SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 January 2026

Day 4
Friday, 23 January 2026

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10:02

Opening remarks

THE CHAIR: Good morning. Now, today we have Counsel to the Inquiry, Mr Mackintosh KC, and I will invite him to give a final oral statement supplementing Counsel to the Inquiry's previous written closing statement.

Closing submissions by Mr Mackintosh

MR MACKINTOSH: Thank you, my Lord. I'm joined by my Co-counsel to the Inquiry, Mr Connal. My proposal, my Lord, is to start with three preliminary matters and then ask three questions. We adopt our closing statement-- the previous closing statements, from Glasgow I, II and III.

First, I thought I should identify what is to come next. Today is the last hearing of this Inquiry. It may assist those who are following online to appreciate that, after today, my Lord faces the task of preparing a report that addresses the remit of the Inquiry and each of its terms of reference, including the making of recommendations.

Prior to the formal setting up of the Inquiry on 3 August 2020, the then Cabinet Secretary announced the terms of reference in Parliament on 15 June. In her remarks, Ms Freeman made plain that the patients and families were to be at the heart of the Inquiry, and that was a key factor in your decision to hear first from those who had been affected by the issues at the Queen Elizabeth University Hospital.

It may also assist to explain that when my Lord has considered all the evidence and prepared his provisional conclusions, the Inquiry team will advise those who are to be subject to criticism what such criticism is to be and the facts that support those criticisms. This process has been described as the sending of warning letters, or Salmon Letters, or even Maxwellisation.

As Lord MacLean explained in the Vale of Leven Hospital Inquiry Report, which is bundle 51, volume 1, document 2, page 258 at page 30, in the third paragraph on the right-hand side of the page there:

> "The whole purpose of the warning letter process is to give notice to individuals and organisations of potential criticism, so that they have the opportunity of making an appropriate response to that proposed criticism. The warning letter process itself ensures fairness for anyone who may be criticised."

My Lord will, of course, then consider all responses to such letters

before submitting your final report to ministers, together with its recommendations. These, of course, may develop those made within the interim report published in March of 2025.

My second preliminary point relates to safety and how it should be understood. In his oral submission for the Board on Tuesday, Mr Gray KC submitted that Counsel to the Inquiry have considered that something is unsafe if it involves an additional risk of avoidable infection to patients. He appeared to criticise that.

That was our approach in the Glasgow III hearing. However, following focused and helpful submissions on this issue by Scottish Ministers, we sought additional evidence and developed our views. These can be found in Chapter 3 of our closing statement following Glasgow IV. We now appreciate that deciding whether a building or service is unsafe involves an assessment of both the likelihood of a harmful event occurring and the consequences of that harmful event.

The test we submit applies is set out in paragraph 188 of our closing statement. There are three circumstances when a particular building system at the hospital would not provide suitable environment for the delivery of safe, effective person-centered care.

The first is that no attempt has been made to apply the conventional framework of risk management and to evaluate the level of risk posed to patients.

The second is where there is evidence to support the conclusion that, in respect of an identified hazard, the likelihood and consequence of an identified harm occurring would give rise to a high or extreme risk in a particular patient group, and there's been no mitigation to reduce the risk to an agreed acceptable level.

The third is, where such mitigation is in place, there is evidence, for reasons that could reasonably have been anticipated, that it's not applied consistently or will be not effective in all cases.

We have therefore not assessed the question of whether any part of the hospital was, or is now, safe against the standard we were using in the Glasgow III hearing, but against the standard developed in Chapter 3 of our closing statement following Glasgow IV, and we've set out those conclusions in our closing statement.

The third preliminary matter is the issue of the criticism advanced to Counsel to the Inquiry. On behalf of the Health Board, Mr Gray has submitted that he continues to maintain the criticism of

the way we ask questions of certain Board staff advanced in paragraph 16-21 of the Board's closing statement following Glasgow III. We've addressed this issue at length in paragraphs 124-136 of our closing statement following Glasgow III.

Whilst we did ask some robust questions of witnesses, those were asked when those witnesses did not answer questions or could not explain inconsistencies between their position and documents. In our submission, we were right to do so. The Inquiry is charged with examining events of the utmost seriousness. It is important that the evidence heard is put to the sternest test.

Furthermore, many of our questions were asked because of specific requests by counsel for other core participants in the informal Rule 9 process. NHSGGC has also taken advantage of that process. It's quite likely that many questions that have aggravated the Board have been proposed by other CPs whose specific perspective of events is opposed to that of NHSGGC.

Had these concerns been raised during the hearing, we could have responded, but that was not done. In any event, we now understand that these concerns only crystallised after the hearing when the Board read our closing statement following Glasgow III. Our conclusions are matters of fact which, if I understand its evolved position, the Board now accepts.

My Lord, I turn now to my substantive submissions. My proposed approach is to reflect on the task that the Inquiry team has carried out over the past five years and then address three questions. The three questions are this: what went wrong with the procurement and why; what harm was caused by the deficient features of the building; and how can this be prevented from happening again?

Reflecting on the task we've carried out, the task of the Inquiry team has been made more difficult. NHS Greater Glasgow and Clyde have long insisted that there was no evidence to back up the concerns over patient safety at the Queen Elizabeth that caused the Inquiry to be established.

The clearest example was paragraph 63 of their first positioning paper from December 2022. I won't put it on the screen, but it's bundle 25, document 10, page 362. That document was adopted as one of the appendices to the Board's closing statement following the Glasgow II hearing in August of 2023.

As a result, much of the work of the Inquiry team has been spent on attempting to work out whether there was a link between patient infections and

identified unsafe features of the water and ventilation system. The Health Board has now reached a delayed acceptance that it is more likely than not that a material proportion of the additional environmental relevant BSI in the paediatric haemato-oncology population between 2016 and 2020 had a connection to the state of the hospital water system.

My Lord, that concession substantially reflects what the Case Notes Review concluded in March 2021. There needs to be some acknowledgment that how the Health Board approached this issue has severely impacted on the work of the Inquiry.

The three impacts that we say are principally the issue are as follows. The Inquiry team had to investigate the alternative, now abandoned, position of the Board in positioning paper 1 itself and the specific arguments set out in the appendix produced by the NHSGGC Director of IPC that included the suggestion that the existence of significant social deprivation in the city of Glasgow may have influenced the rates of hospital-acquired infections in the Schiehallion Unit which, as my Lord knows, has a catchment area covering the whole of Scotland.

The second impact was the Inquiry's appointed experts had to design and carry out their own epidemiological studies without the data that was produced by NHSGGC for the authors of what we eventually called the HAD Report, that is Professor Hawkey, Dr Agrawal, and Dr Drumright.

Thirdly, when the Inquiry team sought evidence, including opinion evidence from persons of skill from those who worked at the hospital who considered that there was a concern for patient safety arising from building systems, including the former lead Infection Control doctor, Dr Inkster, and microbiologists, including Dr Peters and Dr Redding, we were told in no uncertain terms that their evidence on all points should be rejected because they were agreed.

I now propose to turn to my first question. What went wrong with the procurement and why? 24 years ago, the NHS in Glasgow decided to build a new hospital. As Dr Armstrong, the Medical Director, put in her evidence last year, column 21 of her transcript:

> "NHS Greater Glasgow and Clyde thought it was getting a fantastic hospital they'd been working on for a long time, but did not get what they were expecting."

We are clear that the Health Board did not mention the decision not to follow

Scottish Government guidance on ventilation in the wards of the hospital, what we've called "The agreed ventilation derogation", in its Full Business Case. That meant that when the procurement was approved by Cabinet in December 2010, the Scottish Government did not know of that significant derogation. Moving forward to the opening of the hospital, as far as the evidence shows, the government were then still unaware of the agreed ventilation derogation and were not told of the DMA Canyon L8 Risk Assessment from that year until 2018.

In our closing statement, we've set out the errors and missed opportunities by NHSGGC and its contractors and consultants in the period from 2008 to 2015. I don't propose to revisit them all today.

THE CHAIR: Just a matter of detail. You mention the DMA Canyon report. Now, the date of the inspection upon which the risk assessment report was carried out, I think, was 23 April 2008.

MR MACKINTOSH: It was, my Lord. Yes.

THE CHAIR: Migration must have almost been in progress by then.

MR MACKINTOSH: Migration was almost in progress. The report was handed over to GGC staff soon after it was completed. There was always a very limited amount of evidence about exactly when. We eventually had some emails from Mr Watson of DMA Canyon which gave us a date, but the key point is it's clear from the material that the knowledge that the report contained serious concerns about safety was not escalated within the NHSGGC system, and I will come to that in more detail later in my submissions.

THE CHAIR: All right.

MR MACKINTOSH: So, I don't propose to go through all the different errors and missed opportunities. However, I am proposing to review seven questions of particular importance and I hope my Lord won't mind if I don't list them first and then go to them in turns.

THE CHAIR: Yes, all right.

MR MACKINTOSH: So, the first one is what is the relevancy of actions or inactions by the contractors that gave rise to deficiencies in the building systems? This is a matter that was raised by counsel for Currie & Brown and other counsel in written submissions for core participants from, as it were, the contractor consultant side.

Now, without revisiting the submissions of Mr Connal after the coffee break on Tuesday, it may help to explain why this question is relevant in three steps. We have identified a number of decisions or actions by contractors or consultants in the procurement that can

be causally connected to the existence of specific defects in the building.

It's not for this Inquiry to decide where liability or responsibility lies under the various contracts. However, we can, without expressing a view on contractual liability, explain how those decisions or actions are connected to the deficiencies, and that's what we have done. I do wish to pick up on a specific point raised by Ms McCafferty KC on Wednesday concerning Mr Hall's signoff of design drawings for clinical functionality. Ms McCafferty was correct to note that we did not criticise Mr Hall for signing off the design drawings, but the design drawings signoff process in which he played a significant role can be criticised.

In terms of the reduced scope of Currie & Brown's role from January 2010. Mr Hall undoubtedly signed off the design drawings for clinical functionality under delegated authority from the Board's project manager, Mr Moir. Given that he had no technical expertise, was the restriction to clinical functionality clear? In the absence of an express qualification to the approval by Mr Hall of each drawing – and there was none – Multiplex would very likely assume that Mr Hall's signature meant that the M&E – the mechanical and electrical technical contents of design drawings – was approved by the Board.

