Scottish Hospitals Inquiry

Supplementary Note by Counsel to the Inquiry

Following the final oral hearings

20 March 2026

1. INTRODUCTION

1. This Note is produced at the request of the Chair to address developments since the final oral hearings of the Inquiry on 20th to 23rd January 2026. These include a motion passed by the Scottish Parliament, a letter from Anas Sarwar MSP, two Ministerial Statements and a report to the NHS GGC Board on 26 February 2026.

1.1 Scottish Parliament Motion

2. On Wednesday 28 January 2026 the Inquiry was the subject of a motion passed by the Scottish Parliament[1] in the following terms:

> "That the Parliament condemns the culture of secrecy and cover-up that has hidden the truth from patients, families and campaigners and denied them justice in many NHS scandals in Scotland in recent years; recognises that, as the Scottish Hospitals Inquiry draws to a close, many serious questions remain regarding the decision-making process and the role of the Scottish Government; considers that political decision making should be considered by the inquiry, and calls for the Scottish Ministers to authorise the immediate full disclosure and preservation of all communications connected to the contaminated water and inadequate ventilation system and the premature opening of the Queen Elizabeth University Hospital, as well as any subsequent communications relating to the handling of the infection and its cover-up; acknowledges that recent revelations surrounding the Queen Elizabeth University Hospital will have been distressing for patients, their families and staff; understands that this could create uncertainty and fear regarding the safety of Scotland's hospitals and negatively impact staff morale; recognises that patient privacy has to be given the greatest consideration in the publication of any materials, and calls for the Scottish Government to outline how it will urgently restore confidence into the services delivered by NHS Greater Glasgow and Clyde."

[1] A55793497 Bundle 52 Volume 13, Document 21 Page 207

1.2 Letter from Mr Sarwar

3. On 26 January 2026 the Inquiry received a letter from Anas Sarwar MSP[2]. The letter specifically asked the Chair to reopen evidence sessions and take evidence from what he described as "key figures holding political office during the opening of the hospital and the subsequent handling of infections prior to 2019". Mr Sarwar suggested that this should include Nicola Sturgeon MSP, Shona Robison MSP and John Swinney MSP. Mr Sarwar justified this approach in part by asserting that the Inquiry had not scrutinised the role and conduct of Scottish Ministers related to the hospital and that without taking evidence there is a risk that the Scottish Ministers would attempt to use the final report of the Inquiry as evidence that the problems were contained entirely within the health board and could not have been prevented by Government intervention.

4. In the third paragraph of his letter Mr Sarwar states: “NHS Greater Glasgow and Clyde claim that they were under pressure to open the Queen Elizabeth Hospital (QEUH) before it was ready. After the inquiry hearing concluded the health board put out a public statement attempting to clarify that this pressure was internal, but it is still unclear who applied this internal pressure, why they did so, and if it was done due to external pressure that they themselves were under”.

1.3 Ministerial Statements

5. The Inquiry and the hospital were also the subject of at least two ministerial statements.

   a. In the Parliament on 12 February 2026 the First Minister stated:

   > “NHS Greater Glasgow and Clyde recently commissioned and has now received two independent reports on the water and ventilation systems to provide further assurances. The findings of those independent reports were both positive, with a fully compliant ventilation assessment in December 2025, and a fully compliant water system assessment in January 2026. The reports will be considered by the

[2] A55510329 - Bundle 52, Volume 13, Document 20, Page 205.

safety and public confidence oversight group that the Cabinet Secretary for Health and Social Care announced recently."

6. In the Parliament on 3 February 2026 the Cabinet Secretary for Health and Social Care announced the creation of a new Safety and Public Confidence Oversight Group to be co-chaired by Professor Jann Gardner and Professor Sir Lewis Ritchie.

1.4 Report to the Board of NHS GGC

7. The Inquiry Team became aware that a report entitled "Assurance Summary" was made by NHS GGC Chief Executive Prof. Gardner to the NHS GGC Board on 26 February 2026 ("Assurance Summary Report"[3]). Whilst the report is available on the Board's website[4], NHS GGC did not draw it to the attention of the Inquiry. The report directly addresses the question of whether the hospital provides a suitable environment for the delivery of safe, effective person-centred care and so requires to be considered.

2. HOW TO RESPOND TO THESE DEVELOPMENTS

8. A public inquiry is independent of the government that set it up. Parliament must be told of the intention to establish an inquiry[5] and its reports must be laid before Parliament[6]. A public inquiry is a mechanism of public accountability convened by a Minister to inquire into a matter of public concern. In our submission a public inquiry that does not respond rationally and proportionally to public concerns runs the risk of failing to achieve and maintain public confidence in its procedures and its conclusions.

