR CONNAL: Yes.

THE CHAIR: -- and maybe later on Mr Loudon. Right, having said that we find the signature, what then?

MR CONNAL: This was a matter of some controversy as the evidence developed. The contract provides for drawings to go to the project manager, the project manager to approve them, and for the contractor not to build until they've been approved – and for a process of signing----

THE CHAIR: That's a reference to clause 21 of the NEC3.

MR CONNAL: Correct. Then there are detailed provisions elsewhere for the different types of topic that are to be covered in the approval process. The point that I make is that Mr Hall says that he told everybody – and, again, I'm paraphrasing – that the only thing they were signing off was clinical functionality. But, as my Lord will probably have picked up, there's at least some controversy as to the fact that his signature appeared on items.

Now, he will say, "Not a problem, because I made it clear I was only ever signing with that in mind or on that topic", but he just signs them and, of course, if he signs them, they have a contractual effect – if he signs them A, B or C as we've discussed. If he signs them A, it means "Get on and build it." It's just simply that it's not discussed, really.

THE CHAIR: Yes, and, as you point out to me, there may be a question as to what clinical functionality extends to.

MR CONNAL: There is a separate debate about clinical functionality----

THE CHAIR: Yes. Right.

MR CONNAL: -- which is dealt with at some length in Counsel to the Inquiry's submissions – is it as hermetically sealed as Mr Hall might have suggested? Does it apply to various things? – which, in interest of time, I'm not going to go to.

My Lord, that would allow me to move to TÜV SÜD, who are representatives of the other end spectrum. They've put in a long submission. In parts they agree with things said by Counsel to the Inquiry; in

parts they deal with issues that nobody challenged – you know, “Were Wallace Whittle involved in validation?” to take an extreme example. No, no one suggested they were.

So I don’t need to go to any of these parts, and the only general comment I make is that my submission on the correct import of the totality of the evidence of Mr Pardy of ZBP is that he made a number of concessions, in his capacity as a specialist ventilation designer, of things that he could or should not have done. I’m not sure this submission actually reflects what Mr Pardy appeared to concede.

Now, that’s my interpretation of his evidence. I’ll give my Lord one or two references to where they appear but, obviously, the conclusion on the correct interpretation of his evidence is a matter for my Lord.

So if I can pick up a few points quickly. In paragraph 7 of the TÜV SÜD submission, there’s a narrative of what is said to be Mr Seabourne’s evidence, where it’s said:

> “... he was relaxed about the technical advisory team being stood down. According to Mr Seabourne, he and his team were ‘more than capable’ of assessing designs and design information.”

Well, there’s a debate as to whether that was an overly optimistic view, but he did give evidence broadly to that effect. The only issue I take is that it then goes on to say in this paragraph:

> “... [and that] would, of course, include stipulating what NHSGGC was asking for in terms of specifications and [the] requirements.”

I question whether Mr Seabourne’s evidence goes to the extent of accepting that he could have stipulated and specified what was required, for instance, for a specialist ward. That’s perhaps taking a little far – a bit of a *non sequitur*.

My Lord, there’s a general point made in paragraph 22, and the fault may be mine – I’m not sure exactly what this is referring to. It’s a long sentence, submitting that:

> “... when it comes to considering the adequacy or otherwise of a particular feature of the buildings, the relevant feature should be assessed against the outcome which it was requested, or could reasonably be taken to be required, to achieve, rather than against the expectations or opinions of individuals who were not involved in the design and construction process at the time (and who often spoke without proper knowledge of the process and frequently in

hindsight)."

I simply make the general point-- I'm not quite sure who is being targeted by this criticism, or that I can recall any particular challenge being made to anyone on the basis that they weren't entitled to comment on the design of the buildings.

THE CHAIR: Well, at this stage in the closing statement, the author is offering me assistance in how I should approach evidence and submissions, which is always welcome. But they are general points.

MR CONNAL: They are general points. I'm not sure who they refer to, and I'm not sure it's later specified.

There is a point made in paragraph 34, page 8:

> "The draft SHTM 03-01document from 2009 was just that: a draft. It was not a finalised document. At the time of design, no one knew what the finalised version ... might provide ..."

THE CHAIR: What is the relevance of that observation?

MR CONNAL: That's precisely my question, my Lord. It was a contract document.

THE CHAIR: Yes.

MR CONNAL: I don't believe there's been anyone else who has suggested in evidence that there was some kind of doubt over what was going to be provided, and that had any relevance to any of the issues that we----

THE CHAIR: I mean, it was a draft.

MR CONNAL: Yes.

THE CHAIR: The contract recognised it was a draft but said, "Nevertheless, follow it."

MR CONNAL: Yes.

THE CHAIR: Or at least on one interpretation of the contract.

MR CONNAL: Indeed. Now, I needn't reiterate the point about the approach various parties have taken to the value of the ZBP strategy paper. Obviously, there's a difference of view on that. If I could go, then, to 61 – I think this may go a little far – 61 says:

> "... there is no doubt that NHSGGC agreed to the proposal that the rate of 2.5 ACH would be delivered, and that no more than five people could be accommodated in a room from a ventilation perspective."

Now, I accept that there are accurate quotations from some of the documents, but what I suggest to my Lord is that while there's clearly discussion about where the figures came from, which seem to have landed on a maximum of five people in the room, I'm not sure that it's obvious from any of the material this Inquiry had that a specific constraint on the ability accommodate

people in the room was ever really focused upon in any of the materials.

THE CHAIR: The reference to "five people" is taking you to, is it, 40 litres per----

MR CONNAL: Yes, per second----

THE CHAIR: -- per second.

MR CONNAL: Yes, yes. My Lord will perhaps remember that there was some evidence that someone had gone on to IPC and somebody had put a finger in the air and said, "How about-- Let's use five," and there was some debate about that, was then fed back into the process. But I think my point is simply that there is an issue over whether room occupancy should be formally restricted, but it didn't seem to me, with respect, from the evidence that anyone was really at the time thinking about this in the context of constraints on room occupancy.

THE CHAIR: Certainly, we haven't heard any evidence to indicate that, since 2015, that constraint has been applied.

MR CONNAL: Yes. Now, in 67, criticism is made over the use of the phrase, "Mr McKechnie advised NHSGGC to accept the proposal," because it said, "Well, he mentions the guidance. It's a matter for my Lord. I suggest that the suggestion that Mr McKechnie "advised" is a perfectly reasonable point.

In paragraph 69, it's said M. McKechnie had no direct contact with NHSGGC. Now, from what little we know, I'm not sure that's quite right, and, in any event, it's said, "Well, his contact was with Currie & Brown." But unless it's being suggested that if there was an exchange or a meeting and Currie & Brown and Mr McKechnie were in a room, Mr McKechnie would turn to the representative from Currie & Brown and say, "Well, I'm not speaking to him over there. I'm only speaking to you. I'll tell you what I think," and then Currie & Brown would say, "Mr McKechnie thinks," it's to adopt, in my submission, a somewhat technical approach to an accepted contractual structure.

Wallace Whittle and their representative, Mr McKechnie, were the only experts on the plot – if I can use that phrase – at the time, and it's not suggested that Currie & Brown had over themselves the expertise to deal with these issues. So if anybody was commenting on them, it would be him.

(After a pause) My Lord, I have only a few more points on Currie & Brown---

THE CHAIR: On TÜV SÜD.

MR CONNAL: Sorry, TÜV SÜD. Sorry, I didn't notice. Yes, my Lord is right TÜV SÜD. In 86, there's a criticism of statement that CBUs, these units that were deployed, cannot operate at more

than six air changes an hour. The only point that Counsel to the Inquiry was seeking to make is as soon as you decide to adopt these units, you in effect have to accept the proposition that they're not going to be able to provide air change rates compliant with guidance. This point is no more elaborate than that.

My Lord, more significantly, if we go to 109, a suggestion is made in terms that Ward 2A was identified in the Clinical Output Specification as a "general ward". Now, this is a matter entirely for my Lord, but my Lord will recollect-- I'm not going to dig it out for the moment, but the Clinical Output Specification for Ward 2A, which for my Lord's notes is bundle 16 at page 1599, is a document headed----

THE CHAIR: Just give me a moment. Bundle 16, document----?

MR CONNAL: Document 16. Bundle 16, document 16, page 1599. My Lord will remember it. It's a document headed, "Haemato-oncology," talking about the National Bone Marrow Transplant Service.

THE CHAIR: Mm-hmm.

MR CONNAL: It doesn't contain much technical detail, but that's what it's talking about. Therefore, in my submission, the characterisation of the Clinical Output Specification as labelling this a "general ward" is in my submission not a fair one at all, and I thought that that matter had been accepted by both Mr Pardy and indeed Multiplex, and the reference to that is in our submissions at paragraph 699. The reason why it's important is that if one goes on to the next page of the submissions at paragraph 121, the statement is made:

> "It was for NHSGGC to assess, from a clinical perspective, whether this agreed feature [which is air pressure] ... would be appropriate for the different use to which Ward 2A was eventually put."