Ms White from Nightingale, the architects, appears to have thought this to. It seems members of the NHSGGC Project team did not all appreciate that Mr Hall was only approving drawings for clinical functionality but was not checking, for example, the required ventilation output, and we can see that in the transcript of Ms Wrath's evidence in Glasgow III at column 48. Some thought Mr Hall was the technical adviser, and that was Mr Mcleod who was one of the two project managers for the hospitals, column 92.

The next question that I raise is what was the effect of the lack of a change control process and how did that oversight happen? In the contract it signed, the Chief Executive, Mr Calderwood signed on 18 December 2009, NHSGGC agreed to an agreed ventilation derogation which reduced the amount of air being supplied to most of the rooms in the hospital to less than half that required by the draft Scottish guidance that the Health Board had decided to apply to the project.

There was an earlier decision to remove what was called "the maximum temperature variant", and this was issued to contractors on 20 July 2009 as part of the competitive dialogue process. The decision to remove the variant can be found in bundle 43, volume 6, document

32.1, page 603.

The effect of the removal was to limit the maximum temperature inside the hospital broadly to 26 degrees, rather than the 28 degrees set down in the government guidance, and it made it impossible to achieve six air changes per hour in the wards as required by the same government guidance, and effectively resulted in the agreed ventilation derogation being agreed. That the system couldn't achieve what was set out in the guidance is set out plainly by Brookfield Europe, the contractor, in their tender documents, and it's worth perhaps looking at those: bundle 18, volume 1, document 8, page 311.

Now, this is a page from an extensive sequence of documents which make up the tender from Brookfield Europe, which eventually became Multiplex. This is the two pages which set out the Ventilation and Air Treatment Design Strategy. I'm not proposing to go through it in length. We took a number of witnesses to it, but if we go to the next page, 312, we see within the conclusion, in the final paragraph, a reference to the impact of the temperature change, and we discussed that with a number of witnesses but, in our submission, it's clear that Brookfield Europe understood the effect of the maximum temperature variation. It's not immediately clear to us that the Board did.

In our submission, the removal of the maximum temperature variant and the consequential agreed ventilation derogation in the contract were of such significance that they both required to be fully understood and authorised via the governance systems set out by the Board for the new Southern General Hospital project. As far as we can see, the project director did not report either change to those he was supposed to be accountable to, i.e., the new South Glasgow's Hospitals and Laboratory Executive Board, which I will refer to as the "Executive Board".

We know from the papers of that Executive Board and the Performance Review Group, which is a subcommittee of the Board to which it reported, that it was supposed to have a change control system which would enable changes that impact on what the Board was to get to receive approval from that Executive Board. The problem is, as far as can be seen from the evidence, there was no such system, and so the removal of the maximum temperature variant does not seem to have been discussed, and the agreed ventilation derogation was never approved by those governance structures, including the Executive Board.

Many members of the Executive Board gave evidence, and we've set that

out in sections 5.3.7 to 5.4.3 of our submissions. It's now clear to us that the Executive Board did not have control over, or understanding of, what the Project director and other members of the Project team were doing in the negotiations with Multiplex or Brookfield Europe in those final weeks before contract sign. Responsibility must extend beyond those senior members of the Project team to the members of the Executive Board, and we've set that out in paragraphs 16.62 and 16.63 of our closing statement.

THE CHAIR: When you say, "closing statement", the----

MR MACKINTOSH: Glasgow IV one, my Lord.

THE CHAIR: Glasgow IV. I'll take it that, unless you tell me differently----

MR MACKINTOSH: I'd be obliged, because that's probably the way I will proceed.

THE CHAIR: -- that it's the Glasgow IV submission.

MR MACKINTOSH: Now, it's true that an attempt was made to bring in outside voices to the Executive Board, but in our submission, that was not effective. Mr Baxter, as the representative of the Scottish Government Capital Investment Group, had a relatively limited role. Partnerships UK were also represented in the Board and could have been an important voice calling for assurance and rigorous project management, but lack of surviving documentation means we will never know whether Partnerships UK did raise these issues or remained silent. The conclusion that the attempt to bring in outside voices was not effective informs our proposed recommendation at paragraph 1877 of our closing statement, - I mean Glasgow IV – that the Scottish Government should instruct specialist legal advice and representation in all major healthcare projects during the period between the approval of the outline business case and the contract signature. Mr Connal addressed this in some detail on Tuesday.

My third issue, or question, is how did the specialist ventilation wards end up with inadequate ventilation systems? So, a key issue is why it was that the four wards with specialist ventilation needs, including the Schiehallion Unit in Ward 2A and the Adult BMT Unit in Ward 4B in the tower, ended up with three air changes per hour outside lobbied isolation rooms when the guidance said they should have had 10?

We've covered this in detail in section 7.3 of our closing statement and discussed the issues with the clinical output specifications, the use of ADB codes, whether the Design team at TÜV

SÜD should have asked more questions or realised that these were specialist wards but, in our submission, serious consideration should also be given to two factors that can be linked to this failure: the weakness of the Project team and the stand down of the Currie & Brown Technical team. In our submission, these two factors made it inevitable that NHSGGC would not spot the problems before the wards were built and opened.

Firstly, the project team did not have the skills to deliver the hospital that was expected. We've covered this in significant detail in section 5.6.2 of our closing statement, and also in Chapter 8 in paragraphs 1506 and 1571 to 1575. NHSGGC managers appointed personnel to its Project team who had little or no experience of a project of this size scale.

Secondly, on 18 January 2010, a decision was made to do without technical advisers, including mechanical and electrical engineering consultants. The responsibility must lie with NHSGGC and its Project team. We have the letter informing Currie & Brown of the decision and we described it in some detail in paragraphs 614 and 615 of our closing statement. But it's interesting that the high-level information pack issued the following month to those who were bidding for the role of NEC3 supervisor still identified the Currie & Brown technical team as being in post, see paragraph 784. Many members of the project team, including both project managers of the adult and children's hospital did not appear to realise the change. The keeping of technical advisers was essential to getting the hospital the Board wanted.

My fourth question is, what was the impact of the limited involvement of the Infection Prevention and Control team in the New Southern General Project? In our submission, the lack of involvement of the IPC team in the project had a significant impact.

Firstly, two specific oversights in 2009 need to be considered. The first is the key meeting on 18 May 2009, chaired by the then infection and control manager, at which specialist ventilation requirements at the adult hospital were defined. These were not incorporated into the Employers' Requirements and into the contract, see section 5.3.6 of our closing statement. Had they been, not all the isolation rooms would have been built as unsuitable Positive Pressure Ventilated Lobby rooms. Some responsibility of this oversight must lie with the project director but also with the infection and control manager who chaired the meeting.

Secondly, there was no infection and control nurse seconded to the Project

team at the point the agreed ventilation derogation was accepted. The then IPC nurse consultant----

THE CHAIR: A matter of detail. Given what we heard about the Infection Prevention and Control nurse who was later seconded, with the absence of an equivalent person, it made a difference?

MR MACKINTOSH: Well, the problem with that, my Lord, is that the previous infection control nurse who was seconded, which was Ms Rankin----

THE CHAIR: Yes.

MR MACKINTOSH: -- had a higher level of skill.

THE CHAIR: Right.

MR MACKINTOSH: I recollect the evidence of Ms McCluskey, who was the nurse, senior nurse, seconded to the team. When the discussion was had with her about how many people would be required to be in a single room, which we've placed to the discussion about the reduction in air supply to rooms, at that point, if there'd been an infection control nurse in that conversation, we would like to hope that there would at least have been a possibility of it being escalated upwards.

THE CHAIR: Right.

MR MACKINTOSH: Because it's worth remembering at this point, 2009, the Board did have access to an experienced clinician, a Dr Hood, who did later give advice the following year on the renal dialysis room. So, there was a source of advice. The question was whether they would get it.

THE CHAIR: Right. So, in thinking about that point, I should take Ms Rankin as the notional but absent nurse?

MR MACKINTOSH: I think so because I think there's an issue about whether Ms Stewart had the experience at the time that she took the role. But Ms Rankin had left in November, so there's a short gap during which the derogation is agreed when there's no infection control nurse, and that's the moment when the conversation is had about the number of people who can be in the room, or will be in the room, rather.

Now, the then IPC nurse consultant or associate director, who's now director of IPC, explains in-- I think it's her consequential witness statement for the Glasgow IV Part 2 hearing, that when Ms Rankin left, she initiated a recruitment process. But that meant the Project team was without IPC support at a key time whilst the role was filled. In our submission, that contributed to the lack of IPC input into that decision on the agreed ventilation derogation.

The sort of higher-level point, however, which we develop in section 6.4 of our submissions, is the importance of the HAI-SCRIBE system which is the

Scottish Government's healthcare associated infection system for controlling risk in the built environment.

We have found nothing more than the attempted Stage 2 HAI-SCRIBE for the project and it can only be described as entirely inadequate. We've covered it in some detail in section 5.6.7 and paragraphs 672-677. We didn't find any other HAI-SCRIBEs. Whilst HAI-SCRIBE was then relatively new, the novelty of the scheme might explain if the process had been done poorly but not that it was effectively, the large part of the project, not done at all.

Consideration needs to be given to where responsibility lies for not following HAI-SCRIBE. The principal responsibility must lie with the project director and the two senior responsible owners for the New Southern General Project, Ms Byrne and Mr Calderwood. Although, it must be recognised that, on one occasion, Mr Calderwood did ask at a project meeting whether HAI-SCRIBE had been carried out, and we set that out in paragraph 667 of our closing statement.

It's striking that in their statements for Glasgow IV Part 2, the then IPC nurse consultant associate director, now director of IPC, and the then lead ICD explain that they only became aware of the Stage 2 HAI-SRIBE because of evidence to the Inquiry, and we've covered that in paragraph 675.

THE CHAIR: When you say, "only became aware of Stage 2," what do you mean?

MR MACKINTOSH: Well, we asked them, effectively, "What do you think of the Stage 2 HAI-SCRIBE?" We gave them a copy and we asked them their views on it and both of them responded that they weren't aware of the document until we put it to them.

THE CHAIR: Right. So, they weren't aware of the document in the sense of HFN 30?

MR MACKINTOSH: No. They weren't aware of this Phase 2 document that the ICN----

THE CHAIR: Right, which is the pro forma with answers?

MR MACKINTOSH: The pro forma with very, very limited answers.

THE CHAIR: Yes.

MR MACKINTOSH: We put that to them after the author gave evidence and asked them to comment on it and as part of their answer, they both indicated that they only first saw it when we put it to them.

THE CHAIR: Right.