9. It is therefore proper and appropriate for the Inquiry to consider the motion of 28 January 2026, Mr Sarwar's letter, the recent Ministerial Statements and the report to the NHS GGC Board, and determine whether they engage the Inquiry's Remit and Terms of Reference and whether they require the Chair to revisit any potential finding in fact, conclusion or recommendation that has

[3] A55643278 - Bundle 52, Volume 13, Document 17, Page 82.
[4] https://www.nhsggc.scot/downloads/nhsggc-board-meeting-documents-26-february-2026/
[5] Inquiries Act 2005, Section 6.
[6] Inquiries Act 2005, Section 26.

already been the subject of evidence, provisional position paper or submissions by Core Participants or Counsel to the Inquiry.

10. Consequently, the purpose of this Note falls into two parts. To consider:

    a. The extent to which "political decision making" and the role of the Scottish Government have been considered by the Inquiry, why the witnesses identified by Mr Sarwar were not called to give oral evidence and whether that should change, and

    b. What the report to NHS GGC on 26 February 2026 and associated events can tell the Inquiry about Terms of Reference 4, 6, 7 and 9, and whether the public can have confidence that the hospital provides a suitable environment for the delivery of safe, effective person-centred care.

11. Unless explicitly stated this Note should not be read as proposing that the Chair makes any findings or reaches any conclusions not already proposed in our closing statements and submissions in the final oral hearing.

12. Any individual or organisation that the Chair is minded to criticise as a consequence of this Note will have an opportunity to respond during the warning letters (or ‘Maxwellisation’) process. There is therefore no need for further submissions to be sought from CPs in response to this Note.

3. THE ROLE AND CONDUCT OF SCOTTISH MINISTERS

13. For most of its existence the main tasks of the Inquiry have been to understand how the procurement of the hospital worked, what was wrong with the building and - importantly - whether there was a link between building systems and infections. As we set out in Chapter 2 of our Closing Statement following the Glasgow 4 hearing, the position of NHS GGC on these issues changed significantly from absolute rejection of the existence of a causal connection to a very late acceptance that such an infection link did exist.

14. As Counsel to the Inquiry explained on 23 January 2026[7], the approach of

[7] Transcript, Glasgow 4 Closing Submissions, 23 January 2026, Page 5, Column 6.

NHS GGC to this important issue made the task of the Inquiry Team more difficult. However, the role and actions of Scottish Government related to the hospital have been considered by the Inquiry Team in a number of ways.

3.1 The role of Scottish Government in procurement

15. We covered this in detail in PPP 15, "*Governance Structure within the project to construct the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow*", particularly in Chapter 2, "*Scottish Government involvement in procurement*". This analysis was adopted as part of our Closing Statement[8].

16. The choice of site was considered in PPP 15[9] and our Closing Statement following Glasgow 4[10]. The change to the procurement model and the role of the Scottish Government prior to the issue of the tenders was considered in PPP 15[11] alongside the approval of the Outline Business Case[12]. We also addressed it in our Closing Statement following Glasgow 4[13].

17. The lack of Scottish Government awareness of the Agreed Ventilation Derogation at contract signature on 18 December 2009 was set out in PPP 15[14] and our Closing Statement following Glasgow 4[15]. The decision was not reported to the NHS GGC Board, the Performance Review Group or the New South Glasgow Hospitals and Laboratory Project Executive Board ("the Executive Board"). As a result, those organs of NHS GGC had no knowledge of the Agreed Ventilation Derogation and could not inform the Scottish Government of it. In our Closing Statement following Glasgow 4, we addressed how members of the Executive Board (including the Scottish Government representative and the Chief Executive of Partnerships UK) appear to have failed to ask questions or notice that no change control

[8] CTI Closing Statement, Glasgow 4, Pages 138 -139, Section 5.1.1.
[9] Bundle 48, Document 15, Pages 376-377, Chapter 5, Paras 83-88.
[10] CTI Closing Statement, Glasgow 4, Pages 140 -142, Section 5.2.1.
[11] Bundle 48, Document 15, Pages 382-387, Chapter 6, Paras 106-117.
[12] Bundle 48, Document 15, Pages 389-394, Chapter 6, Paras 124-139.
[13] CTI Closing Statement, Glasgow 4, Pages 149-153 and 155-157, Sections 5.2.6 and 5.3.1.
[14] Bundle 48, Document 15, Pages 425-426, Paras 235-238.
[15] CTI Closing Statement, Glasgow 4, Pages 169-172, 175-181 and 182-183, Sections 5.4.2, 5.5.1, 5.5.2 and 5.5.3.

procedures were being used that might have ensured that they learned of the change to the Maximum Temperature Variant and the connected Agreed Ventilation Derogation[16].