Now, that, my Lord, is to suggest a process rather different to anything the Inquiry's heard of in evidence, because, as I understand it, whatever debate there is about the Clinical Output Specification, 2A was always intended to be the national Paediatric Bone Marrow Transplant Unit. So, the suggestion that somehow it was designed as-- it was intended to be a general ward and then put to some other different use doesn't seem to be borne out by the evidence in the Inquiry, and that obviously permeates these criticisms.

But if I may just take a few minutes just to finish on TÜV SÜD, my Lord, 139 discusses isolation rooms. It doesn't, in my respectful submission, pick up Mr Pardy's acceptance that he ought to have looked at the constraints on the use of PPVL rooms for immuno-compromised

infectious patients, nor does it touch on the placing of extracts in these rooms contrary to guidance. The approach taken by TÜV SÜD, my Lord, is probably quite well illustrated in-- if I can go to paragraph 227, where there's a note that the original Clinical Output Specification for Ward 4B makes no reference to air change rates.

Now, if my Lord can just take it from me for the moment, that is correct. It makes lots of technical references to immuno-compromised patients and so forth. The TÜV SÜD position is that since it didn't specify air change rates of 10, 10 air changes need not be provided. Now, the question then is what role is a specialist ventilation designer providing if all you have to do is read what the Board gives you?

The other point that emerges slightly earlier, my Lord, is a proposition-- My Lord will remember the debate about Ward 4B, the changes to Ward 4B, and how things came to be as they did. TÜV SÜD advanced what I suggest is a new theory, and that theory emerges in paragraph 211. Their theory, if I can paraphrase it, is this----

THE CHAIR: Sorry, 2----

MR CONNAL: 211.

THE CHAIR: 211?

MR CONNAL: Yes. The way I paraphrase it is this: the original intention was to have a Haemato-oncology Ward. Then along came the idea of adding a Bone Marrow Transplant Unit, and TÜV SÜD said, in terms, "Once you have the new intention, the correct interpretation of the materials is that you completely ignore everything that has gone before. You have a clean sheet of paper. Nothing that had previously been discussed is relevant." Now, my Lord, our position is that we find that difficult to square with the way things were done, but that is their position.

The only other thing I need to add is to give my Lord the reference to the statement of their approach to the role of the specialist ventilation designer, which you will find in paragraph 337.

THE CHAIR: This is 337 of the TÜV SÜD----

MR CONNAL: "The TUV submissions, yes, and my Lord will see, if you ignore the first sentence, "Clinical output specifications for departments or other areas having a clinical function should set out, in detail and in the clearest terms possible, the relevant patient cohorts and activities ... together with the schedule of accommodation [and so on] ...

In addition, the Health Board's brief should include documentation identifying the environmental parameters of all spaces within such areas, including

precise specification of applicable ventilation parameters ... such as air change rates, pressure differentials, levels of filtration and temperature."

So, the TÜV SÜD position, which I've illustrated by their references elsewhere, is essentially this: that the Board has to specify every last detail and, if it doesn't specify it, it doesn't get to complain if it doesn't get it. My question is what is the point of having a specialist ventilation designer if all they have to do is read off the list and build it. You might as well go straight to build, because there's no application of skill, there's no discussion of guidance, nothing. It's all to be specified by the Board. That, I think, given the time-- I'm sorry, it is taking rather longer than I had anticipated, but that is all I wanted to say about the TÜV SÜD.

THE CHAIR: Right. Now, you're not finished, I gather?

MR CONNAL: No, my Lord, but these are the biggest parts of what I have to say.

THE CHAIR: Right. You may not be able to answer this, but what would your estimate be for time remaining?

MR CONNAL: Three quarters of an hour, perhaps.

THE CHAIR: Right.

MR CONNAL: In some of the-- the case of the other submissions, I'm relatively brief; a little longer on one or two others.

THE CHAIR: Right. Well, that obviously has consequences for other CPs, but my impression is that over the week we have enough----

MR CONNAL: (Inaudible 13:15:03), my Lord.

THE CHAIR: Well, it's a little after ten past one. We will sit again at quarter past two. I anticipate there may be film cameras, so people may wish to be aware of that.

(Adjourned for a short time)

THE CHAIR: Now, Mr Connal.

MR CONNAL: Thank you, my Lord. I'm going to turn very briefly to the closing submissions made on behalf of IBI – essentially the architects. I don't need to say much about these. I would just note in passing that there are two paragraphs there, particularly 6.2 and 6.4, which contain various explanations which I take to be further efforts by Ms White to give a helpful explanation to the Inquiry, and I need to say nothing more about them. They then go on, in section 11 of their submission, to make what are described as observations but are perhaps suggestions for things that could be done by the Inquiry. We'll find that on page 5 of their submissions.

Now, I only mention these briefly. In 11.1.2, they explain that there's an English technical bulletin about updated design requirements in that jurisdiction, which is commended to the Inquiry, and it may be that NSS or the like may have some comment to make on the suggestion that you should pay particular attention to that.

In 11.1.3 they draw the Inquiry's attention to something called:

> "... the principles of the 'golden thread' of fire and safety design in high-risk buildings introduced under the Building Safety Act 2022."

Now, this is, to be fair, a new idea, at least to this Inquiry, and if other CPs have anything to say on the suggestion that my Lord should pay attention to that as a helpful area of assistance, no doubt we will hear from them on that front.

THE CHAIR: Yes. As you correctly say, I think this reference to this English statute is the first time that we've seen it in the Inquiry. Now, what I will value – assistance from somebody at some stage – is a sort of analysis of what is meant. I've had a look at the 2022 Act, and it's quite lengthy and detailed, and I wasn't confident that I, perhaps, would immediately get the point that IBI are trying to make. So, if anyone is prepared to take on that role, that would be useful.

MR CONNAL: Thank you, my Lord. Then, the final point they make is that there's an English process on managing derogations and reporting derogations from standards and guidance, and my only point there is, of course, we've heard from NSS that Scotland is already working on a process for this in Scotland, and I've no doubt that NSS will be well aware that there's a process in England and will be looking at that – not necessarily to follow it, but to take it into account. Beyond that, I don't need to say anything more about IBI.

So far as Multiplex is concerned, the only thing I need to do for the purposes of these submissions is simply to note in passing that Multiplex record, at paragraph 2.3, that Counsel to the Inquiry's statement provides what they describe as "a fair summary of the evidence led ... in respect of the issues [of which they had] knowledge", and we're grateful to them for that confirmation. Beyond that they add nothing more, so I need say nothing more either.

That brings me out of the construction group, if I can call it that, into governmental bodies. I deal first with NSS, and there's much common ground between Counsel to the Inquiry and NSS. To take as an example, in paragraph 20 of the submissions that have been lodged by them, they comment on the

epidemiological analyses by various parties and suggest that:

> "... the analyses show consistent patterns: an increase in bloodstream infections caused by environmental organisms following the move to [the new hospital], and a subsequent decrease after control measures ..."

That is common ground, and we're obliged to NSS for stressing that that increases confidence in the overall picture with which my Lord has been presented.

Likewise, in 21, my Lord will remember there was a discussion in the evidence of what involvement, if any, NSS had or did not have in relation to the refurbishment process in Wards 2A and 2B, which seemed to be at points the subject of some dispute. Paragraph 21 sets that matter out in some detail and, if anything, I suggest, points to the value that they could have added to that process had their full offers of assistance been accepted.

My Lord, they also comment on various proposed recommendations. Now, this may have been covered in our earlier document, but in paragraph 34 there's a proposal to broaden out one of our proposed recommendations, and we're content with that proposal. That's paragraph 34.

THE CHAIR: Sorry. Counsel to the Inquiry are content with---- ?

MR CONNAL: With what is suggested by NSS. Indeed. Now, in paragraph 39, and in particular in subparagraph (i), there is, I think, a suggestion there that other steps could be taken to improve matters involving templates, and so forth, but it doesn't quite match. There may be some question of people talking past each other.

What Counsel to the Inquiry have really been focusing on here is ways in which the protection of the public money involved in such a major project can be achieved, and we're not entirely convinced that what NSS propose would achieve that in the way that our recommendation would, but that's ultimately a matter for my Lord.

If I just stick with that paragraph for the moment, subparagraph (iii). This touches on what we've described as the obligation of co-operation which, my Lord will remember, in the evidence appears in the NEC3 form of contract, which is the contract form that was adopted in this case and also in other public contracts, we understand. Now, on page 16, NSS say:

> "The 'obligation of co-operation' is an NEC contract condition and is integral to the ongoing management

of the contract."

All we say is, if that is so – and we don't disagree with it – then it would be helpful to have the maximum mutual understanding recorded between the parties as to what that does or does not oblige them to do.

THE CHAIR: I'm just seeking to remind myself what Counsel to the Inquiry said on this point that NSS are engaging on. Can you----?