MR MACKINTOSH: Now, this must mean that neither of them looked for any of the HAI-SCRIBEs even after the hospital opened and concerns were raised about the ventilation systems in

wards 2A and 4B.

Now, it should be noted that the lead ICD in question left the Board in 2016, but the director of IPC has been in post and closely involved in issues around Queen Elizabeth ever since. In our submission, the reasonable but troubling conclusion is that they were simply not interested in this important process as applied to the project.

Now, it's fair to say that the version of HAI-SCRIBE that was in force in 2009 does not formally allocate responsibility for applying its principles to the IPC Management team, but these are the people in the Board who best know the importance of IPC. They were the available experts. Some responsibility for the failure to follow HAI-SCRIBE must therefore be placed at the door of the Infection Prevention and Control Management team at the time.

Now, the fifth question is, where does responsibility lie for water safety failures? My Lord touched on this in the question a moment ago. In Glasgow IV Part 1, we heard evidence of how the hospital water system was filmed possibly 18 months before the hospital opened.

I won't revisit in detail the failures to respond promptly to the 2015 and 2017 DMA Canyon L8 risk assessment. But, in our submission, those events must be seen in the context of the extent to which NHS Greater Glasgow and Clyde comply with its own water safety systems policy, which can be found, the version that was enforced at the time when the hospital opened, in bundle 27, volume 2, document 1, page 5.

The Board now appears to accept that the resourcing for building maintenance at the time of the opening was inadequate, but we go further. When the hospital opened, there was no water safety plan or written scheme for the site and the necessary authorised persons water, and authorising engineer water had not been appointed.

At those documents being produced or the persons appointed, there is every reason to think that the water system would have been better managed and the biofilm, microbial proliferation or widespread contamination found at the start of the water incident would not have grown to the extent it did. We address these issues in detail in paragraphs 1261-1268 of our most recent closing statement and section 6.1 of our closing statement from Glasgow III.

Mr Calderwood's lack of understanding of his responsibilities as a duty holder for water was striking. But responsibility for these failures also falls on other shoulders, and by following what's in the water safety systems policy, including the director of facilities as

designated person water and the infection control manager as designated person pseudomonas in those roles, but also as co-chairs of the Board water safety group. Also, the General Manager of Estates, later Head of Corporate Estates.

The sixth question is, was there a lack of questioning by senior staff? As we noted in paragraph 76 of our closing statement, it was a key conclusion of the Vale of Leven Hospital Inquiry that in dealing with the issues that prompted that inquiry, many NHSGGC managers failed in one of the fundamental aspects of management, namely to ask questions.

The key paragraph in chapter 1 of that report should be revisited. I wonder if we can put it on the screen. Bundle 51, volume 1, document 2, chapter 1, page 238. So, this is the section, my Lord, headed "Management". If we can zoom in a little bit? So, the first part I've already quoted before, "The importance"----

THE CHAIR: Yes?

MR MACKINTOSH: The monitors keep flashing on and off. There we are:

> "The importance of questioning.
>
> It was surprising how managers at different levels within an organisation like NHSGGC failed in one of the most fundamental aspects of management, namely to ask questions."

Now, this text was published in 2014 when the Vale of Leven report reported. Then there's a discussion of culture:

> "The culture.
>
> Quite apart from a number of individual failures to investigate and be aware of what was actually happening at in the VOLH, it became apparent that there was systemic failure. Ultimately this can only be described as a management culture that relied upon being told of problems rather than actively seeking assurance about what was in fact happening.
>
> To take an example from the evidence, a manager who has a responsibility to ensure the delivery of high quality care cannot fulfil that duty simply by relying on being told when a specific problem emerges and reacting to the problem. Some managers with responsibilities for the VOLH also had responsibilities for other hospitals operated by NHSGGC, but the Inquiry's focus, of course, was only on the VOLH, and in consequence I cannot comment on their broader performance. Nor do I know how prevalent this style of management would be generally within NHS Scotland.
>
> Nevertheless, the clear lesson

to be learned is that an important aspect of management is to be proactive and obtain assurance that systems and personnel are functioning effectively."

Now, in our submission, my Lord, that conclusion was made nearly more than a decade ago by Lord MacLean and it applies almost word for word to the evidence that we've seen and the conclusions we can reach. Particularly, as the way we've described it, and what's been described to us, as exception reporting, the idea that you expect your direct reports to report exceptions from successful performance to you and therefore assume that everything else is good.

In my submission, one can take the evidence of a number of witnesses and read that text and see the same issues reflected in their evidence of their conduct in '15, '16, '17, '18 and maybe even later.

THE CHAIR: Certainly. I think you put that specifically to Mr Calderwood.

MR MACKINTOSH: We did.

THE CHAIR: Yes.

MR MACKINTOSH: I don't think we put it to some of the other managers, but I think it's a fair reflection on their evidence, looking at it in context. I should just say at this point probably that it's worth emphasising that we acknowledge that people make mistakes, that an individual mistake is something that is unfortunate and needs to be learnt from, but probably shouldn't, unless it's a particularly serious one, be one that will be picked up by a public inquiry. It's the repeated mistakes and the systemic issue of them that concerns us more but I'll return to that later.

In our submission, these observations apply just as much to the procurement of the Queen Elizabeth and the GGC response to its flaws as they did to the Vale of Leven. To some extent, the issues facing this Inquiry are the same as faced at the Vale of Leven Inquiry.

In paragraphs 12.2 and 12.3 of their closing statement, GGC do appear to accept that criticism of this sort can be applied to the procurement of the hospital. But from reading this section, I gain the impression that the concession only runs to an undefined point after handover. In our submission, this lack of--

THE CHAIR: Sorry, this is 12.2?

MR MACKINTOSH: 12.2 particularly.

"So, a pattern emerges [say the Health Board], from the evidence of lack of scrutiny and challenge in respect of project governance on behalf of NHSGGC. Many witnesses consider the responsibility for

particular issues sat elsewhere, leading to no one taking responsibility of those issues. No individual acted in bad faith. [I'm not sure that's the test]. It was simply a failure to allocate, and adequately specify roles, and ensure the reporting lines were in place. These issues would not occur in the present NHSGGC."

Then, 12.3:

"This issue was particularly acute when it came to receiving advice on the design of the hospital. There was little expertise from the Board to cope with a project of this magnitude. The Board was accepting what it was told during the design and construction phase. It was reliant on the technical team and did not properly interrogate what it was told. The Project team operated on assumptions that others would take responsibility. This all had manifested in the absence of full commissioning and validation. At handover, authorised persons were not in place. When they were identified, they required significant training. The Board was poorly advised but lacked the expertise to challenge that advice. The Board is in an entirely different place."

Now--

THE CHAIR: That includes the assertion that the Board was reliant on the technical team, and we're talking about the design approval phase. There was no technical team in place.

MR MACKINTOSH: Yes. I read that as the Board was reliant on the contractor's Technical team.

THE CHAIR: Right.

MR MACKINTOSH: But--

THE CHAIR: Fair enough.

MR MACKINTOSH: -- that's consistent with the evidence from the evidence from the project director, who feels that, in some unclear way, he received an instruction not to challenge technical matters with the contractor, though we were never really able to pin down if that instruction was given or where it came from.

If we go back to the previous page from the Vale of Leven, we notice that Lord MacLean observes that his focus was on the Vale of Leven Hospital and, in consequence, I cannot comment on their board of performance. Well, he's describing events in 2008, 2009, and 2010 in the Vale of Leven. This concession applies to events in 2008, 2009, 2011 in the New Southern General Hospital. To some extent, there is a corroboration here. He's seeing similar problems in a different part of the same organisation at the same time.

In many ways, we have already discussed the lack of questioning extended, and it extended to the members of the IPC Management team, the Board Water Safety Group and, as I'll come and develop later, extends possibly in the case of the IPC senior Management team to the present day.

Key staff, including people whose actions were subject to comment in the Vale of Leven Hospital Inquiry Report, did not ask questions about their new hospital, even when deficiencies were brought to their attention by many people in 2015. At best, these public servants focused on the task in front of them or the reports from their direct reports.

They were not prepared to ask questions, which brings me to the question of – this is the seventh of my seven – was there a failure to act in June 2015? By the end of June 2015, it was clear to anyone who cared to listen that there were flaws in the ventilation system of two key specialist wards: Ward 2A and 4B.

Other issues took time to emerge as understanding developed, but it's not correct to describe the emergence of problems within those two wards as gradual, evolving, or iterative. The return to the Beatson of the regional Bone Marrow Treatment unit after five weeks due to concerns over the ventilation system placed the relevant managers and the Board on notice that there were flaws with the ventilation system of their building. In our submission, it's a complete abrogation of responsibility to fail to investigate the whole system and its procurement at that point.

The letters sent by Dr Peters and Dr Inkster at the start of July 2015 – which be found in bundle 14, volume 1, document 26 at pages 414 and 420 – resigning or, as the ICM put it, demitting their sessions as Infection Control doctors, was a red flag that required action.

The then medical director did order an investigation into culture within the IPC team in response, and that investigation ultimately resulted in the appointment of Dr Cruickshank and an improvement in relations between colleagues, but there was no comprehensive investigation into the safety of the building.

Had such an investigation been carried out in 2015, four things might have happened. The extent to which the agreed ventilation derogation applied to different parts of the hospital would well have been discovered in 2015, and its implications understood; the decision to make the isolation rooms Positive Pressure Ventilated Lobby rooms, which are not suitable for highly infectious for

immunocompromised patients, would have been discovered, and the programme to rectify them would have begun earlier; it would have been realised that, in effect, no part of the HIS grave system had been applied to the construction of the hospital. I appreciate there was at Stage 2, but it's entirely unsatisfactory.

In the general climate investigation, there would have been a good opportunity to understand the weaknesses of the water system, and that would have been a matter of two months after-- three months after the DMA Canyon Report was handed over.

Now, there was an attempt the following year when Mr Powrie reported on 26 May 2016 – which is an email at bundle 20, document 68, page 1495 – of the existence of the agreed ventilation derogation. If you remember, my Lord, he attached the ZBP ventilation strategy document to his email, which set out the justification for that derogation such as it was.

There was then an exchange of emails that resulted in Mr Seaborne's email of 23 June 2016, which we come to know as we are where we plan to be, and that's at bundle 12, document 104, page 813. But Mr Seaborne's email raises far more questions than it answered, and should also have prompted an investigation.