18. We covered the process of production and approval of the Full Business Case ("FBC") in 2010 in PPP 15[17]. Neither the Agreed Ventilation Derogation nor the decision to largely dispense with the team of technical external advisors was included in the FBC by NHS GGC, reported to the Gateway 3 Review team[18] or discovered by PWC as part of their 2010 review of the governance arrangements[19]. The Scottish Government was thus unaware of these issues when Cabinet approved the FBC and the project was authorised to proceed.

19. The Gateway 3 reviewers clearly expected to be told if the project had changed. Neither NHS GGC nor Scottish Government were able to supply the Inquiry Team with the documents supplied to the Gateway 3 Reviewers in October 2010[20]. However, we recovered an email from a Scottish Government Programme & Project Support Manager to Ms Byrne on 8 June 2010 in which she is asked to confirm, "that there have been no significant changes in the Project scope or overall risk level since the last Review"[21]. Although this email was never received by Ms Byrne it was intended for her as Senior Responsible Owner; and in Glasgow 4, Part 1 she was asked how she would have answered the question. She explained that at the time she would have read this in the context of the Gateway 3 Review and would have then said there were no significant changes. However, at the time Ms Byrne did not know of the "Agreed Ventilation Derogation". When pressed she accepted that this departure from Employer's Requirements was a significant change of the sort described in that email[22]. The Scottish Government was not told.

20. Scottish Government civil servant Mike Baxter was a member of the Capital

[16] CTI Closing Statement, Glasgow 4, Pages 164-168 and 510-514, Sections 5.3.7 and 8.3.19.
[17] Bundle 48, Document 15, Pages 430-439, Chapter 9, Paras 253-265.
[18] Bundle 48, Document 15, Pages 426-430, Paras 238-252.
[19] Bundle 48, Document 15, Page 428, Para 244 and CTI Closing Statement, Glasgow 4, Page 185, Section 5.6.1, Para 574
[20] A51601881 - Bundle 52, Volume 13, Document 8, Page 49.
[21] A52315885 - Bundle 43, Volume 2, Document 30, Page 341.
[22] Transcript, Helen Byrne, 30 May 2025, Page 62, Column 119.

Investment Group (CIG). He gave both a written statement and oral evidence to the Inquiry in the Glasgow 4, Part 3 hearings. He explained that the Scottish Government's interest was not in the contents of the contract but in ensuring that the procurement process had been properly carried out[23], and that oversight did not look at technical matters and was more focused on finances and timescales, rather than compliance. The Scottish Government were reliant on NHS GGC raising deviations and issues[24]. Mr Baxter's evidence was that derogations were not disclosed in the FBC and had any issues been disclosed, advice would have been sought from HFS and raised with NHS GGC prior to approval[25]. He would have expected any derogation from guidance to have been reported to Scottish Government by NHS GGC[26], but the derogations were not disclosed[27].

21. It appears that the Scottish Government's position is that CEL 19 (2009)[28] and the Policy on Design Quality for NHS Scotland (particularly Annex A of the Policy)[29] contained sufficient reference to SHTMs in the context of use of ADB Sheets to oblige health boards like NHS GGC to build in compliance with SHTMs. If this was the intention it was too obscure and entirely ineffective[30]. In 2009/10 the Scottish Government assumed that internal mechanisms for approval existed to take assurance that guidance was properly considered[31]. These did not exist in NHS GGC. The three lines of defence in governance or assurance structure did not work[32]. The Scottish Government did not know of departures from guidance.