MR CONNAL: I think this is where we have suggested that there should, in effect, be some compulsory discussion and resulting protocol on the particular contract, as between selected contractor and customer, discussing and agreeing the extent to which that obligation does or does not actually proceed – actually require action. It's a topic that is current, my Lord. I happened to note just the other day that a leading construction commentator was saying that this is a clause that many parties are actually trying to take out of contracts, because they think the uncertainties over what it means leads to litigation, which is a cost they would rather avoid. Just taking that at face value, it does suggest it is an important matter on which discussion and agreement might assist.

THE CHAIR: How do you define the difference between you and NSS? What I'm reading – looking at the NSS text – is that circumstances differ, and one shouldn't be too prescriptive, but I may be wrong about that.

MR CONNAL: Well, the position I think, adopted in subparagraph (iii) is – this appears on page 16 – that:

> "The specific detail of how both parties intend to operate this is typically a project governance matter [fine] which can be set out in the appropriate section of the contract and associated documents, as required."

THE CHAIR: Right.

MR CONNAL: It may be that not being too prescriptive is what that means, and all that Counsel to the Inquiry are suggesting is that, given its potential importance, there should be a mechanism for ensuring discussion and agreement and recording.

THE CHAIR: Right.

MR CONNAL: That's all there is to it. In subparagraph (iv) there's some comment about different possible forms of contract but, of course, we, perhaps understandably, didn't comment on any form of contract other than design and build. Other contracts might require different result remedies, and this focuses on this question of having what was sometimes called "a shadow design team", or certainly the availability of expertise.

I think my Lord may remember that Mr Winter, when he gave evidence, indicated that when he was on the contracting side, he quite often found that the client turned up with a range of people who kind of matched the advisers that he had. Now, I'm not wanting to be prescriptive about this, but that's the essential point there.

So, in subparagraph (vi), page 17 – this still is in 39 – it says:

> "NSS is concerned about the workability of paragraph 1876(c). In particular, the proposed role is beyond the professional capacity of one individual."

Now, this may be our fault, because our recommendation was that:

> "... boards should ensure the appointment of a suitably qualified and experienced construction professional during ... contracts who has the remit to ensure the works meet the [employer's requirements] (or equivalent) ..."

Now, if that was worded to suggest it had to be a person, I'm happy to withdraw that. In the contract that is in front of my Lord, at least as a possible proposal, the idea was that a firm of experts should provide that service, and I've no difficulty with that concept, but we do maintain the view that someone with that role, some person or group, should be in place.

My Lord, if one moves to paragraph 40, which deals with our recommendation in paragraph 1877, this is the one which suggests that there should be government legal advice in and around contract at key points. Now, this is not supported by NSS. We note all the points they make, and all we say is that given what we say is the ultimate responsibility for a project of this scale, we suggest that something along these lines would be of assistance in protecting the public interest. Precisely how it's done, we know that depends on any individual case, but we do maintain that's a sensible suggestion.

(After a pause) My Lord, in paragraph 47, NSS suggested our recommendation in paragraph 1886 should be widened. We're content to record our acceptance of what is suggested by NSS there. In 48, NSS touched on the possibility that a review might lead to the creation of a regulator, or the extension of someone's powers----

THE CHAIR: I'm sorry, my fault entirely, which paragraph again?

MR CONNAL: 48 of NSS' submissions.

THE CHAIR: Right. Okay.

MR CONNAL: Now, they then say they would need to take into account possible unintended consequences,

including possible need for further staff. Beyond the need for further staff, I'm not sure what's being referred to here, and it's not necessarily obvious – for instance, if one was to decide that the role of HIS might be reshaped to make them a regulator with compulsory powers – so I simply make the point there's nothing further to assist us on there.

Then they make some further comments on which I really needn't comment, beyond reminding my Lord that we did accept the general proposition that if there is to be someone who might be described as a "regulator", because of the cooperative nature of much of the actions of NHS Assure, it shouldn't be that body that should be morphed into a regulator, if that was to be done. Beyond that, I have nothing further to add on the position of NSS as set out in their submissions.

Now, that brings me rapidly to the submissions by Scottish Ministers. If I could, just as a matter of note, start by saying this: that, in our submission, it is clear that at full business case stage Scottish Ministers did not know about the ventilation derogation, the change in the maximum temperature, or what we've called "the standing down" of the Technical team because they hadn't been told about them, so any suggestion to the contrary is not, in our submission, correct. The----

THE CHAIR: Sorry, just for my note, the advanced-- sorry, the agreed ventilation derogation----

MR CONNAL: The change in the maximum temperature variant, as we've called it, and the standing down of the Technical team.

THE CHAIR: Thank you.

MR CONNAL: Now, just to start generally on the Scottish Ministers' position, because it colours everything else, the thrust of the position adopted by Counsel to the Inquiry, rightly or wrongly, is to pick up on a comment by the then Minister, Ms Freeman, which is that there are risks of being too hands-off with boards. We take from the Scottish Ministers' submission that they are quite keen to stay hands-off and to retain the existing, as they would say, "demarcation lines", and we seek to persuade your Lordship that, as the public would see the Scottish Ministers as ultimately responsible, they should do more to reflect that.

It's probably illustrated, my Lord, by paragraphs 17 and 20. Here, the Ministers refer to "the blueprint for good governance" that we touched on earlier today. They set out some principles that emerge from that document, and they suggest in paragraph 20 that:

"Adoption of these principles should avoid the various issues

identified by Counsel to the Inquiry in various places."

Frankly, we disagree. The creation of principles of a general and non-obligatory nature of this kind, we suggest, will not do what is being suggested to ensure effective oversight, in an adequate fashion, of major infrastructure projects, and that is an unrealistic submission; understandable, but in our submission, unrealistic.

My Lord, just in passing, we noticed what the minister said in paragraph 24, another reminder that Ms Freeman had envisaged undertaking a wide-scale review of the culture of NHSGGC and other health boards, but that really might have been superseded by this Inquiry. I'm not sure that's the way my Lord might interpret the terms of reference, as a widespread review of the culture of NHSGGC, although obviously a number of cultural issues have been dealt with and, of course, it doesn't touch on other health boards. So the question arises whether Ministers still intend to follow this through or not. We have no particular view on that but, clearly, that's a matter that's in their minds.

Ministers also, as with NSS, disagree with the suggestion of them having legal advice, to which we say this. Ministers, ultimately, are responsible for these things. They fund them, and

they're ultimately responsible for the Health Service. We argue that if, through legal scrutiny, they were to find a flaw detrimental to the public interest in a contract being entered into by a board, why would it be undesirable or inappropriate to raise this? In fact, they complain of the possibility of conflicting advice. Precisely the point, because by definition, in that scenario, the Board would not have picked up the point. What's the problem?

So, I mean, whether you need to create an additional accountable officer in the shape of the chief executive of the NHS for major projects, I don't know. It doesn't matter. My point is simply that we see this as a helpful suggestion which might, depending on how it is deployed, assist to avoid some of the issues that we had.

THE CHAIR: When you use the expression, "ultimately responsible," do you have in mind the terms of National Health Scotland Act 1978, which imposes an obligation to provide a Health Service on-- well, originally the Secretary of State and now the Scottish Ministers, or do you have in mind wider responsibilities, such as political responsibility?

MR CONNAL: I think I see it in two different ways. On one view, one could interpret that statutory provision as laying down ultimate responsibility----

THE CHAIR: Subject, of course, to the delegation.

MR CONNAL: To delegation, but, in addition, the public, we would suggest, see the Ministers as responsible for the Health Service, whatever niceties might be set out in the act, and all we're suggesting is that they should take a bit of a more active role in particular respects.

The same point probably comes up in one of our more, perhaps controversial, recommendations, which is focused, in particular, on what happens if a problem is identified. So, if one goes to paragraph 37, the point we're trying to make here is-- Because we had quite a lot of evidence, my Lord will recall, about, "Oh, well, if things crop up, somebody would speak to somebody else and somebody would hold somebody else to account, and things would happen. The picture would not be good." All we're suggesting here is imagine a situation where, after investigation by the NHS, it was decided that a senior officer of a board-- needn't be the chief executive, might be another senior officer-- senior officer of a board was responsible for or causing a significant problem, about which the Board weren't doing anything.

At the moment, that person could be removed -- if on the Board, they could be removed from the Board, but their employment would remain in place. We're purely suggesting that if you say to the public, "Oh, yes, we've taken them off the Board, but he's still employed by the Health Board, drawing whatever salary and benefits are available, and the Board aren't doing anything about it and we can't do anything about it," that seems to me with respect to be a sort of cry of helplessness that the public would find difficult to understand. If the Board do something about it, fine, but then the reserve power wouldn't be required.

The one point that we make, just to finish what I say about the Ministers, is that there are lots of things that can be done. We simply raised the question, in light of the context that we have here, about the absence of the word, "compulsion," in many of the areas that we've discussed. Things can be done. People can speak to people. There can be meetings. Holding to account, whatever that is, can happen, but there may be a need from time to time for an ability to compel things to happen without dubiety.

My Lord, I have nothing more to say on the Scottish Ministers point, which brings me in order to the submissions by MDDUS. These are lengthy. I don't intend to go through them. In some respects, much of what they say agrees with what Counsel to the Inquiry have

suggested.