Stepping forward a further year, it's also worth noting that the evidence of the then Chief Executive, Ms Grant, was that it was the SBAR of 3 October 2017 by Dr Redding and her colleagues that resulted in her, the Chief Executive, and the then Chair, Professor Brown, learning about the ventilation issues in the hospital. They didn't know until then that it took a whistleblow----

THE CHAIR: So, we're talking about October 2017?

MR MACKINTOSH: We are.

THE CHAIR: Right.

MR MACKINTOSH: Now, of course, Ms Grant had arrived in-- I can't be sure if it was March or April, but the earlier part of the year.

THE CHAIR: Certainly in some time in that year.

MR MACKINTOSH: Yes, and Professor Brown had been imposed since the first month of 16. But it appears to be the case that it took the SBAR, the whistleblow, by Dr Redding and her two colleagues, to cause the Chair and the Chief Executive to learn about the problems that had been reported in 2015.

In my submission, that speaks to a repeated lack of a desire to ask questions by those who reported to Ms Grant. It amounts, in our submission, to wilful blindness. Now, this Inquiry has had to

reconstruct a procurement process that took place more than 15 years ago.

In our submission, it's reasonable to conclude that an investigation carried out just six or seven years after the event – the event being the signing of a contract – and only a couple of years after the opening of the hospital, would have been more likely to produce conclusions faster and more efficiently because the second project director was then still employed by NHSGGC, more documents and materials would have been made available, Currie & Brown were available to answer questions, Multiplex was still on site, and the final completion certificate had yet to be issued. Memories would have been fresher.

The contrast with the rapid response of NHS Lothian and its decision to report concerns about the ventilation in the Edinburgh hospital this Inquiry has been looking into to the Scottish Government, almost as soon as they came to light, is striking. Now, on Wednesday, Ms Crawford KC, for the Scottish Government, highlighted the NHS Lothian response. If I understood, the point being made was that oversight systems now exist to ensure that issues like this are highlighted and addressed. Our response has to be that that submission is only partially effective.

The Glasgow hearings have been considering the situation in contrast with Lothian, where a Health Board did not ask questions, did not disclose to ministers, and did not help, and arguably continue to do some of those things even now. Our submission is that oversight systems and guidance currently in place are not set up to deal with such a recalcitrant Health Board.

So, to summarise those seven issues or questions, a broad summary of the answer to these questions is that the response of NHSGGC, its managers and directors, to defects in the water and ventilation system of the hospital, was inadequate due lack of effective governance, lack of use of technical advisers, and a significant and long-standing aversion to asking questions.

I'm proposing now to move on to my second question: what harm was caused by the deficient features of the building? I must start this section by acknowledging the real harm and distress caused to patients and, in the case of the children, their parents; in the case of adults, their families, in the Queen Elizabeth University Hospital and the Royal Hospital of Children in the years after the hospital opened in June 2015.

This impact is powerfully summarised in their statements and in the submissions produced and made by my learned friends Mr Love KC and Ms

Connelly. I don't propose to revisit them. I don't think I can do justice to the extent of the impact by picking individual remarks or individual sections from, with one exception, statements. But we will all listen to them, and my Lord's heard them all.

In our closing statement, we described the widespread contamination, or biofilm growth or microbial proliferation, found in the water system in the early months of 2018, found by NHSGGC staff. Now, in our submission, there were a material number of bloodstream infections amongst the patients in the Schiehallion Unit who acquired bloodstream infections linked to that water. We cannot say exactly how many patients were affected but, in our submission, it's important to note that Dr Drumright's later work, when she had access to all the data, is consistent with it being around a third of cases. That, of course, is broadly the same as the conclusions of the Case Notes Review.

NHSGGC now accepts that there was an exceedance in the rate of environmentally relevant bloodstream infections amongst paediatric haemato-oncology patients in the Royal Hospital of Children in the period 2016 to 2020, with a decrease when remedial measures began to be put in place in 2018. That is more likely than not the material portion

of these additional BSI had a connection to the state of the water system. I think it's fair to say that a lot of the effort of the Inquiry team has been put into investigating that issue.

This concession covers the period prior to 2018 when Dr Peters and others were raising concerns about the availability of water testing results and the operation of the IPC team, the period of the water incident in Ward 2A in 2018 up to decant, and the period in 2019 when Dr Inkster was investigating gram-negative infections in Ward 6A as Chair at IMT.

I want to make a few specific observations on ventilation. The evidence shows that the ventilation system of the hospital was not validated against any standard before opening. On Tuesday, you asked Mr Gray if validation had now been done, and he said he "would take instructions but would be surprised if it had not been done."

Mr Steele's evidence, if we look at column 75 of his transcript, shows that validation had only been carried out in "selected wards across a number different floors: Level 4, Level 6, Level 5, Level 7". The last couple of days we've been just producing a list. Ward 2A, 2B was validated by Sutton Service International after reconstruction in February 2022. That document is bundle

52, volume 10, document 45, page 225. Ward 4B was validated in November 2017 by H&V, and their ventilation report of 6 to 10 November 2017 is referred to by Mr Poplett in his first ventilation report. That's bundle 21, paragraph 10.8, page 571.

Ward 4C was verified, rather than validated, on 16 and 17 January 2020 by Correct Air Solutions Scotland Limited, but was found to be deficient for immunocompromised patients. That's Mr Bennett's report, bundle 21, paragraph 8.27, pages 689 and 690. I should say that, subsequent to that, there was a risk assessment done, which we discussed in our submission. Critical Care, HDU and ICU were verified in 2019 and 2020 but not validated. Critical Care isolation rooms were verified in 2022 – Mr Poplett's report, bundle 21, paragraphs 10.4-10.6, pages 570-571 – and some rooms we know in PICU – that's Paediatric Intensive Care Unit – were verified by Correct Air Solutions Scotland Limited and we have that in Mr Poplett's bundle 21, paragraph 10.50, page 579.

Now, it may be that Professor Steele has confused validation and verification, but the key point to make today is that the whole hospital ventilation system has not been validated. The general wards have not been validated. It's most concerning that it's still not been done.

However, in respect of actual harm caused by deficient features of the ventilation system, the question is harder to answer. We accept NHSGGC's view that a non-compliant ventilation system does not mean it's necessarily less safe, and I think that was Mr Poplett's position as well.

However, the point we make is that a reduction from 6 air changes an hour to 2 ½ to 3 air changes an hour does increase the risk for highly immunocompromised patients who are placed in general ward standard rooms. This accords with Professor Humphreys' view early on in the Inquiry. So, that's Professor Hilary Humphreys, 12 May 2022, column 52.

It's also important to recognise, as Mr Bennett and others did, that there were no HEPA filters in the general rooms, meaning that harmful fungal spores, such as aspergillus, will pose a risk to immunocompromised patients in general rooms. If the air change in general rooms is reduced from 6 air changes per hour, then plainly that must increase the risk to immunocompromised patients to some extent.

Given the devastating consequences of such an infection for those highly immunocompromised patients, then, in my submission, that risk

is increased to a material degree. Beyond saying that, I don't propose to repeat our assessment of what risks remain because we've set that out in detail in our closing statement.

However, in light of the change of position by the Health Board and its continued insistence that in all respects the hospital is now safe, I should revisit one issue and that is the importance of risk assessment. Now, it's difficult for a public inquiry to do anything other than to ask for a proper assessment of risk. That, after all, is the heart of risk management.

Now, I agree with Mr Gray when he said on Tuesday afternoon that risk management has to be robust in order to demonstrate safety. Whilst some attempt has been made to consider the risks arising from inadequacies in the ventilation system of some specialist ventilation boards, the Health Board have never attempted to formally assess the risks arising from the fact that 1,300 rooms in the hospital are supplied with air at a rate half of that provided for in the Scottish Government Technical Memorandum that the GGC decided would apply to the project and is now in force.

It should also be appreciated that the supply of air to these rooms is such that having more than five persons in each room drops the rate of supply per person below that provided for in the building regulations for all buildings with mechanical ventilation. Now, we've addressed this at length in our closing statement at paragraphs 1182 and 1183, 1751, 1898 and 1899.

Now, NHSGGC, my Lord, have pledged to implement all your final recommendations. Now, we proposed two recommendations on the need of carrying out a risk assessment of these wards, and that's at paragraph 1898 and 1899. I hope it's not presumptuous to point out that it will take the Inquiry a few more months to finalise its report. It's therefore open to NHSGGC to take steps now to carry out such a robust risk assessment of the ventilation to the general wards and these rooms without waiting for my Lord's final report.

The final section of my submission, rather longer than the other two, is the question three. How can what took place be prevented from happening again? Now----

THE CHAIR: I wonder if I can (inaudible 12:00:00). I think we're moving away from the procurement process and the consequences of the procurement process.

MR MACKINTOSH: Yes, my Lord.

THE CHAIR: Now, one of the points you made this morning is that the

Inquiry had to reconstruct the procurement process.

MR MACKINTOSH: Yes, my Lord.

THE CHAIR: So, it wasn't really just a question of going to GGC and saying, "Tell us about it." You were looking at events which had happened before 2015, and you had information from a number of sources. Now, it occurs to me that yesterday I was guilty of a very lazy and inappropriate remark in discussion with Mr Love. This arose, I think, from the discussion we were having at that point. It's relating to a point that was made by GGC in paragraph 6.14 of their closing statement.

MR MACKINTOSH: Yes, my Lord.

THE CHAIR: Now, first point, what we see set out in GGC's only-- the only closing statement which they would wish me to have regard or-- that's not fair, the only closing statement which they put forward to the Inquiry at this stage is that-- they include the sentence:

> "Pressure was applied to open the hospital on time and on budget and it is now clear that the hospital opened too early. It was not ready."

Now, I didn't ask Mr Gray about this. We do not find an explanation there of what the "pressure" was or what he has in mind by "pressure" and I didn't ask him as to why it was clear that the hospital opened too early.

Now, where I was lazy and, quite frankly, simply wrong in my exchange with Mr Love was to say, "Well, that is what GGC say. Therefore, they're in the best place to say it." Now, that I think is wrong because whether or not GGC are in a good position to say any particular thing depends on the state of institutional knowledge at a particular point in time.

Going back to what you say about the Inquiry having to reconstruct the procurement process, if the Inquiry had to do this, then it may be that GCC, by the time we get to 2022, 2023, are certainly not in a position to draw on any information which is not available to the Inquiry. So, I have to recognise a laziness of thinking on my part. Now, having said that by way of preliminary, I do not recollect Counsel to the Inquiry making anything of the hospital opening too early. Now, am I right about that?