22. Our conclusion on this issue is set out in Chapter 9 of our Closing Statement following Glasgow 4[33], and amounts to this:

[23] Transcript, Mike Baxter, 16 September 2025, Pages 31-33, Columns 57-62.
[24] Glasgow 4, Part 3 - Witness Statements, Volume 1, Mike Baxter, Document 1, Page 21, Para 57.
[25] Glasgow 4, Part 3 - Witness Statements, Volume 1, Mike Baxter, Document 1, Page 16, Para 42.
[26] Transcript, Mike Baxter, 16 September 2025, Page 21, Column 37.
[27] Glasgow 4, Part 3 - Witness Statements, Volume 1, Mike Baxter, Document 1, Page 16, Para 42.
[28] Bundle 48, Document 1, Page 4.
[29] Edinburgh 1 - Bundle 3, Volume 1, Document 2, Page 125.
[30] CTI Closing Statement, Glasgow 4, Pages 566-567, Para 1828.
[31] Transcript, Mike Baxter, Transcript, 16 September 2025, Page 39, Column 73 and Page 40, Column 75.
[32] CTI Closing Statement, Glasgow 4, Pages 511-512, Paras 1659-1661.
[33] CTI Closing Statement, Glasgow 4, Pages 548-549 and 566-567, Sections 9.5 and 9.11.

a. The creation of NHS Assure in 2021 is an acceptance that national oversight and support as it previously existed was not adequate.

b. There was no Scottish Government involvement in scrutiny of the Construction Contract between issue of the tender and contract signature, notwithstanding that it was Scottish Government money at stake. We have proposed a specific recommendation on this issue[34] which the Scottish Ministers have not currently welcomed[35].

c. The Gateway 3 Review and FBC process did not reveal any of the contentious issues and the FBC itself allowed the inference to be drawn that all was in accordance with the ERs[36].

d. The involvement of PUK and Scottish Government officials on the Executive Board did not reveal the lack of a change control process[37].

3.2 The role of Scottish Government at the time of handover

23. We addressed the handover of the hospital in our Closing Statement following Glasgow 4[38]. At the time of handover and opening the Scottish Government did not know of the Agreed Ventilation Derogation or that there were issues with the water system before handover or of the terms of the 2015 DMA Canyon L8 Risk Assessment[39].

Rule 8 Request of 11 February 2021

24. On 11 February 2021 a request in terms of Rule 8 of the Inquiries (Scotland) Rules 2007 was sent to the Scottish Ministers, requesting that the following information be provided to the Inquiry[40]:

[34] CTI Closing Statement, Glasgow 4, Page 585, Para 1877.
[35] Glasgow 4 -Core Participants' Closing Statements - Closing Statement on behalf of the Scottish Ministers, Document 1, Pages 12-13, Para 27.
[36] CTI Closing Statement, Glasgow 4, Page 511, Para 1660.
[37] CTI Closing Statement, Glasgow 4, Pages 148-149, 166-168 and 510-513, Paras 443-444, 510-512, 1657-1666.
[38] CTI Closing Statement, Glasgow 4, Page 507, Section 8.3.16.
[39] A33870103 - Bundle 6, Document 29, Pages 122-415.
[40] A32159231 - Bundle 52, Volume 13, Document 5, Page 27.

"In respect of the Queen Elizabeth University Hospital, Glasgow (QEUH):

3.1 Copies of briefings and advice to the Scottish Ministers, and any responses from the Scottish Ministers where it concerns: issues regarding ventilation; issues regarding drainage; issues regarding water.

3.2 Copies of all correspondence between the Scottish Ministers/Scottish Government and NHS Greater Glasgow and Clyde Health Board where it concerns: issues regarding ventilation; issues regarding drainage; issues regarding water."

25. The Scottish Ministers did not provide any documentation in response to that request that would indicate that; before the hospital opened, they were aware of the ventilation deficiencies, the Agreed Ventilation Derogation, issues with the water system or the substantive content of the 2015 DMA Canyon L8 Risk Assessment.

Section 21 Notice of 2 May 2023

26. On 2 May 2023 a notice in terms of section 21 of the Inquiries Act 2005 was served on the Scottish Minsters, requiring that the following information be provided to the Inquiry[41]:

"1. For the period 1 January 2014 to date, a chronological narrative explaining the Scottish Ministers' awareness of the possibility of water contamination and of concerns with the water system within the QEUH campus, the information provided to the Scottish Ministers by NHS GGC on that subject and the steps taken by the Scottish Ministers in response. In particular, the narrative should identify the information provided to the Scottish Ministers by NHS GGC, relating to:

(i) The investigations carried out or instructed by NHS GGC in relation to the possibility of water contamination within the QEUH campus (including features of the water system which might pose a risk of contamination (for example, the use of flow straighteners)).

[41] A43549255 - Bundle 52, Volume 13, Document 6, Page 35

(ii) The commissioning, validation and verification of the water system and what those procedures showed.