I tried to find a main message and, in our submissions, my Lord, we suggested at least a degree of caution in deciding whether the change of direction indicated by Professor Gardner can actually be achieved. In part, of course, that arises from the presence in senior positions of some parties who might be thought have been the drivers of the previous, now recanted from, line, and if there's one message that I take from the submissions by MDDUS, it is that, that they agree with that issue of challenge.

They do set out, my Lord will see when my Lord goes through them again in detail, comments on a range of individuals, some still in post, some not. I wouldn't want to be thought to have endorsed all the language deployed about these individuals, but we do commend my Lord to read these passages. We adopt the same approach, subject to the same caveat, about some of the passages on whistleblowing, which my Lord will find starting with paragraph 52 on page 27.

Beyond that, my Lord, I only----

THE CHAIR: Sorry, just before I lose your point, could you just repeat that you're "adopting what appears in the MDDUS statement in respect of" which paragraph?

MR CONNAL: Well, what I've said is that my Lord will find a series of paragraphs dealing with individuals which start at page 11, in paragraph 14, and continue for a considerable period of time thereafter, dealing with a whole range of people. All I'm saying is I'm not to be taken to have endorsed every word that's used there, but I do commend these passages as helpful to my Lord to read.

Then I'm pointing out that I'm adopting a similar approach about the comments on whistleblowing, which start on page 27, paragraph 52. So, again, not to be taken as adopting every word, but I commend them for my Lord to read.

On page 56, there is a suggestion that independent experts should report on various functions on an annual basis for five years after the Inquiry's recommendations. The suggestions are there should be independent reports on water ventilation and IPC. Without going into the detail, we are content to endorse the suggestion for water and ventilation, but we hope it's not necessary to do anything similar for IPC.

Then, finally in this document, there is an annex which contains ongoing concerns about the state particularly of Ward 2A. All we wish to say about that is that a lot of these issues could be dealt with by, if it was thought appropriate, a new validation report on the Ward 2A ventilation. That's what I want to say

about MDDUS.

Now, that leaves two submissions, my Lord, the one on behalf of the Cuddihy and Mackay families, and the one on behalf of the group which we're calling "Patients and Families". Each of these submissions contain what I'll call for simplicity "quotations" from various participants setting out their experiences. Speaking personally, reading these as a parent I confess to finding quite difficult, but perhaps that's the point. They're setting out the impacts of what has happened on them as individuals, and I needn't take my Lord through these.

The summary that I would take on the Cuddihy and Mackay submissions is that the system just didn't work, and on the question of personal responsibility, which my Lord and I discussed earlier today, I suggest it's fairly clear on which side of the line the Cuddihy and Mackay submissions fall in terms of personal responsibility.

In terms of the patients and families' submissions, I've made the point about some of the quotations, I won't make that again. On page 4 in paragraph 1.5----

THE CHAIR: Just give me a moment.

MR CONNAL: Sorry, my Lord. Patients and families, page 4, paragraph 1.5.

THE CHAIR: Yes.

MR CONNAL: I just want to draw attention to the first sentence there that the Inquiry's remit has not been assisted by what they describe as:

> "… the belligerent, confrontational and dismissive attitude and tone demonstrated by [NHSGGC] witnesses."

This is again a situation where perhaps the adjectives aren't the ones I would have selected, but I can quite understand why something along these lines was perceived by those representing those who had encountered the challenges that we've all heard about.

Likewise, just taking another short reference, my Lord, because most of it I'm not going to touch on, on page 52, at the foot of page 52 is a series of bullet points. A number of impacts have been selected. We'll see the first bullet point is the:

> "… anger that the HAD report was produced so desperately late in the day and, also … [from their perspective] to seek to undermine the independent Inquiry experts."

Then they go on to make other comments. So one can understand again that sentiment given what we've heard. I've almost finished, my Lord. Page 54, another of the bullet points:

> "There is a concern that the Inquiry and the hospital are

downplaying the events in Ward 4B …"

Well, insofar as that's directed at Counsel for the Inquiry, we regret if any such impression was given and that's certainly not our intention, to downplay 4B. Sorry, it's the fourth bullet point on page 54.

THE CHAIR: The point being, this is the adult haemato-oncology ward, and it seems now to be accepted that does not meet-- I think the question really arises on air change rate.

MR CONNAL: Yes.

THE CHAIR: Families are concerned that the Inquiry is downplaying that, but you would wish to assure them that is not your perspective?

MR CONNAL: That's certainly not our intention, and in fact we suspect that our persistence with challenges over 4B is a matter of not downplaying, but we have pushed that argument perhaps further than some other participants would have liked.

That would only leave me with two points to pick up. In paragraph 10.1, which my Lord finds on page 60, we see there an explanation of the position. I note the second sentence:

"At the heart of this suffering lies not only the technical failures of a hospital meant to provide sanctuary and healing, but also a fundamental abdication of responsibility by the Scottish Government …"

So it's interesting, perhaps, what I've been saying just a short time ago about the Scottish Ministers, but the patients and families' representatives are also concerned about that issues. They then go on to make various suggestions on which it would be unnecessary for me to comment, but the main point they make there.

The only other one, my Lord, is the point that's made on page 74, which is, as we understand it, a suggestion that the Inquiry should not come to an end when my Lord delivers his report, but should be kept open in an attempt to ensure that various changes which are thought desirable are actually carried into effect.

Now, we've looked very carefully at this suggestion. We think that the comparison with the Infected Blood Inquiry is perhaps not a fair one, because in the Infected Blood Inquiry there was much more focus on the role of government, rather than, let's say, the role of a board with government as being a secondary player, and also because they had the issue of compensation still to be dealt with at a later stage. So it's not an exact comparison, but we express the hope that there are adequate mechanisms in place for ensuring that

any steps that my Lord regards as desirable can actually be taken.

Having concluded what I have to say about the submissions by the patients and families, these conclude my submissions, with apologies for having overrun the time allocation that I had originally anticipated.

THE CHAIR: I have prolonged the submission by my questions, Mr Connal. Can I ask you just to repeat your response to the proposal on page 74 of – this is not your expression; this is my expression – continuing the Inquiry to police the recommendations. Now, the first point you make is that the analogy with the Infected Blood Inquiry is not a complete one.

MR CONNAL: Yes.

THE CHAIR: Did you make a second point?

MR CONNAL: Yes, we simply suggest that, given everything that has happened from NHS Assure onwards, we hope that it should be possible to convince even the most doubtful reader that there are mechanisms in place and being operated, which will ensure that any recommendations my Lord makes will be carried through.

THE CHAIR: Right. Thank you, Mr Connal.

Now, Mr Gray, I think you indicated that you too wish to make an oral statement, so I would welcome you to the position which we've previously used for witnesses.

Closing submissions by Mr GRAY

MR GRAY: Yes, my Lord. NHSGGC has previously prepared, as my Lord is aware, written closing submissions, which I would formally adopt just now, and, my Lord, at this juncture I would make a brief supplementary submission on behalf of NHSGGC.

My Lord, the purpose of the Inquiry has been to determine the safety of the water and ventilation systems of the Queen Elizabeth University Hospital and the Royal Hospital for Children, with particular reference to how the systems were designed, built, commissioned, operated, maintained, and tested.

My Lord, "safety" has been defined by the Inquiry as whether the systems previously presented, and now present, an avoidable increased risk of infections to patients. My Lord, it is submitted that the Inquiry can find that the evidence clearly shows that the hospital is now safe. In my submission, the evidence of the Inquiry experts is that there is no longer an increased infection rate, and experts are aligned on that conclusion. Rigorous monitoring is in place and

systems have improved, reflected in my submission and the very positive independent audits recently undertaken by Mr Poplett of the ventilation and water systems, respectively.

My Lord, NHSGGC has listened to the evidence given at the oral hearing----

THE CHAIR: Mr Gray, I needn't tell someone as experienced as you this. If you're reading this, you adopt a reading speed, and your reading speed is faster than my writing speed. So just could I invite you to bear that in mind?

MR GRAY: Indeed, my Lord, indeed. I do apologise.

THE CHAIR: No.

MR GRAY: My Lord, NHSGGC has listened to the evidence given at the oral hearings and has read all evidence presented in writing. My Lord, as has been stated in evidence on a number of occasions in this Inquiry, NHSGGC is the largest health board in Scotland, providing a vital public service to in excess of one million people.

My Lord, as an organisation, it takes the onerous responsibilities which it owes to its patients extremely seriously; and against that background, it is a matter of the greatest regret and concern in equal measure that in relation to many of the issues with which the Inquiry has been concerned it has been clear from the evidence led that there have been

significant failures on the part of NHSGGC. My Lord, these failings are acknowledged and accepted.

My Lord, as was stated in the written submission, it is a matter of profound regret that those who NHSGGC care for have experienced distress, anguish and suffering as a result of these events, and NHSGGC offers a full and unreserved apology for the distress and trauma experienced by patients and families during this time.