MR MACKINTOSH: Yes, my Lord. Firstly, it's worth saying that, as far as I can recollect, beyond one particular aspect of pressure, there was no evidence from the senior GGC people involved in opening the hospital, from Dr Armstrong down, and Mr Calderwood, about pressure, either from them or from anyone else.

The aspect that did exist, of course, was that it's a massively complicated task merging multiple hospital sites into one

site and probably the best witness to explain that was Dr Stewart, who'd been the Deputy Medical Director. He, I think, was responsible for Acute Services at the time of opening and described in his statement – albeit we didn't ask him a lot about it in oral evidence – the complexities of that task.

So, there was a massive choreography to move everybody into the hospital at the right times to the right services that are available. I certainly have a recollection that when one read one reads Acute Infection and Control Committee, or Board Infection and Control meeting minutes, or the IMT-- IPC and Management team, you get the sense of that from presentations being made and discussions and things. So, there's pressure in the sense that it would be a good idea to meet the target because otherwise it will be difficult for everybody, there will be failures. But we didn't detect, in the evidence, pressure in the sense of, "Open it earlier than was planned."

Then turning to my Lord's question, from my recollection of Professor Steele's approach, he didn't seem to be-- I mean, he was quite candid about that. He didn't have information about things that happened a long time before he took over as Director of Estates. Similarly, although-- and the Independent Review didn't have access to GGC's contract documents around the procurement because of the litigation. That was the reason that was given.

So, nobody other than this idea of, "We really ought to get this project delivered on time because that's what you should do," thought to ask about pressure and GGC certainly didn't advance that until that sentence. So, that's probably the reason it sort of stands out as rather surprising.

I mean, it could be just the internal pressure because internal pressure to meet a deadline is not really that surprising. I mean, we said in our submission that it's, to a degree, commendable that the project was delivered on time and on budget. So, that may be what people were talking about, but it's not something that's been advanced as anything more than that desire to get delivered on time.

THE CHAIR: Now, what evidence about the hospital opening too early and it not being ready do we have? We had Mr Powrie, I think, describing many subcontractors on site----

MR MACKINTOS: Yes.

THE CHAIR: -- carrying out what I took to be snagging work.

MR MACKINTOSH: There certainly was that and, of course, there was a small amount of work that happened after

the move, when issues like the one that's described in that paragraph of the HEPA filtration filters not being in housings arose. There were issues around holes, around light fittings, I seem to recollect, in certain wards.

THE CHAIR: In relation to the HEPA filters, which according to this paragraph is an obvious example, am I right in thinking that Multiplex's position is they were told to omit?

MR MACKINTOSH: Yes, there's a document----

THE CHAIR: Is that a correct recollection on my part, or----

MR MACKINTOSH: Whether it's contractually correct, I can't say, but there is a document prepared by ZBP in '12 or '13, which lists what's to go in the ventilation of the isolation rooms in Ward 2A and it's housing only. But we've never been able to work out from the available documentation whether that's, as it were, internal within the contractor side or something that the Board has approved.

This is the problem with reconstructing this material because, as we've explained in our closing submission, certain witnesses are not available for reasons of health and other more serious concerns. The contract itself is-- I mean, I'm not a – I'll freely confess – commercial construction lawyer. That's why I'm grateful for the

assistance I've always had from Mr Connal in that respect and the Solicitor to the Inquiry, but the way that the agreed ventilation derogation was in the M&E clarification log took us a long time to work through.

So, one of the difficulties in this Inquiry is trying to reconstruct a series of negotiations that happened a decade ago and it's all very well for witnesses on the contractual commercial side to say, "If you just look in the log, it's all clear," but you've got to find the log. You've got to know what the log is. You've got to work out how it fits into the contractual documentation.

So, we, I think, found paragraph 6.14 as somewhat of a surprise because although there was a pressure to open time on time because of the obvious consequences, we'd not heard anything else in our investigations.

THE CHAIR: Right. Do we have any evidence of how that-- I mean, let's assume for the moment that it-- Well, I'm not quite sure what one can assume on the basis of these rather broad-brush statements, but does this link in with deficiencies in ventilation from your perspective, or deficiencies in the water system from your perspective?

MR MACKINTOSH: So, there's two points, I think, to make. Firstly, it's worth remembering that the ventilation system

wasn't validated.

THE CHAIR: Yes.

MR MACKINTOSH: But it wasn't validated because they hadn't got around to it. It was unvalidated because they hadn't-- It wasn't validated because they didn't know they had to validate. So, I'm not sure a few extra months would have caused validation to happen. You have to understand, by reading the necessary guidance and having access to technical people, that validation is required, and that seems to be missing.

The second problem is that the bigger problems with the hospital ventilation system that flow from the agreed ventilation derogation or from the decision to only fit positive pressure-ventilated lobby rooms are not small issues. In fact, they're very hard to fix, and so, had the builders just continued for a few more weeks, that issue wouldn't have been fixed.

It had to be spotted, and one of the things that's striking about the correspondence that Dr Peters has with various people in '15 is that she's probably at the very point of the realisation in respect of the paediatric wards' issues, is that her emergence is growing, because it's not like she's supplied with a list of deficiencies. She goes around and says, "Well, where's the pressure gauges? Why is there a hole in the ceiling?" It's a gradual process that crystallises by the end of June, but it's-- the idea that a few more weeks would have fixed these problems forgets that no one understood these problems existed.

THE CHAIR: Anything else you want to say on that?

MR MACKINTOSH: Not on that, thank you, my Lord.

THE CHAIR: All right.

MR MACKINTOSH: Now, what I'm supposed to do is to move on to this third question. So, what I propose to do – and I'm grateful to him for this – is to lift something from Professor Cuddihy's final witness statement. Well, actually, it isn't the final one; it was the final one when I was drafting this. The one produced for the Glasgow IV Part 2 hearing, and it can be found in Volume 3 for the hearing of 16 September of this year. It's document 6; it's from page 242. He describes what his statement is, "A Father's Plea for Governance That Protects the Vulnerable" and he structured his statement under five headings.

I rather felt the headings were useful for, I hope he won't take this badly, a broader analysis of the issue. The headings are, "The Illusion of Safety", The Silence of Broken Systems", The Cost of Complacency", "A Demand for Accountability", "Leadership Accountability: the Missing Link".

Now, what I propose to do is to borrow those headings and use them to look at the questions inherent in them to help the Inquiry reach conclusions on its remit and terms of reference. So, let's start with, "The Illusion of Safety." Hospitals should be safe. Risks should be understood and managed. Patients should, in broad terms, be able to consent to the risks they run in treatment. Those who run hospitals should strive for safety. They may never achieve the avoidance of all risks – that is, to some extent, impossible – but the expectation of patients, their families, the public, and the clinicians who treat the patients is that those who provide the equipment in the buildings will act to prevent the buildings causing infections.

Now, the clear message that I took from the patients and families is the last thing they imagined is the hospital they and their loved ones attended was exposing them to water that was contaminated with micro-organisms that should not be there, or should not be in there in those proportions, and which made them sick or failed to protect them from airborne micro-organisms. The Queen Elizabeth University Hospital and the Royal Hospital for Children looked state-of-the-art, it looked new, but we now know, and it's long been suspected that to some extent, that was an illusion.

So, the next issue heading was, "The Silence of Broken Systems". Now, I think I've discussed these to a great degree already. Not only was there a failure of the systems within NHSGGC that procured and commissioned the hospital from 2009 to 2015, but the management systems remained broken from '15 onwards and the Board took too long to discover the deficiencies of the water and ventilation systems for fundamentally the same reasons that had undermined their ability to procure and commission the hospital. They're the same reasons we see in the Vale of Leven report. Support for this analysis can be found in section 9.10.2 of our Glasgow IV closing statement, and the parts of our closing statement following Glasgow III, which we identify in that section.

I don't propose to walk through the many occasions in which clinicians, principally Dr Peters and Dr Inkster, raised concerns about patient safety in the Queen Elizabeth and were ignored, rebuffed, or had their views minimised, but I note there's now no substantive challenge to that analysis in the most recent GGC closing statement.

However, there's one particular issue I do want to look at because I think it helps us understand the events of 2019, and that is the idea of an Executive

Control Group. In our submission, the initial response to the water incident in March 2018 was collegiate and effective. That may have had much to do with the work of Dr Inkster as the Chair of the IMT. However, there was a failure to create an effective system to which the chair of the IMT could be accountable and to whom she could report.

This was the idea of the Executive Control Group, discussed at paragraphs 951 and 1683 of our closing statement, an idea I do recollect approved of by Dr Mumford and Ms Dempster when they gave evidence at the end of Glasgow III. My Lord will have noted at the time when we asked questions and in our submissions that we have had concerns about the way in which the Medical Director, Ms Grant-- sorry, Ms Grant, the Chief Executive, and other NHS managers involved in the Water Review Group that approved the decant on 18 September 2018, seemed to initially suggest that responsibility that decision fell on Dr Inkster as chair of the IMT.

The decision was clearly one for the executive leadership of the Board, given the widespread impact on different patient groups across the hospital and the Board services, and yet repeated attempts were made to avoid taking responsibility for it. In our submission, the failure to set out clear lines of authority and responsibility, separating the tactical response to the incident by the chair of the IMT from the whole Board response when wards were to be closed or decanted was a factor in how matters came to a head in August ’19.

To some extent, we see that lack of structure in the brief decant to the Clinical Decision unit in early ’19, when there’s an informal huddle, when Ms Grant comes over to discuss the merits of the decision.

In contrast with the position advanced by the Board, it’s our submission that in August 2019, NHSGGC managers and directors were unhappy with Dr Inkster continuing to investigate the hypothesis that there were still infections linked to the building systems. That there was an excess of infections, albeit a reducing one at that point, has now been confirmed by expert evidence, which the Board now accepts.

This contradicts the view reached by some of the Board’s witnesses at the time that there were no excessive infections in August ’19. This is the very period at which Dr Armstrong, the Medical Director, argued in her evidence that Dr Inkster and Dr Peters were putting their professional interests ahead of the patients by talking about excess infections, and you find that in the transcript of Dr Armstrong, columns 227 to 230.

In our submission, now we have the epidemiology, those concerns have no basis. There was an issue that required to be examined. The Inquiry should conclude that the removal of Dr Inkster as IMT chair in August ’19 was a clear case of an organisation that wanted to shut down debate rather than follow the science.

Now, at this point, it’s probably making-- make a slight aside and make a response to an observation about recommendations that arose from the submissions on behalf of the Scottish Ministers on Wednesday by Ms Crawford about section 51 and Schedule 5 of the (Scotland) Act 1998, and the devolution settlement, and who the Health Board can employ, which was said to relevant to our recommendations, and those recommendations are at paragraph 1702.