(iii) Any reports obtained by NHS GGC from experts, consultants and other suitably qualified people (whether internal or external to NHS GGC) in relation to the safety of the water system.

(iv) Any material changes made by NHS GGC to the water system (whether the physical infrastructure or system of working) which were made as a result of concerns about its safety. For the avoidance of doubt, this request includes permanent and interim steps taken to rectify, remediate, upgrade or otherwise mitigate risk potentially posed by the water system.

(v) Any assurance (internal and external) that NHS GGC has received that the steps referred to at 1(iv) above have successfully addressed concerns about the safety of the water system.

(vi) Any other steps which NHS GGC has been advised to take with a view to maintaining or improving the safety of the water system (now or in the future), what those steps are, whether it plans to take those steps and, if so, when.

2. A list of all documents provided by NHS GGC to the Scottish Ministers to vouch, evidence or otherwise report on the matters referred to in paragraph 1 of this request. Insofar as the documents on this list have not yet been provided to the Inquiry, the documents themselves should be produced with the response to this request.

3. An explanation of steps taken, or instructed, by the Scottish Ministers independently from NHS GGC to investigate the possibility of water contamination and concerns about the water system at the QEUH campus, vouch the effectiveness of remedial and control measures taken by NHS GGC and achieve assurance about the current safety of the water system. Supporting documentation should be listed and provided to the Inquiry if not already produced.

4. A list of the principal witnesses from within the Scottish Ministers (whether present or former employees) who can provide information on the foregoing matters together with a summary of the key issues to which each witness can speak."

27. The Scottish Minsters provided their response within a narrative that contains a detailed timeline of the Scottish Ministers' understanding of key dates and event in the period 2015 to 2019[42]. It states that the 2015 DMA Canyon L8 Risk Assessment was not made public in 2015, and that the Scottish Government were not provided with a copy or aware that it had been commissioned until the Health Facilities Scotland/ Health Protection Scotland (HFS/HPS) review started in 2018[43]. Attached to the timeline was a version of the Oversight Board timeline with which the Inquiry Team is long familiar[44]. The timeline does not show any evidence of the issues being reported or escalated by NHS GGC to the Scottish Ministers.

28. There is no evidence within the narrative and documents provided by the Scottish Ministers to indicate that between January 2014 and July 2015 they were aware of the 2015 DMA Canyon L8 Risk Assessment or the various issues with the water system in the section 21 Notice of 2 May 2023.

Section 21 Notice of 17 May 2023

29. On 17 May 2023 a notice in terms of section 21 of the Inquiries Act 2005 was served on the Scottish Ministers, requiring that the following information be provided to the Inquiry[45]:

> "The following request relates to the Queen Elizabeth University Hospital campus ("QEUH"), and specifically to the ward areas where a concern about the safety of the ventilation system (including its suitability for the relevant patient cohort) has arisen. Based on the Inquiry's current knowledge, these areas are Wards 2A, 2B RHC, 4B, 4C, 5, 6A, 7 of the QEUH and the HDU / ICU / PICU critical care area. However, if there are other areas about which a concern has arisen, those areas should be included in the response. It may be convenient to structure the response to this request on a ward-by-ward basis.
>
> 1. For the period 1 January 2014 to date, a narrative explaining the Scottish Ministers' awareness of risks to patient safety (whether actual or potential)

[42] Bundle 52, Volume 1, Document 37, Page 609.
[43] Bundle 52, Volume 1, Document 37, Page 610.
[44] Bundle 52, Volume 1, Document 37, Page 629.
[45] A43749858 - Bundle 52, Volume 13, Document 7, Page 42.

associated with the ventilation system within the QEUH campus, the information provided to the Scottish Ministers by NHS Greater Glasgow and Clyde Health Board (“NHS GGC”) on that subject and the steps taken by the Scottish Ministers in response. In particular, the narrative should identify the information provided to the Scottish Ministers by NHS GGC, relating to:

(i) The investigations (including risk assessments) made into the incidence and the risk of infection connected to the ventilation system within the QEUH campus.

(ii) Air sampling carried out during this period and whether that showed evidence of airborne pathogens in areas where patients were present or in patient pathways.

(iii) HAI where an airborne source was suspected.

(iv) Commissioning, validation and verification undertaken in relation to the ventilation system, when and where it was carried out and what it showed.

(iv) Any material changes made to the ventilation system (whether the physical infrastructure or system of working, including the introduction of annual verification, ventilation policies and audits) which were made as a result of concerns about its safety. For the avoidance of doubt, this request includes permanent and interim steps taken to rectify, remediate, upgrade or otherwise mitigate risk potentially posed by the ventilation system.