THE CHAIR: Right. I've got "a full and unreserved apology for the pain and trauma experienced at this time".

MR GRAY: Indeed, a full and unreserved apology for the distress and trauma experienced by patients and families during this time.

THE CHAIR: Distress. So it's an apology for an outcome.

MR GRAY: This is an unreserved apology, my Lord, for the failings which have been unequivocally acknowledged by NHSGGC and for the distress and trauma which those failings and consequential events have caused to patients and families.

My Lord, NHSGGC has taken steps to foster a culture where clinicians and staff should feel confident to report concerns and that those concerns will be acted upon and that they will be supported throughout the process. My

Lord, these improvements are ongoing, and Professor Gardner gave evidence of the steps that have been taken and the steps that will be taken in future.

My Lord, NHSGGC has listened to the evidence of the expert panel, and whilst no definite link between any infection and any confirmed source of infection was ever established----

THE CHAIR: Sorry, give me that again. When you're talking about the expert panel, you mean the-- I don't think we ever formally designated them as a panel, but you mean Dr Mumford and her colleagues?

MR GRAY: Indeed, my Lord.

THE CHAIR: Yes. Sorry, I interrupted.

MR GRAY: -- and, my Lord, whilst no definite link between any infection and any confirmed source of infection was ever established, the experts all agree – including the HAD experts, my Lord – that on the balance of probabilities, there was an infection spike apparent during the water incident----

THE CHAIR: Now, when you use-- Perhaps I should get the formulation first. "While no definite link ever established, the experts were agreed, including Professor Hawkey and Dr Drumright and Dr Agrawal, that there was an infection spike." I then interrupted you.

MR GRAY: -- that there was an infection spike apparent during the water incident. My Lord, NHSGGC accepts that there was, on the balance of probabilities, an increased risk of infection during that period, and it has acknowledged in the written submission that, on the balance of probabilities, there is a causal connection between some infections suffered by patients and the hospital environment, and in particular the water system.

THE CHAIR: Right. Have you finished the formulation? Because I think I have questions arising out of it.

MR GRAY: Perhaps I could just finish by saying, my Lord, that experts agree that there is no longer an increased infection rate, and that, in my submission, further supports the conclusion that the hospital is safe.

THE CHAIR: Right. When you use the expression, "no definite link ever established", could you tease that out for me, please?

MR GRAY: Yes, my Lord. The point I'm seeking to make is that, as my Lord will recall, Direction 1 in relation to this public Inquiry was that any findings would be made, the standard being on the balance of probabilities, and that in the course of the evidence that was led before the Inquiry, there was in fact no evidence established that there was a definite link.

THE CHAIR: Well, it's the

expression “definite link” that I want your help with.

MR GRAY: Greater than on the balance of probabilities.

THE CHAIR: Right.

MR GRAY: And of course, Counsel to the Inquiry’s closing submission is that my Lord should find that, on the balance of probabilities, there was a causal connection between some infections and the water system, and that is entirely accepted, my Lord.

Having regard to what my submission has been misreporting by the media of NHSGGC’s written submission, it is important to highlight that the admission made by NHSGGC is on the balance of probabilities. That reflects entirely the position taken by the Counsel to the Inquiry and that the Inquiry is not concerned with whether there was any definite link or not; but as a matter of fact, no evidence was led to that effect.

THE CHAIR: And that’s consistent with the findings of the case note review in respect of the ‘86 cases.

MR GRAY: Yes, my Lord.

THE CHAIR: Now, you say there was an infection spike apparent during the water incident. Now, would I be right in identifying the water incident as a reference to the IMT which was established in March 2018?

MR GRAY: Yes, my Lord.

THE CHAIR: And I don’t think was closed until the end of 2019. Is this a convenient moment for me to take you to your closing statement?

MR GRAY: Yes, my Lord.

THE CHAIR: Now, can we go to paragraph 4.2? Now, what you’ve just said, Mr Gray, is that there was an infection spike apparent during the period March 2018 to the end of 2019.

Now, it appeared to me that what you’re saying in paragraph 4.2 is there was an exceedance in the rate of environmentally relevant bloodstream infections – which might be a more formal way of describing a spike – among the paediatric haemato-oncology patients in the RHC in the period 2016 to 2020, which, as I recollect, would be consistent with evidence we heard.

MR GRAY: Indeed, my Lord.

THE CHAIR: Right. So, is the period whereof exceedance 2016 to 2020, which of course includes, but extends beyond, the water incident?

MR GRAY: Indeed, my Lord.

THE CHAIR: Right.

MR GRAY: I don’t depart at all, my Lord, from what is set out in paragraph 4.2, that it is accepted that there was an exceedance in the rate of environmentally relevant bloodstream infections amongst paediatric haemato-oncology patients in the RHC in the period 2016 to 2020.

The only point which I seek to make by talking about the period of 2016 to 2018 is that the evidence showed that whilst there continued to be an exceedance after 2018, it did begin to decline as a result of the various measures taken, including those to the water system by way of chlorine dioxide dosing.

THE CHAIR: Right. You anticipate my taking you to 4.3, because the position-- Just so I'm absolutely clear, the position of GGC is there was an exceedance of infections in the period 2016 to 2020.

MR GRAY: Yes, my Lord.

THE CHAIR: However, from a date after the end of 2018, associated perhaps with the chlorination of the water ,that rate of exceedance declined. GGC accepts that there's a causal relationship between that exceedance and the state of the water system.

MR GRAY: Entirely right.

THE CHAIR: Now, can I just, while we're at this sentence, look at the first sentence of paragraph 4.3? You begin by saying it's broadly acknowledged there's no definite link, and we've talked about that.

> "NHSGGC accepts, having regard to the evidence led, that it is more likely than not that a material proportion of the additional environmentally relevant BSI ... had a connection to the state of the hospital water system."

Now, why do we see the words "material proportion"?

MR GRAY: My Lord, that's simply adopting the words used by Counsel to the Inquiry and the question that was asked in their closing submission, to my recollection.

THE CHAIR: I don't think it is, because you've accepted additional incidents.

MR GRAY: Yes, my Lord.

THE CHAIR: You've accepted a causal connection. Why do we find the expression "material proportion"?

MR GRAY: As I say, my Lord, my recollection is that that was the terms used in the questions posed by Counsel to the Inquiry, but really to reassure my Lord, I (inaudible 15:15:34) between some infections and the material proportion.

THE CHAIR: Right. Can I strike out "material proportion"?

MR GRAY: Yes, my Lord.

THE CHAIR: We'll check in the formulation, but I take it that GGC have taken their own view of the evidence.

MR GRAY: Yes, my Lord----

THE CHAIR: Right.

MR GRAY: -- but it coincides with that of Counsel to the Inquiry because, in

my submission, whilst the positions of experts instructed (inaudible) not align at the outset, by the time the evidence of all experts had been concluded, there was in my submission a concurrence of views that there had been an exceedance during the period which I have described which, on the of probabilities, was causally connected, in relation to some infections, to the water system.

THE CHAIR: Would I be right in thinking that almost as soon as a Professor Hawkey was sitting where you were sitting, he didn't contest that proposal?

MR GRAY: No, he didn't, my Lord.

THE CHAIR: No, and Dr Drumwright confirmed it.

MR GRAY: Indeed, but, as my Lord will recall from the first report provided on behalf of-- by Dr Agrawal, Drumwright, and Professor Hawkey, that was not their position and, following the iterative process of exchange of reports and supplementary reports being provided, there was that consensus.

THE CHAIR: Now, I interrupted you, Mr Gray. The last note I have is the agreement of experts.

MR GRAY: Thank you, my Lord. My Lord, it should be emphasised, in my submission, that what is accepted following the conclusion of the expert evidence is the probability of a link between the hospital environment and some infections, as my Lord and I have just discussed. It is no more specific than that. The Inquiry has not explored the question of any link between the hospital environment and any individual patient.

THE CHAIR: That would have been beyond its terms of reference.

MR GRAY: Indeed, my Lord. No evidence was led to demonstrate any link between the hospital environment and any individual patient. The Inquiry's remit and terms of reference, as my Lord has just observed, did not extend to consideration of a link between the hospital environment and a link to infection in any particular or individual case.

THE CHAIR: I would accept that, but I would also understand that GGC accepts the conclusions of the CNR report, which were directed at individual cases.

MR GRAY: Indeed, my Lord. My Lord, media coverage of NHSGGC's submissions in recent days has portrayed wrongly, in my submission, that NHSGGC accepts a link between the hospital environment and infections in certain individual cases of infection. That is not the case, and it is important, in my submission, that this point is emphasised, lest there be any doubt or misunderstanding on the matter.

THE CHAIR: Sorry, it's my fault. I agree with you that the Inquiry has not looked at individual cases. The Case Note Review did look at individual cases and came to the conclusions which are published in its report of March 2021. As I understand it, GGC accepts these conclusions.

MR GRAY: It accepts that the conclusion that there was a causal connection between some infections and the water system. As my Lord is aware, the Case Note Review has looked at particular cases of infection and has reached conclusions in relation to them specifically, none of which have been published, or of which NHSGGC has any knowledge.