That was that in broad terms, the submission the Ministers be provided with the power to, in extremis, transfer the running of a Health Board to commissioners or replace the whole Board or parts of the Board. In our submission, this can be done by a limited development to the powers in sections 77 and 78 of National Health Service (Scotland) Act 1978.

THE CHAIR: Could you-- My fault, Mr Mackintosh, could you maybe take a step back with----

MR MACKINTOSH: We’ve leapt.

THE CHAIR You’ve taken us to August of 2019 and Dr Armstrong’s evidence and then you’ve moved, I think, too quickly for me----

MR MACKINTOSH: Yes, I appreciate that, my Lord. So this----

THE CHAIR: -- to a matter of statutory competence raised by Ms Grant.

MR MACKINTOSH: Exactly, so the reason that I made the leap, and perhaps I should have explained it, is that if we think about the heading we were starting on, “The Silence of Broken Systems” that Professor Cuddihy had chosen, which I borrowed.

We discussed the brokenness of the systems and the procurement at length, and I don’t propose that we revisit them, and we’ve discussed the problems of questions not being asked about the building in ’15, ’16, and ’17, and another aspect of a broken system is the way that the Board’s management, as it were, managed Dr Inkster and her IMT. That was clearly a very intensive stressful period for everyone – and I’ll come to what that might mean in a moment – but the Board had to deal with the consequences of having such a series of significant and publicly notable incidents.

So our submission is that firstly, there should have been some form of

Executive Control Group, and not having it meant that the tension between individuals in the IMT, and also between the idea that we should investigate because that's where the data was going from Dr Inkster, or the idea that because the chlorine dioxide system was fitted, the water was fine now, from perhaps others, that could have been better resolved if, as I think Dr Mumford said in her expert evidence in November 2024, there had been a clear method by which the senior management of the Board could take the advice and then they make the decision.

So, whether it's to partially close the ward to new admissions or reopen the ward, the board executive needed to make the decisions and take responsibility for it, but to do so on the advice of Dr Inkster, rather than putting all the pressure on her to stop her investigating.

THE CHAIR: Right, so when you talk about the "Board Executive" you mean the executive directorate?

MR MACKINTOSH: I mean the executive directorate, because I got the impression from the evidence of Professor Steele, the Medical Director, Dr Armstrong, and others, that they would go back to their offices from the IMT, or people would come to them from the IMT and report about what happened in the IMT.

So one gets the impression that Dr Inkster is dealing with the incident. She's investigating it, sort of live in the IMT. This is being reported back to senior people, and they're worrying about it. Now, perhaps they're right to worry about it, but what they should do is hear the advice and then make a decision, not do what, in our submission, they then do, which is to say, "Well, actually, the personal relationships have broken down" and close her down. Because I mean, there's a striking section in Ms Watts' submission that deals with a particular member of staff who describes the finding of-- I always get this micro-organism wrong, Elizabethkingia miricola, which was initially identified on the Space Station. A witness----

THE CHAIR: Or has been known on the----

MR MACKINTOSH: Had been-- But it doesn't just exist on space stations, is the point that I think is being made, but the impression is gained from that particular non-technical witness that that's what they thought Dr Inkster was saying, that this was somehow a space bug that turned up their ward. I think that just illustrates the idea that there's a technical discussion to have and there's an executive decision to have. The two of them need to be separate, and that is what Dr Mumford and Ms Dempster

talked about, I think from some experience and knowledge south of the border, in their evidence over those two days in November '24. Now, the leap, which is purely a case of me trying to find somewhere to put a particular response----

THE CHAIR: Before we come to the leap, just a matter of detail. Can you remind me if what we're talking about is a temporary measure or something that should be in place on a permanent basis.

MR MACKINTOSH: Oh, no, it's a tool to be used. Of course, there's a very difficult decision about, "When do you turn on an executive control group?"----

THE CHAIR: All right, thank you.

MR MACKINTOSH: -- because you clearly can't have one the whole time. That would be terribly inefficient, but we do have evidence about the establishment of things called gold command groups and that's not an unusual part of incident management in public services now and then they don't exist all the time. So they exist when they need to exist.

THE CHAIR: Sorry, I interrupted you.

MR MACKINTOSH: No, well, I then of course made this big leap.

THE CHAIR: You were about to take me to section 51.

MR MACKINTOSH: So, the reason I take the leap and the reason I put it here is because as we develop at some length in our submission – and I won't repeat this – there was some evidence that when the decision was made to take the Board to Stage 4 of the national framework, there was discussion about whether to go higher at stage 5. Ms Freeman gave evidence about this, and we asked Mr Wright, who'd then been Director General, about it.

Now, Ms Freeman was very open that she decided not to at the time and I think she gave the impression she might have slightly regretted that on reflection. It was our submission that the Government should review its toolbox of materials or methodologies so that it has some method in the case of the largest health boards of doing more than simply imposing an oversight board in a practical way because we could well understand Mr Wright's evidence of how impractical Stage 5 of the framework could be.

So my response to Ms Crawford's submission is this: when we reviewed the legislation to draft our submission, we did not envisage the Scottish ministers employing anybody. The Scottish Ministers routinely set out bodies, appoint people to bodies, replace members of bodies, all applying relevant statutes. In our submission, this is the same sort of thing, and that section 77 and 78 of the

NHS Health Service Act could be adjusted to give a more practical toolbox and it doesn't need to step over the boundary of addressing reserve matters, which of course would be difficult for my Lord as well, or employing people who the Scottish Government isn't permitted to employ.

This might be an appropriate moment to stop for a coffee because I've reached a short gap.

THE CHAIR: Are you on track?

MR MACKINTOSH: I think I'm a little bit ahead of time, my Lord. As your Lord knows, I operate a system of written notes and pages, and I have 31 pages and I'm on page 25.

THE CHAIR: Right. Again, I think there's probably a bigger demand on coffee than on some days, so if we were to sit again at ten to twelve.

MR MACKINTOSH: I'm sure I'd finish by lunchtime, my Lord.

(Short break)

THE CHAIR: Mr Mackintosh.

MR MACKINTOSH: My Lord, during the coffee break, we were reflecting, Mr Connal and I, on the impact of the opening of the hospital and the submission by GGC in paragraph 6.14. I think there can be a clear line drawn, which is in respect of the problems that we identify with the ventilation system, so that's the air change rates not being according to guidance, the wrong sort of isolation rooms, even the lack of HEPA filtration in the housings in Ward 2A, the fact that the hospital opened on time as scheduled has no impact. Because fundamentally, the ventilation deficiencies were not understood at that point by many of the people in GGC, particularly outside the Project team, and had been forgotten almost, I think you can infer, within the Project team.

When, however, you turn to the water system, it's more nuanced. We know that simply because of where a large construction project can get to, by accepting the hospital on the day they did in order to meet the long-planned schedule for the moving of all the services across Glasgow, the consequence was there were lots of contractors on site. A number of the Estates and Facilities witnesses who gave evidence, largely in Glasgow III, described the effect of that large number of Estates people, but, of course, it's now a GGC building.

THE CHAIR: Sorry, the large number of contractors?

MR MACKINTOSH: Contractors, sorry, but it's now a GGC building, so they have----

THE CHAIR: I mean, the problem

with the Estates people is there----

MR MACKINTOSH: There's too few of them.

THE CHAIR: Yes.

MR MACKINTOSH: So, it's now a GGC building. They have to be managed. They have to be kept an eye on. I mean, in certain areas they have to follow infection control HAI-SCRIBE procedures. At the very simplest, there have to be logs kept of who's there and what they're doing. The effect is, of course, that the limited sized Estates and Facilities team, which is already too small, is placed under a higher degree of pressure.

Now, in our submission, it's a reasonable inference to think that putting that small Estates team under a higher degree of pressure before opening, which, of course, is the time when the DMA Canyon report is being finalised, may well have had an impact on the well-described failure to act on its recommendations and escalate it within the organisation.

But the pressure was to open as scheduled and that pressure was, as far as we can tell, not made by people who knew about the ventilation derogation and the other deficiencies, for the simple reason that by 2015, outside the Project team, people didn't appear to really know. I hope that assists in the question you asked before the coffee break.

THE CHAIR: Yes, that does.

MR MACKINTOSH: Yes, so the next section, taking the headings from Professor Cuddihy's statement, is the cost of complacency. Now, I've already described, and we've described in our submissions, the not asking of questions and the Board has accepted the failure to manage the water system has a connection to harm experienced by patients. We say that for certain patient groups some of the ventilation systems pose risks that require to be properly assessed and managed.

We've identified many occasions when senior staff and directors of NHSGGC failed to ask questions, to an extent that we've already said, before the coffee break, amount to wilful blindness, or you can see it as a sense of complacency. But there are a couple of further examples that arise after the water incident, one of which is rather recent, that fit into that idea of not asking questions, of challenging those who ask questions of you, what you might see as a form of complacency.

The first is the response to the Case Note Review in March 2021. As we saw in evidence in Glasgow III and Glasgow IV, key NHSGGC staff up, to and including director level, did not want to accept the conclusions of the Case Note

Review on infection link. As Mr Connal has set out, directors appear to have decided to keep quiet on the matter rather than face up to the conclusions on infection link of that distinguished and capable group.

So, that's an example of a response to being challenged. Rather than accepting that there may be some merits to it, giving it credit for its expertise and the detailed level of its work, instead pushing back, perhaps complacently. But this more recent example is the----

THE CHAIR: Sorry. You use this as an example of-- Well, I suppose, yes, I'm with you. "Complacency" suggests inaction, but I see that if one is complacent, one might just reject the whole proposition that things, to some extent, may have gone wrong.

MR MACKINTOSH: So, complacency could cause you to not ask questions, and therefore could be-- and if you do it enough and frequently enough, it becomes a culture. If that complacency is happening when you have been told things that are a problem, then it becomes wilful blindness because you know about it but you're still not looking. But equally when you are challenged, when someone says, "Here is a problem," if your response is to push back, to not be open to ideas, then that is an aspect of complacency. You're complacent in your own position, in your own certainty.

So, one example, which I've just discussed, is the response to the CNR but the second one is that SBAR, the one prepared in November 2024 and sent to the Director General of Health and Social Care by Professor Gardner. Now, it reads that faced with questions and opinions from experts and people of skill, the IPCC and Management team of the Board, again, respond with accusations of bad faith and denial that a problem exists.