(v) Any assurance (internal and external) that NHS GGC has received that the steps referred to at 1(v) have successfully addressed concerns about the safety of the ventilation system.

(vi) Whether NHS GGC has been instructed or advised to take any other steps with a view to maintaining or improving the safety of the ventilation system (now or in the future), what those steps are, whether it plans to take those steps and, if so, when. If NHS GGC does not intend to take those steps, its explanation for that.

2. A list of all documents provided by NHS GGC to the Scottish Ministers to vouch, evidence or otherwise report on the matters referred to in paragraph 1 of this request. Insofar as the documents on this list have not yet been provided to the Inquiry, the documents themselves should be produced with the response to this request.

3. An explanation of steps taken, or instructed, by the Scottish Ministers independently from NHS GGC to investigate the risks posed by the ventilation system ventilation system at the QEUH campus, vouch the effectiveness of remedial and control measures taken by NHS GGC and achieve assurance about the current safety of the ventilation system. Supporting documentation should be listed and provided to the Inquiry if not already produced.

4. A list of the principal witnesses from within the Scottish Ministers (whether present or former employees) who can provide information on the foregoing matters together with a summary of the key issues to which each witness can speak."

30. The Scottish Minsters provided their response within a narrative that contains a detailed timeline of the Scottish Ministers understanding of key dates and event in the period 2015 to 2019[46]. Neither the documents produced or the timeline show any evidence to indicate that between January 2014 and July 2015 the Scottish Ministers were aware of the ventilation deficiencies set out in the notice or the Agreed Ventilation Derogation.

Gateway 4 Review

31. During the procurement, design and build of the QEUH/RHC the project was subject to an Office of Government and Commerce (OGC) Gateway Review. Reviews 1 to 3 were discussed in PPPs 13 and 15. The Gateway 4 Review (readiness for service) took place between 31 March and 2 April 2015[47]. The Senior Responsible Owner was then Project Director Mr Loudon. The review was to be shared with Scottish Government's Accountable Officer[48].

32. Delivery confidence of the project was rated Green, meaning that "Successful delivery of the project/programme to time, cost and quality appears highly likely and there are no major outstanding issues that at this stage appear to threaten delivery significantly"[49].

[46] Bundle 52, Volume 1, Document 37, Page 609.
[47] Bundle 52, Volume 1, Document 37, Page 609 and Bundle 48, Document 15, Page 440, Chapter 14, Para 270.
[48] A33998288 - Bundle 43, Volume 2, Document 37, Page 371.
[49] A33998288 - Bundle 43, Volume 2, Document 37, Page 373.

33. The Gateway Review 4 explains that "Following approval of the Final Business Case (FBC) in late 2010, the project team ran a highly successful competitive dialogue procurement. Contractors were appointed, and following a construction period the Board took handover of the building in January 2015, five weeks ahead of schedule. Following a period of commissioning, the project is now preparing to start migration in late April."[50]

34. Nothing within Gateway Review 4 gave rise to concerns surrounding the water and ventilation system. There were no references within the Gateway 4 Review to the pre-filling of the water system, the concerns of the South Sector ICD (Dr Peters) about the isolation rooms in Ward 2A or the concerns of the Regional Sector ICD (Dr Inkster) about the isolation rooms in Ward 4B (that had included her sending United States Center for Disease Control ("CDC") guidance to Mr Moir and Mr Loudon on 26 February 2015[51]).

Acceptance of the hospital by NHS GGC

35. As discussed in Provisional Position Paper 13, NHS GGC took possession of the QEUH/RHC building on 26 January 2015. On 29 January 2015, the Stage 3 Sectional Completion Certificate[52] was issued by NHS GGC. It certified that sectional completion was achieved on 26 January 2015. This was four weeks earlier than the Scheduled Completion Date of 28 February 2015. Attached to the Certificate are the Supervisor's (Capita Symonds') Notification of Defects dated 26 January 2015, and the Project Manager's (Peter Moir) Schedule of Incomplete Works dated 26 January 2015[53]. The defects correction period is noted as ending on 26 January 2017. The Certificate is signed by Peter Moir as Project Manager[54] and John Redmond for Capita Symonds. Nothing within the Stage 3 Sectional Completion Certificate[55], the Notification of Defects or Schedule of Incomplete Works gave rise to concerns surrounding the water

[50] A33998288 - Bundle 43, Volume 2, Document 37, Page 374.
[51] Bundle 14, Volume 1, Document 8, Page 191.
[52] A32402295 - Bundle 12, Document 3, Page 23.
[53] A32402295 - Bundle 12, Document 3, Pages 24-25.
[54] Peter Moir singed as Project Manager but the Inquiry understands that his designation was Deputy Project Director - A54702300 - CTI Closing Statement, Glasgow 4, Page 20, Para 27.
[55] A32402295 - Bundle 12, Document 3, Page 23.

and ventilation system. In retrospect this failed to capture all deficiencies.