Therefore, what NHSGGC accepts is what is essentially, as I understand, not contentious within this Inquiry: that there was, on the basis of the expert evidence available, evidence that on the balance of probabilities my Lord could find that there was a causal connection between some infections and the water system; and that the use to which one could have regard to the Case Note Review was – as Counsel to the Inquiry put it in their closing submission – by way of a cross-check to confirm or otherwise the view that had been reached on the basis of the expert evidence led; that in terms of accepting the Case Note Review,

inevitably, NHSGGC is not able to do more than to accept that there was on the balance of probabilities, as found by the Case Note Review, a causal connection between infection suffered by some patients and the water system. That is precisely the conclusion advanced by Counsel to the Inquiry.

My Lord, if I may move on, unless---

THE CHAIR: Oh, please do.

MR GRAY: -- my Lord's got further questions at this juncture. My Lord, I was making certain submissions about media coverage and would simply just pick up from where it left off, that media coverage of NHSGGC's submissions in recent days has portrayed wrongly that NHSGGC accepts a link between the hospital environment and infections in certain individual cases of infection, as I just indicated to my Lord. That is not the case, and it is important that this point is emphasised, lest there be any doubt or misunderstanding standing on the matter. It will be clear, in my submission, that inaccurate media reporting on such important and sensitive matters will inevitably result in distress to patients, families, staff, and all who use the services provided by the Queen Elizabeth University Hospital and the Royal Hospital for Children.

THE CHAIR: My fault entirely, Mr

Gray. I'm being somewhat pedestrian here. What I want, at dictation speed, is what you say has been wrongly reported.

MR GRAY: My Lord, media coverage of NHSGGC's submissions in recent days has, in my submission, betrayed wrongly that NHSGGC accepts a link between the hospital environment and infections in certain individual specified cases of infection. That is the principal respect in which it is submitted that there has been misreporting, and that has had, in my submission, very unfortunate consequences. Because of that, it is important that the point is emphasised that no such admission was made of that specific nature.

The reason, in my submission, that it is important to make the position clear is that inaccurate media reporting on such important and sensitive matters will inevitably, in my submission, result in distress to patients, families, staff, and all those who use the services provided by the Queen Elizabeth University Hospital and the Royal Hospital for Children. The impact of such distress from misreporting by the media, particularly upon patients, families, and those who have lost loved ones cannot, in my submission, be overstated.

My Lord, in my submission, the Inquiry can have confidence that NHSGGC is a very different organisation

to the one that was involved in the design, build, construction, and validation of the hospital.

THE CHAIR: A matter of small detail, has the hospital building been validated in any respect?

MR GRAY: "Had it", or "has it"?

THE CHAIR: At any time in its history since handover?

MR GRAY: I would need to take instructions on that matter, my Lord, but I would be very surprised if it has not, because the failings with which this Inquiry is concerned and which have been accepted by NHSGGC have been addressed comprehensively, in my submission, in particular, those in relation to defects in the water system and ventilation system, but it is a matter upon which, if I may, I will take specific instructions, my Lord.

THE CHAIR: It may or may not be important, Mr Gray, but the point you're making at the moment is not about validation. The point you're making at the moment is about an organisation. However, in giving me a timeframe to compare organisations, you ran through a period beginning with design, going through construction, and, in the way you put it, ended with validation. Now, we've heard evidence that validation has a particular meaning in a construction contract. The only evidence as to

whether validation is required – and I use that in a very loose way – comes in relation to ventilation.

But the reason I picked you up was it was your expression, and I took it that, by using it, you related it to something that had happened. I don't think we've heard any evidence of validation in the sense that we've had evidence about – in other words, the client satisfies himself by means of an independent, appropriate person that he's got what he wanted. That is my only point, but I appreciate that you are making a different point at this stage.

MR GRAY: Yes, and the point that I am making, my Lord, is that if one looks at that period of time and one looks at NHSGGC now, in my submission they are very different organisations in terms of the approach and their attitude to ensuring that the failings with which this Inquiry are concerned have been addressed. I would also submit that this is a different organisation to the one that was faced with the incidences of infection that the Inquiry has considered.

It is, however, as Professor Gardner made clear in her evidence, an organisation which is continuing to learn. Professor Gardner was in my submission in no way complacent about the position and that it is an organisation which continues to learn, and the evidence presented to the Inquiry has informed that learning process for NHSGGC. If my Lord makes the recommendations which he is invited to make by Counsel to the Inquiry, then those recommendations will inform further improvement.

Now, in relation to recommendations, NHSGGC, as my Lord is aware from the written submission, has proposed its own recommendations to the Chair, and those recommendations are aimed at enhancing national reporting of infection so that hospitals in the NHS Scotland Estate all report infections in the same way, allowing for better monitoring. The proposed recommendations are also aimed at ensuring colleagues who wish to raise issues, whether formal whistleblowing or otherwise, are listened to and supported.

My Lord, on behalf of NHSGGC, as was stated in the written submission, I would wish to repeat that it offers to my Lord its full assurance that it will take forward any and all recommendations which may be addressed to it in due course by my Lord to the fullest extent possible.

My Lord, if I may turn now to the question of the manner in which the NHSGGC has changed. My Lord, in my submission, whether a hospital is safe or unsafe requires to be looked at holistically, and that includes culture. My

Lord, if there is not a culture that allows colleagues to raise concerns, be listened to, and for them to be assured that their concerns will be acted upon, there is a very real risk that they will not raise those concerns at all.

My Lord, if those at the forefront of patient treatment cannot raise concerns, obviously those concerns cannot be acted upon, and, my Lord, in this regard, the Inquiry heard evidence from Professor Gardner and, in my submission, her evidence was forthright. She accepted unequivocally failings in culture. She explained that those failings were being acted upon and that they would continue to be acted upon.

My Lord, core participants express a degree of scepticism in my submission of Professor Gardner's evidence. In short, they question why they should believe what she is saying. The answer to that, in my submission, is that Professor Gardner has not attempted to hide failings. She does not suggest that the failings have been fixed. She explains that work has been done and that work will continue to be done, and, as I submitted earlier, my Lord, she does not show any complacency. Professor Gardner does not suggest that NHSGGC should wait for the outcome of this Inquiry and the Chair's recommendations. She is in my submission ensuring that

proactive steps are being taken.

In short, in my submission Professor Gardner demonstrates many of the key qualities of leadership which are seen to be crucial to effect cultural change, those qualities of leadership having been identified by both Sir Robert Francis and Mr Malcolm Wright in their evidence on the subject of effective cultural change when giving evidence to the Inquiry.

My Lord, in her evidence Professor Gardner apologised to the whistleblowers for the distress they experienced----

THE CHAIR: Well, did she?

MR GRAY: My Lord, I would invite my Lord to read Professor Gardner's evidence in full and to form his own view as to the manner in which her evidence was given, the tenor of that evidence, the sincerity of that evidence. When looked at as a whole, in my submission an apology and a proper and appropriate apology was made by Professor Gardner, but it is a matter for my Lord as to the impression which he formed from her evidence and the way she gave it.

THE CHAIR: I thought it appropriate to re-read the transcript of Professor Gardner's evidence last week. I mean, I have a recollection of the way in which she gave her evidence, and I make no observation of a critical nature, but I think she only uses "apology" in the context of, understandably, not being

able to apologise on behalf of the Board. That's entirely understandable and, as I said to Mr Connal this morning, for someone who only comes into post in February of last year she might have nothing personally to apologise for.

I mean, I thought it worthwhile noting what the transcript indicates that she said and at column 159 on the transcript for 9 October:

> "I am sorry that individuals did not feel listened to by the organisation and were not treated in a way that allowed them to feel empowered and to be able to be harnessed into a solution and were not afforded that opportunity."

Now, I don't say that's an inappropriate form of words. I'm not questioning that Professor Gardner is a sincere person with excellent ambitions for GGC. I merely make the point that on my reading of the transcript – and I'll be corrected – I do not find an apology to the microbiologists who brought forward concerns.

MR GRAY: There is in my submission an apology that was made for the distress that they experienced in general terms, as my Lord has provided from reading from the transcript, and that apology, which was adopted fully and unreservedly in the written submission on behalf of NHSGGC, is repeated today.

In particular, my Lord, it is acknowledged that whistleblowers were not treated in a manner that allowed their concerns to be fully listened to and acted upon. That was, it would appear, against a background of an unprecedented situation of significant complexity at a time when there were clearly tensions amongst all staff about how that situation should be handled.

That, however, my Lord, I entirely accept is not an excuse. The manner in which whistleblowers were treated was not acceptable and I would invite my Lord to accept from the evidence of Professor Gardner that it would not happen now.

Now, where any colleague wishes to raise concerns, the evidence of Professor Gardner in my submission was clear. They will be listened to and will be made, if they wish, to be part of the resolution. (After a pause) In respect of term of reference 4, my Lord, in my submission, contrary to the position before, the culture now encourages reporting of concerns.