This has to be seen along with the general conclusion that I think my Lord's entitled to conclude, that it's been repeatedly the case that when microbiologists and others raised issues relating to patient safety linked to the hospital in the field of infection prevention and control, they've been rebuffed or ignored and had their views minimised. In my submission, that speaks of that complacency.

THE CHAIR: I'm just reflecting on the November 2024 SBAR in the name of the Infection Prevention and Control team, and I heard a submission from Ms Watts as to who I should understand the team to be. That was addressed, of course, not to Professor Gardner, who was not in post at that time, but to the then Chief Executive, Jane Grant.

MR MACKINTOSH: It was and I

asked her questions about that----

THE CHAIR: Yes, right. I wonder if when one looks at the language used, particularly at the last section of the SBAR, one would be entitled to draw an inference as to what-- The terms in which they express themselves to the then Chief Executive, would it be fair to assume that the authors must have thought-- well, they must have thought what is stated, but they also thought that, having regard to the nature of the organisation they were in, that it was appropriate to use that sort of language in a communication with the then Chief Executive.

MR MACKINTOSH: Yes, it speaks to the concept of an in-group and an out-group, that-- I mean, we all do this at times. When you're in a team, you discuss events in a different way within the team as you discuss them with other people. That's the nature of working life for all humanity. But, in this case, in my submission, that document, at the very highest level is written from a perspective of certainty, "We can say those things. No one's going to push back."

In my submission, that's what worries me about this. It's a repeated feature and it's going to be very difficult to shift. I should say that when that document arrived in the Inquiry office, we did ask the lawyers for the Health Board who the authors are and we have an answer. Broadly speaking, I think Ms Watts is correct, but I'm sure that can be passed to my Lord. It's not our habit to bundle these one-line emails that we get from----

THE CHAIR: Yes.

MR MACKINTOSH: They're very prompt in responding generally, the lawyers for the Health Board, to bundle them. But we were given the names of the authors by the Health Board solicitors. The professor's next heading is "A Demand for Accountability", and I thought this would be a good place to discuss an issue that you discussed with Mr Love yesterday on accountability and how it should work.

Now, Professor Cuddihy points out that the NHS Scotland Blueprint for Good Governance mandates that executives should be held to account for failure. When he gave evidence, Professor Brown talked to the importance of this. Mr Connal discussed it when he made his submissions at the opening of this hearing on Tuesday.

The fact remains that no one in that in-group has been held to account by NHSGGC. The only people challenged by NHSGGC for their decisions appear to be Dr Redding, Dr Inkster and Dr Peters. Now, it remains our position, as expressed by Mr Connal on Tuesday,

that the position of NHSGGC on personal responsibility is untenable, given the reality that harmful decisions or actions or failures, post-act, described in our submissions were carried out by individuals, either alone or in groups as part of their duties.

I wanted to respond to paragraph 7.1 of the NHSGGC submission and a section that follows afterwards. If I understood what Mr Gray was explaining on Wednesday, his submission was that it would be appropriate to criticise individuals involved in the procurement and the construction but not those involved in the response to infections due to the intensity of the events as they sought to respond to a complex, unprecedented situation.

That is set out in 7.1 but it flows through the rest of the submission, and we have some difficulty understanding the line that's been drawn here. So, firstly, there's no clarity about when this complex and unprecedented situation began and therefore the point after which individuals should not be criticised. In our submission, the only possible date for the start of such a complex, serious and unprecedented incident is the start of the water incident in 2018.

It can't be the reaction to the opening of the hospital because they accept criticisms of the Procurement team. So, if March 2018 is the start of the incident----

THE CHAIR: Sorry, not prior to the-- I missed your----

MR MACKINTOSH: Sorry. It can't be that this intensity of the incident also applies in 2015, because-- if I understand, the GGC position now is that it's appropriate to criticise members of the Project team. So, if it is correct that this incident of such intensity and seriousness starts in March 2018, and there was a serious incident that started at that point, then that, of course, would enable, if justified and necessary, the making of criticism of individual actions prior to that date, because the explanation, the mitigation of the incident wouldn't apply.

Of course, that would include the defensive responses of NHSGGC managers and the Medical Director when faced with ICDs and microbiologists who wished to raise concerns about the ventilation or water system. Most principally, the response to the issues raised by Dr Peters and Dr Inkster when they sought to demit office as sector ICDs in July of '15.

Secondly, whilst it must be correct that from March 2018, individuals were responding to a complex, serious and unprecedented incident and that may well explain or even mitigate conduct that could otherwise be criticised, it must be

the case that it can only do so when the conduct complained of has a plausible link to the intensity of the event.

An example of an unconnected event might well be the way that the report into Dr Redding's Stage 2 whistleblow turned into a critique of the failings of Dr Peter's conduct. There's no basis to suggest that that was impacted by the intensity of the water incident.

If criticism of the author of that report is necessary to deliver on the Inquiry's remit, then it would be justified and wouldn't be excused, as it were, by the water incident.

THE CHAIR: There is, just listening to you, perhaps another problem. As I understand it, Mr Gray presents a sort of moral culpability test. He accepts those involved in procurement and supervision of the contract might be appropriately individually blamed, I think, because that's a less pressured environment in which they're working. But there is, as I understood him, less moral culpability to be attached to someone who is doing the best they can in difficult circumstances and perhaps making a mistake.

Now, I come to my point. If one has heard evidence from candidates for personal attribution of responsibility who, in their evidence, may make general points about difficulties in which they were trying to respond to but do not say, "Well, perhaps things could have been done differently but I was so pressed at the time," in other words-- if one is to apply Mr Gray's criterion, does that not require an evidential basis? In other words, looking at what the candidates said in their evidence--

MR MACKINTOSH: I don't think you have to limit it to what the candidates said. You don't have to have insight, is what I'm suggesting----

THE CHAIR: But if the candidates don't say anything about it----

MR MACKINTOSH: It's better if they have insight, I think would be a better way of putting it. One of the quandaries that the Counsel team are worried about a lot is-- and I won't name them because it would be the general antithesis of the point I'm trying to make, but one can conjure up the names of a number of people lower down in the organisational structure who kind of failed to do things, done things not particularly well, failed to understand things, or done things wrong that have bad effects.

Yet, when you either look at their experience level and their position in the organisation, or you look at the pressure they were under in terms of, particularly in Estates teams, the resource implication, and you notice that they've only done one thing that we're criticising them for, it becomes, in my submission,

slightly unfair to do anything other than note that the thing they did or didn't do had a consequence, but to make it clear that either they were well out of their depth-- Maybe they were asked to supervise water when they were an electrician. Maybe they hadn't received appropriate training. Maybe there weren't enough people available.

Now, sometimes that will come, and obviously there's an excellent candidate in the first few weeks of Glasgow III who absolutely accepted that he'd made a mistake. But there are other candidates who didn't really accept they made mistakes. But when you look at what they actually had as skill sets, it's hard to entirely blame them.

I think I had a section which I didn't say, but I'll just-- I think I can use it here. If you look at the Project team, and read our submissions on the Project team, there are people on the Project team who were clearly well out of their depth. Is it entirely fair to blame them for being out of their depth? To some extent, everyone should have the insight to say, "Why am I doing this? This is well beyond my skill set" but, equally, the people who put them there have a much higher level of responsibility.

But, in some senses, that distinction applies to my criticism of Mr Gray's threshold because the third part of the criticism is that if you argue that the action, or failure to act, was affected by the intensity of the events, and therefore you shouldn't criticise them, in my submission, there are two limits.

The first relates to the extent to which the individual involved had authority or control over the events, or even if their actions made the events worse-- intensity of events worse. In essence, it's harder to complain that your individual action or inaction are excused by events you make worse, when you have a high level of executive responsibility for the whole response. Some of the people involved in the 20 August 2019 meeting that decided to remove Dr Inkster, that would definitely apply to them.

There's also a second aspect. If the conduct that you've done or you've not done is something you've been doing for years, the fact that you did it during a moment of intensity ceases to be mitigation.

Again, without naming the managers involved, I think one can usefully look at a couple of examples of relatively senior managers who applied the principles of exception management and not asking questions over many years. The fact that they did some of those-- they failed to ask questions during the water incident can't be explained by

the intensity of the water incident because they'd been doing it a long time.

So, where does that take us? In our submission, we've identified a number of such individuals in our closing statement and said what they did and why it had harmful effects. I know my Lord will wish to be fair, and I would invite my Lord to apply the approach I've just described to the question of whether to identify them.

Of course, one should only identify people where the thing they did requires to be identified in order to give effect to the terms of reference of the Inquiry.

In broad terms, I would adopt Mr Love's careful submissions on the importance and necessity of identifying persons responsible for significant and relevant failures because if you, my Lord, were not to identify individuals, as my Lord has said in questions, the whole exercise becomes academic and ultimately----

THE CHAIR: Sorry, what exercise?

MR MACKINTOSH: The exercise of working out what went wrong. If you work out what went wrong, and you describe it as a management failure, as a systems failure, then no one ever learns because human beings think by stories. You have to be able to tell the story completely, and it's only by understanding the personalities and the pressures they're under and the pressures they cause that you can really understand what has happened.

The Professor's final heading is, "Leadership accountability", what he calls the missing link. I would commend his plea for leadership accountability to my Lord. Given the Board's position that it has learnt, that it has changed, the Inquiry requires to consider whether you, my Lord, can accept that that change is real and effective.

This is where the work we asked Sir Robert Francis to do comes into play. There have been no shortage of incidences, often in the health service but not always, where organisations have been seen to fail, and where individuals in those organisations have drawn those to the attention of those in charge, have been rebuffed or minimised, or had detriment, and the organisations have not changed, at least in the short term, and things have continued to happen to the detriment of patients or users or whatever.

Now, there is no shortage of policies or guidance in this area. Indeed, it's not my Lord's remit to suggest new national policies in this area. This isn't an Inquiry into whistleblowing directly. It comes in through Term of Reference 4. So, why is it that health organisations and others keep deflecting and denying evidence when faced with evidence of risk to

patient safety?

In our submission, it's a lack of leadership accountability. Senior leaders, effectively, need to know that if they show wilful blindness or complacency or don't ask questions when patient safety issues arise, in due course, they will be held to account in a meaningful way.

My Lord will have read Sir Robert Francis's report for the Inquiry in bundle 51, volume 1. We sought the report not to have him reach conclusions because he's not a part of the panel, but to give my Lord an accessible way to have access to his long experience of investigating the role of whistleblowing and the importance of speaking up and having safety in doing so.