36. Ian Powrie, Sector Estates Manager/ Senior Board General Estates Manager, gave evidence to the Inquiry in the Glasgow 3 hearing. He explained that the Board needed to complete handover when it did to meet patient migration target dates and to allow for sufficient time for operational commissioning[56]. This was the rationale for early handover[57]. Mr Powrie explained that there was pressure on the estates department due to the workload pressure[58] and numerous issues at the hospital requiring support and management, resulting in estates personnel working long hours, even post patient migration[59].

37. The 2015 DMA Canyon report was delivered to QEUH/RHC on 6 May 2015. In our closing statement following Glasgow 3 we set out what was (and was not) then done with it by the NHS GGC Estates Team[60]. In Glasgow 4, Part 1, Mary Ann Kane, Interim Director of Facilities explained that handover did not run smoothly and there was pressure felt by the estates team due to what she described as 'the failings of the building and the contractual arrangement'[61].

Knowledge of senior NHS GGC staff

38. Mr Loudon succeeded Alan Seabourne as Project Director. He provided a draft statement which was published on the Inquiry website, subject to a caveat regarding Mr Loudon's ability to complete the statement[62]. When asked, Mr Loudon could not recall whether an L8 risk assessment had been carried out at handover[63]. He maintained that he was unaware that the report had been commissioned and was not aware of any action plan in connection with the report[64]. Mr Loudon appeared to be unaware of the ventilation

[56] Glasgow 3 - Witness Statements, Volume 1, Ian Powrie, Document 7, Page 237, Para 33.
[57] Glasgow 3 - Witness Statements, Volume 1, Ian Powrie, Document 7, Page 424, Para 260.
[58] Glasgow 3 - Witness Statements, Volume 1, Ian Powrie, Document 7, Page 219, Para 17.
[59] Glasgow 3 - Witness Statements, Volume 1, Ian Powrie, Document 7, Page 421, Para 255.
[60] CTI Closing Statement, Glasgow 3, Chapter 5, Page 219, Paras 65 & 70-73; Chapter 8, Section 6.1, Page 525, Paras. 16 & 20
[61] Glasgow 4, Part 1 - Witness Statements, Volume 1, Mary Anne Kane, Document 6, Page 512, Para 158 and see CTI Closing Statement, Glasgow 4, Section 8.3.18, Page 508, Paras. 1649-1650
[62] Glasgow 4, Part 3 - Witness Statements, Volume 4, David Loudon, Document 6, Page 451.
[63] Glasgow 4, Part 3 - Witness Statements, Volume 4, David Loudon, Document 6, Pages 475-476, Para 62.
[64] Glasgow 4, Part 3 - Witness Statements, Volume 4, David Loudon, Document 6, Page 476, Para 63.b).

derogation until Mr Seabourne's email of 26 May 2016[65]. Mr Loudon further states he was unaware of concerns raised by Dr Peters with Jackie Barmanroy in respect of PPVL rooms[66].

39. Alan Seabourne was Project Director until 2013 (he was no longer in employment by NHS GGC at handover and hospital opening, having been succeeded by David Loudon). Mr Seabourne did however give evidence to the Inquiry that he did not know whether the Agreed Ventilation Derogation[67] would have been recorded in the Full Business Case (FBC), as the FBC did not contain much technical detail[68]. Mr Seabourne was clear that he was not aware of any concerns in respect of ventilation when he left post in 2013[69], and he did not recall giving information to Mr Loudon regarding the derogation[70].