My Lord, as was submitted in the written submission, 2025 marked the beginning of a new chapter for NHSGGC with new leadership. A new structure is in place, as spoken to by Professor Gardner, and NHSGGC is dedicated to providing the best care possible for its patients and to fully support in its staff to enable it to provide this care.

My Lord, to repeat what is said in NHSGGC's closing submission, staff and clinicians should feel assured that if there is an issue that they identify that they will be listened to. Equally, patients and families should feel assured that NHSGGC is fully supportive of its clinicians and staff, and external agencies should be assured that incidents will be reported with full cooperation and transparency.

My Lord, NHSGGC repeats that, in a number of respects, its management of the issues investigated by the Inquiry fell well below what patients, families, clinicians and staff should expect.

THE CHAIR: My fault, Mr Gray. Did you say, "Repeats in a number of respects"-- and I just fell behind.

MR GRAY: So, the-- I apologise again, my Lord.

THE CHAIR: No, no, no. It's I'm not fast enough.

MR GRAY: My Lord, that the NHSGGC's management of the issues investigated by the Inquiry fell well below what patients, families, clinicians and staff should expect.

My Lord, whilst those failings are acknowledged in full, it is submitted on behalf of NHSGGC that all of its staff and clinicians, at all times, did what they considered was best for patients, acting in good faith. The evidence shows that they were dealing with an unprecedented situation. There was, as I've indicated earlier, significant stress put on individuals and systems. The systems in place were tested beyond breaking point and those tensions were not managed. In this regard, too, it is submitted that lessons have been learned.

My Lord, it is submitted that the evidence led before the Inquiry does not support that any individual put self-interest or organisational interest before patient safety. It is also submitted that the evidence does not support that there was a cover-up.

THE CHAIR: With apologies for interrupting, "cover-up" is not a word that we find in the terms of reference.

MR GRAY: No. I think, my Lord, it may have been a term used by some witnesses. I may be wrong in my recollection, but that is my recollection.

THE CHAIR: I mean, it has a certain history, I suppose, but it's not a term that I can address directly. What I can directly address is the language of the terms of reference, which I think the relevant provision is term 4, "deliberately concealed or failed to disclose evidence of wrongdoing or failures in performance or inadequacies of systems." Whether "cover-up" is a useful substitute for the terms of reference, I'm not sure.

MR GRAY: No doubt in considering

all matters relevant to the terms of reference, my Lord will consider the evidence given by witnesses and their credibility and reliability, and it may be in that context that my Lord would consider the submission which I make, but it is a matter for my Lord. It is important nevertheless, in my submission, for the submission to be made that at no point, in my submission, was there any cover-up.

THE CHAIR: And does that comprehend failures to disclose failures in performance or inadequacies in systems?

MR GRAY: Yes, my Lord. In terms of any cover-up of those inadequacies, it is submitted there was no such cover-up.

THE CHAIR: Well, I don't want to detain you over-long and be more pedestrian than is necessary, but the expression "cover-up" might be an informal way of describing deliberate concealment, but a "cover-up" to me is something different than a failure to disclose.

MR GRAY: Absolutely. I entirely agree, my Lord.

THE CHAIR: Yes. So, it may be that you're just concentrating at the moment on deliberate concealment.

MR GRAY: Indeed, my Lord.

THE CHAIR: Right. Sorry for being so slow.

MR GRAY: No, no, not at all, my Lord, and a failure to disclose could be entirely inadvertent. What has been stated in evidence, my recollection is that in some respects employees of NHSGGC or the organisation as a whole engaged in what I recall was described as a "cover-up" and that is not accepted.

My Lord, failures in communication are acknowledged. It is also acknowledged that those communication failures led to increased anxiety for patients and families. But that, in my submission, does not support the finding that any individual deliberately concealed something for the purpose of self or organisational interests, as alluded to, to be considered under term of reference 4.

My Lord, NHSGGC did not get the hospital it asked for. When the hospital opened, it's clear from the evidence that there was significant work ongoing, with many contractors still on site. Court action is ongoing against Multiplex and others.

THE CHAIR: As a matter of minor detail, I think the Inquiry is aware of the Court of Session action that was, I think, served in January of 2020. My recollection is that there are four defenders in that action, Multiplex and three others. I wasn't clear from the closing statement whether there are other litigations ongoing.

MR GRAY: There are indeed, my

Lord, and I think the-- If my Lord would allow me just one moment to confirm whether----

THE CHAIR: Surely, yes. It's a matter of small detail, but it's just to understand what was being said in the closing statement.

MR GRAY: I think from recollection, there are three additional actions which are ongoing, my Lord. Yes, my Lord, the main action, as my Lord has indicated, was raised by NHSGGC in the Court of Session against Multiplex, their parent company, and Currie & Brown. As I indicated to my Lord, four additional actions were raised by NHSGGC; three against Multiplex and their parent company, and one against Currie & Brown in respect of separate issues pertaining to the Queen Elizabeth and RHC build.

THE CHAIR: I don't want to take you away into detail. The three additional actions and the one action, does that deal with cladding, or maybe deals with a number of issues?

MR GRAY: I'm afraid I would need to take instructions on that, my Lord. I'm not----

THE CHAIR: I'm taking up your time, Mr Gray. Please. We can perhaps explore that otherwise.

MR GRAY: Yes, Lord. My Lord, it is submitted, however, that the Inquiry is not the appropriate forum to consider any claim against Multiplex. Remedial work has been carried out to address issues with the building and steps have been taken to ensure that colleagues are fully trained and have the necessary expertise such that the built environment can be managed so that it is entirely safe for patients.

My Lord, turning, if I may, to some very brief submissions about-- in relation to infection risk. As I indicated earlier, my Lord, NHSGGC accepts that the expert evidence shows, on the balance of probabilities, that there was an increase in infections, and experts are aligned on that conclusion. NHSGGC has worked continuously to improve the hospital infrastructure to the extent that it now presents a safe environment for the delivery of care for all patients.

My Lord, in my submission, in respect of water, the experts' evidence supports that the system is now managed to the point that it is undoubtedly safe. That includes monitoring filtration and dosing, and it also includes, importantly, ensuring that those with appropriate expertise are responsible for the system and are fully trained on it, and it is submitted that the Inquiry should make a finding to the effect that the system is now safe.

My Lord, it is accepted that the

ventilation system does not meet the standard in SHTM 03-01. However, my Lord has recognised in the interim report that infection control is multifactorial. Monitoring of air quality is in place, and steps are taken to manage risk. Again, it submitted that the Inquiry should make a finding that the system is, accordingly, safe.

THE CHAIR: Consistent with what you said, I think, very early in your submissions, if I am to accede to your invitation to express any views on the word "safe", I would have to have regard to the culture of the responsible organisation.

MR GRAY: Indeed, my Lord.

THE CHAIR: I mean, it's not simply a question of measuring air quality.

MR GRAY: I entirely accept that----

THE CHAIR: Right.

MR GRAY: -- my Lord.

My Lord, in relation to the management of infection risk, infections must be reported to ensure that overall risk is properly monitored, and standardised reporting and strengthening national surveillance, it is submitted, will assist with this monitoring. That is the basis for NHSGGC's suggested recommendations as to national monitoring.

My Lord, in conclusion, NHSGGC wishes to repeat that patients and their families are at the centre of everything that NHSGGC does. The same is true of staff. It is submitted that the situation faced by NHSGGC was unprecedented, but failings are acknowledged in full, and an unreserved apology is repeated.

NHSGGC, my Lord, in my submission, is a different organisation to the one it was. It is continuing to learn and improve and, as I indicated to my Lord earlier, this Inquiry is a vitally important part of that process. My Lord, patients and families can have confidence in the built environment and should be assured that they will experience high-quality, specialist, and expert care from committed expert clinicians in a hospital which is safe.

My Lord, in her report to the Inquiry on the subject of risk management, Dr Mumford concluded that, "No healthcare organisation is without risk." In order to determine whether the hospital is now safe for patients, the management of risk within the organisation should be examined. The risk management must be robust, with active management and monitoring of the water and ventilation systems, and monitoring of infection rates responsive to any anomalous finding, and, more crucially, responsive to concerns raised at all levels from ward to board with a learning and just culture.

THE CHAIR: I can go to the report,

but, “crucially, responsive to ...”?

MR GRAY: To concerns raised at all levels from ward to board with a learning and just culture. It is submitted, my Lord, that the steps recommended by Dr Mumford are precisely those which been taken by NHSGGC, and which continue to be taken, my Lord, in its commitment to safety. The success of which is reflected, in my submission, in the very positive independent audits, to which I have referred, of the water and ventilation systems respectively.

My Lord, that commitment to safety will continue, assisted by the recommendations, or proposed recommendations, which NHSGGC endorses fully, and the proposed independent scrutiny of its actions going forward, which it welcomes.

THE CHAIR: Can I just revisit the last sentence?

MR GRAY: Yes, my Lord.

THE CHAIR: “That commitment to safety will continue,” and then you made some reference to recommendations.

MR GRAY: Yes.