In his report, I was struck by the way that he started his explanation from, as it were, the ground up with the Seven Nolan Principles of Public Life. That of selflessness, integrity, objectivity, accountability, openness, honesty, and leadership. Without accountability, they have no value. They just become words that people talk about in meetings.

In our submission, when you talk about the senior people – the director levels, the Board level members – my Lord should ask whether those individuals conducted themselves in a manner consistent with the Nolan Principles.

Now, on Tuesday afternoon, Mr Gray stated that lessons have been learned, and in the closing statement, I looked for references to lessons being learned. If we look in paragraph 17.3, after expressing, "profound regret" for those who have experienced "distress, anguish and suffering as a result of these events"-- Firstly, I would emphasise the first sentence doesn't contain an apology for the actions of NHSGGC:

> "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."

It doesn't say, "…as a result of the failure to act of the Board."

> "NHSGGC offers an unreserved apology for the distress and trauma experienced by patients and families during this time."

That's an apology for secondary consequences. There's no apology for what the Board did.

> "NHSGGC has listened to the evidence of all those impacted."

Indeed, it has. It has been represented every day of this Inquiry, and we understand that members of staff have viewed this Inquiry within their offices.

> "Shortcomings have been identified."

There are shortcomings identified in this submission. "Lessons have been learned." Now, the reference to "Lessons have been learned" also occurs in paragraph 8.10-- It's not 8.10 at all. Allow me a moment just to find my reference because that is not the right paragraph. There isn't a paragraph 8.10, so I must have mistyped.

THE CHAIR: Certainly not in----

MR MACKINTOSH: Just allow me a moment to--

THE CHAIR: -- closing statement.

MR MACKINTOSH: -- get the document on the screen. Sorry, 3.10. This is a quote from the first NHS positioning paper. We don't need to put it on the screen because it's set out in paragraph 3.10. In the second sentence, it states, "[The Board's] position throughout has been", and then there's a quote from the positioning paper.

From the second last line of that quote, it says, "lessons have been learnt". But, in my submission, at no point – either back in December 2022 when the Board was challenging the infection link, or now, when it isn't – have these lessons been actually identified to the Inquiry in a formal sense. The witnesses certainly didn't identify the lessons. Knowing what the lessons are would help to give confidence in which is otherwise a bold, unsupported assertion, but we don't have that.

In fact, in our submission, there is precious little to suggest the Board has really changed. The words are there and we have yet to see any real action to suggest that anyone other than its Chair and Chief Executive, who I would definitely accept from the criticisms I've just made-- there is any real appreciation of what needs to change, let alone there's been real change in both culture of the organisation and how it has responded to the evidence laid before it over the past decade.

In our submission, at a minimum, three things need to change.

THE CHAIR: Perhaps we shouldn't get too hung up on-- Well, start again. The 3.10 quotation is the Board stating its position as to what the purpose of the Inquiry is.

MR MACKINTOSH: It is, and what it's saying then is that its lessons have been learned.

THE CHAIR: Well, is it?

MR MACKINTOSH: No, that's a fair point. Yes, no, I see what you mean, my Lord, yes.

THE CHAIR: Yes. I mean, if we look at that, that's the Board saying that, from its point of view, "This is what the Inquiry should do, and among the things the Inquiry should do is"----

MR MACKINTOSH: Is finding out

whether lessons have been learnt.

THE CHAIR: -- "where mistakes have been made. Therefore, the Inquiry has to determine whether or not a mistake has been made"----

MR MACKINTOSH: No, you're right, my Lord. I should stop----

THE CHAIR: -- "and whether lessons have been learnt." So, I mean, it's, if anything, holding the Inquiry to its task.

MR MACKINTOSH: Yes.

THE CHAIR: What the Board is saying there, and repeating in its final closing statement, is that this Inquiry has to determine whether or not mistakes have been made, and if it determines that mistakes have been made, that lessons have been learnt. Now, that would seem to, if anything, elevate the bar for the Inquiry to assure itself that lessons have indeed been learned.

MR MACKINTOSH: It would do, but it would undermine the point that I was making, which I need to row back on slightly. The current position of the Board is that they have learnt lessons.

THE CHAIR: Yes.

MR MACKINTOSH: I think I'm unfair to suggest that they were saying in December '22 explicitly in that text that they had then learnt lessons, but it's ----

THE CHAIR: No, no, I don't think they are saying that.

MR MACKINTOSH: No, but I think it is fair to say that when their staff gave evidence – senior staff – there wasn't a lot of evidence of what the lessons were, and the point I'm making is that some clarity now after the change of position about what the lessons have been learnt are, would, I think, have assisted my Lord in understanding whether the change of position is effective and real.

I then went on to say that, accepting of course that the current Chair and Chief Executive, based on the Chief Executive's evidence, clearly understand there needs to be a change, we haven't seen any evidence that the rest of the organisation, whether it's the Board itself, the other directors, the managers, senior clinicians, do understand what lessons they have learned because up until 9 October they weren't accepting, in some respects, there were any lessons to be learnt around certain aspects of the Inquiry's work.

It's because of this lack of detail, this reference to, for example, policy changes and governance changes that occurred prior to the change of position, that we worry that the change isn't real, that it's just from the top down. Now, it isn't to say that Professor Gardner clearly has an important and difficult job to do to change the direction of the Board, and it would be wrong to do anything other than

to acknowledge that will be a difficult task for her and the chair but, in our submission, in order for this change to be real and effective, three things have to happen.

Firstly, there has to be accountability when mistakes are repeatedly made or when complacency and lack of/failure to ask questions repeatedly happens. Everyone can make an isolated mistake or fail to act, but that's not what we're talking about here. Those who repeatedly fail to act or question over many years when there was a good reason to do so, or when they noticed there was a problem, need to be held accountable for that. When key people have retired, then unfortunately the ability to do so will fall entirely upon this Inquiry by making findings in its final report.

There needs to be a cultural change in NHSGGC. That will have to come from the top. Professor Gardner says she wants to change the organisation. In our submission, to do so she has to demonstrate that that change has started and give a clear and cogent explanation of why change is needed and what lessons are learned. Our recommendations in paragraphs 1900 and 1901 are designed to do just that. The Board does not have to wait until my Lord reports. It could act now to make the public statements and apologies we've described in broad terms in paragraph 1901 and start the work to retrain the Board members and members of the Corporate Management team in the manner we propose in paragraph 1900. Such action could of course be criticised as coming very late, but they would show a direction of travel, which might enable confidence in the Board to recover even now.

Thirdly, NHS Greater Glasgow & Clyde has to know that the Scottish Ministers will not tolerate a failure to change. Over the two occasions she gave evidence, Ms Freeman acknowledged that there is to some extent an inconsistency between the devolved and local nature of the Health Boards and the reality that the people of Scotland see the Scottish Government and the Scottish Parliament from which it comes as holding ultimate responsibility for the health service in this country.

In our submission, the Scottish Government and NHSNSS need to have the tools to deal with health boards that persist over many years in maintaining that everyone else is wrong in the face of the evidence. Without such better tools, something like the events that have been the focus of this Inquiry are likely to happen again.

Now, I don't propose to revisit Mr

Connal's response to Mr Love's proposal that the Inquiry continue to exist after the report is produced, other than to draw attention to our proposed recommendation at paragraph 1906 that is addressed to the Health, Social Care and Sports Committee of the Parliament, in which we propose that the Committee conduct a review 18 months after the publication of the final report to the extent to which its recommendations have been implemented.

My Lord, that concludes the substantive elements of my submissions. I've got one final remark to make. Is there anything else I can assist with?

THE CHAIR: No. I don't think there's any question that occurs to me.

MR MACKINTOSH: So, at this point, my Lord, can I just take the opportunity to extend my thanks to the witnesses, the Inquiry team and the legal teams supporting the core participants, and also to you, my Lord? With that, you have the submissions of the Senior Counsel to the Inquiry team and my submissions. Unless there is anything further I can assist you with?

THE CHAIR: No, thank you very much, Mr Mackintosh.

Closing remarks

THE CHAIR: Now, turning to address the room, as Mr Mackintosh emphasised at the beginning of what he had to say, this is not the end of the Inquiry; there's much work for me and the rest of the Inquiry team still to do in preparing a final report, albeit that Counsel to the Inquiry have carried out their part in the work of the Inquiry. So, it's not the end of the Inquiry, but it's the last occasion when the Inquiry is at, as it were, public facing, and I would accordingly wish to take the opportunity to make a few remarks.

I have heard the evidence of, I think, 186 witnesses. Now, all that has been helpful. Some, as legal representatives have acknowledged during this last week, has been very powerful and very moving, and consequently effective. Can I express my thanks to all the witnesses who gave evidence and provided witness statements? Perhaps I should particularly acknowledge their patience with me as I slowly learned from their experience and, in many cases, their expertise. But in thanking the witnesses, can I also thank those who, typically in core participant organisations but more generally as well, have assisted the Inquiry in responding to requests for information and providing the many thousands of documents that the Inquiry has considered? Now, these will typically have been individuals within

organisations who had to maintain their day job at the same time as assisting the Inquiry.

Can I also thank the legal representatives: the legal representatives in this room who present the public face, as it were, of core participants, but also the legal representatives instructing those counsel and others who have made oral presentations? I know I speak for the Solicitor to the Inquiry, who is indeed sitting in the room, when I say that the Inquiry has been very appreciative of the cooperative and highly professional conduct of those in solicitors' offices, who instruct the legal representatives who appear in the Inquiry hearing room.

Mr Mackintosh gave an example of how quickly Central Legal Office had responded to a request, and the solicitor to the Inquiry's experience with the Central Legal Office has been universally good, but his experience with all other solicitors instructing those present here has been equally good. I'm appreciative of that and would wish to add my thanks.

Can I also thank Counsel to the Inquiry, their junior counsel, and every member of my Inquiry team, each of whose work has been essential to bringing this Inquiry to its present stage? It is only a part of the Inquiry team's work, but organising the hearings in this Inquiry is a very substantial task, including IT support to those engaged. I may be wrong, but I cannot recollect a day that has not proceeded to timetable.

Now, that is not true of every forum by any means. It appears to me that the Inquiry team have done a remarkable job, and I'm very grateful for that. As I've said, while counsel have played their part, there is much work for me and the rest of the Inquiry team to do before we're in a position to submit a final report to the Minister, and so that is what we must set about doing. With that, can I wish you a good day?

(<u>Session ends</u>)

12:43