THE CHAIR: Now, which recommendations were you referring to?

MR GRAY: All the recommendations that are proposed by Counsel to the Inquiry, my Lord. Just for my Lord’s note, it may assist if I just read the last sentence again.

THE CHAIR: Sure.

MR GRAY: That commitment to safety will continue, assisted by the recommendations, or proposed recommendations, which NHSGGC endorses fully, and the proposed independent scrutiny of its actions going forward, which it welcomes. Those, my Lord, are the submissions which I make at this stage.

THE CHAIR: Now, I have some questions for you, Mr Gray. I appreciate we allocated this afternoon for your contribution. I don’t see our timetabling as essentially compromised, but what I would proposed to do is sit until half past four. First of all, does that cause you any difficulty?

MR GRAY: None at all, my Lord.

THE CHAIR: As I say, I propose we will sit until half past four, and not beyond half past four, but I appreciate there may be those in the room who have made their plans on the basis of a half past four finish and, therefore, if anyone wishes to leave, I would fully understand. But, as I say, there’s maybe one or two questions I----

MR GRAY: Indeed, my Lord.

THE CHAIR: -- would value your assistance on, Mr Gray.

Questions from The Chair

THE CHAIR: Now, can I begin by settling in my mind the evolution of GGC's position, because I think you point out in your closing statement that, having had regard to the evidence heard, GGC's position has evolved.

Now, GGC previously submitted a number of closing statements and, if I'm correct, the first closing statement was following the hearings in 2021 and is dated 15 December 2021. The second submission followed the June 2023 Glasgow 2 hearings. That closing statement or submission appended two positioning papers which had been previously provided, one dated 14 December 2022 and the second dated 5 April 2023. After the Glasgow 3 hearings towards the end of 2024, you submitted a closing statement dated 31 January 2025.

Now, there then followed a procedural hearing on 11 March 2025, which was planning for the Glasgow 4 hearings. I took the opportunity to draw your attention to the terms of Inquiry Direction 9 and suggested to you that the closing statement of January 2025 had not dealt with specific facts, and you were gracious enough to agree with me on that, and as a result you provided a response to the Direction 5 request, and I have to stress that my powers are limited to the request on 26 June 2025.

Now, I think it would be fair to say that that remained a fairly high-level document.

MR GRAY: Yes, my Lord.

THE CHAIR: Then on 23 December 2025, following the three parts of the Glasgow 4 hearings, you have provided us with your most recent closing statement.

Now, you explain at paragraph 1.4 of your most recent closing statement that the submissions contained in it supersede all positioning papers and all previous submissions on the evidence. Am I right?

MR GRAY: Yes, my Lord. I can confirm that paragraph 1.3 of the final submission supersedes paragraph 21 of the submission following Glasgow 3 in relation to the assessment of the evidence. My Lord, the submission as regards unwarranted criticism of witnesses and the manner in which they gave evidence is maintained, my Lord.

THE CHAIR: Sorry, give me that again. What is maintained?

MR GRAY: My Lord, the submission as regards unwarranted criticism of witnesses and the manner in which they gave evidence is maintained. So that was a submission made following the Glasgow 3 hearings. Beyond that, Counsel to the Inquiry's assessment of the evidence is entirely accepted.

THE CHAIR: Right, can I just make sure we're looking at the same documents? In relation to what is maintained, which of your closing statements would you wish me to look at? The Glasgow 3 one?

MR GRAY: Yes, my Lord, in which criticisms were made of, in certain respects, the approach that had been taken by Counsel to the Inquiry in relation to witnesses and the manner in which they gave evidence. The criticisms that were made were set out between paragraphs 16 and 21 of the submission following Glasgow 3. So that, my Lord, is prior to my Lord's invitation to me to provide further supplementary submissions.

THE CHAIR: Right. So you maintain the-- As far as Counsel to the Inquiry's assessment of evidence, you accept that?

MR GRAY: Yes, my Lord.

THE CHAIR: In referring to "the assessment of evidence", that's the assessment of evidence in Counsel's submission after Glasgow 4 and I assume also after Glasgow 3?

MR GRAY: Indeed, my Lord.

THE CHAIR: All right. However, you maintain the position in paragraphs 16 and 21 of the closing statement after Glasgow 3, which includes a submission that Counsel for the Inquiry has adopted a plainly partisan and adversarial approach?

MR GRAY: Yes, my Lord.

THE CHAIR: And their evidence is subject to unjustified criticism.

MR GRAY: **I**ndeed, my Lord, and the criticism, my Lord, is not withdrawn. It is one which was made on the basis of the impression which was formed by Counsel to the Inquiry's approach to certain witnesses.

THE CHAIR: What were the features of the approach which led to your criticism?

MR GRAY: My Lord, that in the approach taken, Counsel to the Inquiry had adopted what in our submission was a plainly partisan and adversarial approach, which appeared to advance the interests of certain individuals to the detriment of NHSGGC and, more importantly, the public interest.

THE CHAIR: Who were the individuals whose interests were being advanced?

MR GRAY: It would have appeared to have been the interests of whistleblowers, my Lord. My Lord, that impression was one which was based on one's professional judgment and experience. I entirely accept that it may not have been Counsel to the Inquiry's intention to adopt such an approach, or indeed to give such an impression, but

that was the impression which was created and it was most unfortunate. I----

THE CHAIR: Sorry.

MR GRAY: Sorry, I was just going to conclude, my Lord, by saying that I accept immediately that such impressions are entirely subjective and it is ultimately a matter for my Lord to determine as to whether the criticism is found to be valid or not.

THE CHAIR: Well, I would have been assisted in that, Mr Gray, had you raised the point at the time, which I can't recollect you having done.

MR GRAY: I did not raise the point at the time, my Lord. As my Lord will appreciate, we are in an Inquiry. This is not an adversarial process, and it is my Lord's Inquiry and I have no doubt that if my Lord had considered that the approach being taken was inappropriate, that my Lord would have taken such action as he considered appropriate.

Added to that, in some respects, my Lord, the impression of Counsel to the Inquiry's approach having been as I described and really to some extent crystallised when one saw the terms of the written submission following evidence as well. But my Lord is entirely correct in his recollection: no objection was made and it was not made for the reasons which I have given.

THE CHAIR: (After a pause) Can I take a step back to talk in a general way about safety? Now, as you have correctly said, at the stage of Glasgow 3 the question used to explore the notion of safety was "avoidable risk". In Glasgow 4, one might see a different approach associated with "risk assessment" and "risk management".

Now, the Scottish Government has produced a number of policy documents. There are acts of the Scottish Parliament. I have in mind: the Patient Rights (Scotland) Act of 2011, the NHS Scotland Quality Strategy – that's a policy document. The statutes which I have in mind are the Patient Rights (Scotland) Act 2011 and the Patient Safety Commissioner for Scotland Act 2023.

Now, what one might see in these policy documents, standards and statutes are the aspirations that Government is putting forward in respect of safety in hospitals. Now, it occurs to me that one should have regard to these before making any statement about safety in hospitals. Do you have comment on that?

MR GRAY: Yes. If my Lord has in mind that the terms of reference require the Inquiry to determine whether the hospital buildings provide a suitable environment for the delivery of safe, effective, person-centred care, and whether any of those statutes or

guidance may be relevant to the consideration of what essentially is meant by the phrase “safe, effective, person-centred care”.

In my submission, what may constitute a suitable environment for delivery of safe, effective, patient-centred care must inevitably be multifactorial and would embrace not just the physical environment, but also a whole range of other issues that have been discussed by witnesses in evidence, including the competency of staff, the governance of the hospital, the existence of an appropriate culture, and so on.

If I am correct that the environment is multifactorial in the way I’ve described it, then, in my submission, it’s very likely that all the documents and guidance to which my Lord has referred would have some relevance and provide some assistance in determining that question.

THE CHAIR: I mean, it occurs to me that, in part, safety is about an aspiration and it’s, in part at least, about what a society is trying to achieve, as expressed in policy and statute?

MR GRAY: Yes, my Lord.

THE CHAIR: Right. I think we’ve seen reference in the closing statements to the report of the Vale of Leven Inquiry. Do you have any comment on the utility of referring to that?

MR GRAY: It is clearly an inquiry

which explored issues of failings in a hospital environment and my Lord may find assistance in having regard to its terms, but I have no particular submission to make about it, my Lord. And of course, I think perhaps only passing reference has been made to it in evidence, but that wouldn’t prevent my Lord having regard to it if my Lord found it of assistance.

THE CHAIR: Well, precisely. I think you’re right in saying that hardly any reference is made, and this would apply to other inquiries such as the Infected Blood Inquiry, but would I nevertheless be entitled to look at these reports?

MR GRAY: Yes.

THE CHAIR: I have other questions, Mr Gray, but it’s now half past four, and I said I wouldn’t sit beyond half past four. We will convene again, and can I ask you to be back tomorrow for ten o ‘clock?

MR GRAY: Yes, of course, my Lord.

THE CHAIR: Thank you.

(Session ends)

16:33