40. Former NHS GGC Chief Executive Robert Calderwood discussed there being a formal management team in the Scottish Government which individual health boards reported to[71]. Mr Calderwood described the reporting arrangements between health boards and the Director General of NHS Scotland and Cabinet Secretary:

> "There was a formal, monthly meeting between chief executives and the director general of NHS Scotland, and then there was a six-monthly meeting with the Board and the performance management team to review the Board's performance against targets, which the Cabinet Secretary may or may not sit in on, and then, finally, there was an annual public accountability review meeting which was held

[65] Glasgow 4, Part 3 - Witness Statements, Volume 4, David Loudon, Document 6, Page 462, Para 39.b) and Bundle 12, Document 104, page 813.
[66] Glasgow 4, Part 3 - Witness Statements, Volume 4, David Loudon, Document 6, Page 468, Para 51.a).
[67] CTI Closing Statement, Glasgow 4, Page 187, Para 580.
[68] Glasgow 4 Part 1 - Witness Statements, Volume 3, Alan Seabourne, Document 5, Page 149, Para 34.
[69] Glasgow 4 Part 1 - Witness Statements, Volume 3, Alan Seabourne, Document 5, Page 172, Para 54(c).
[70] Glasgow 4 Part 1 - Witness Statements, Volume 3, Alan Seabourne, Document 5, Page 172, Para 54(d); Glasgow 4 Part 3 - Witness Statements, Volume 3, Robert Calderwood, Document 1, Page 43, Para 146.

annually to receive the Board's annual accounts and report on performance, which was chaired by the Cabinet Secretary and the Board chairman."[72]

41. Mr Calderwood did not recall an occasion during his time as Chief Executive when he had to report issues with the water or ventilation system to Scottish Government, nor was he aware of colleagues doing so.[73] Mr Calderwood maintained he was not aware of issues in respect of water systems[74], had not seen the 2015 DMA Canyon Report previously[75] and only became aware of issues with ventilation in respect of bone marrow transparent patients after patient migration[76].

NHS GGC Risk Registers

42. There is no mention of risk arising from the water system at QEUH/RHC in the NHS GGC Corporate Risk Registers until August 2018[77].

43. There is no mention of risk arising from the ventilation system at QEUH/RHC in the NHS GGC Corporate Risk Registers until September 2019[78].

Statement of Shona Robison MSP

44. Shona Robison MSP provided a written statement to the Inquiry[79]. She first became aware of concerns in respect of QEUH/RHC when they were reported to HPS in March 2017[80]. She explained that in the period when she held the offices of Cabinet Secretary for Health, Wellbeing and Sport and the Cabinet Secretary for Health and Sport from April 2014 to June 2018, she could not recall being briefed on adequacy or lack thereof of information from NHS GGC

[72] Glasgow 4 Part 3 - Witness Statements, Volume 3, Robert Calderwood, Document 1, Page 43, Para 146.
[73] Glasgow 4 Part 3 - Witness Statements, Volume 3, Robert Calderwood, Document 1, Page 43, Paras 147-148.
[74] Glasgow 4 Part 3 - Witness Statements, Volume 3, Robert Calderwood, Document 1, Page 43, Para 150.
[75] Glasgow 4 Part 3 - Witness Statements, Volume 3, Robert Calderwood, Document 1, Page 49, Para 166.
[76] Glasgow 4 Part 3 - Witness Statements, Volume 3, Robert Calderwood, Document 1, Page 44, Para 151.
[77] Bundle 45, Document 29, Page 333.
[78] Bundle 45, Document 36, Page 446.
[79] Glasgow 4 Part 3 - Witness Statements, Volume 2, Shona Robison, Document 3, Pages 60-71.
[80] Glasgow 4 Part 3 - Witness Statements, Volume 2, Shona Robison, Document 3, Page 66.

regarding the ventilation and water systems at QEUH/RHC[81]. That is consistent with the evidence that knowledge of these issues was not held by Scottish Government prior to the hospital opening.

Additional Material Received, July 2025

45. The Inquiry received five further documents with the final version of Ms McQueen's statement[82]; one of which was the Note of a Meeting between Sandra Aitkenhead, Jim Leiper and Professor Steele, dated 16 and 19 December 2019 and 10 January 2020[83].

46. As set out in our Closing Statement following Glasgow 4[84], this document came to the Inquiry via the Scottish Ministers and not via NHS GGC.

47. In our Closing Statement we did make reference to the meeting of Ms Aitkenhead with Mr Leiper and Prof. Steele in respect of the appointment of staff to formal statutory roles in terms of water system management[85], the budget for the estates function[86], ZUTEC and CAFM[87] and the decision not to appoint an Independent Commissioning Engineer[88]. However, we did not draw specific attention to the fifth from last bullet point in the section headed 'Lessons Learned'[89] which states:

> "Political pressure was also being felt and no consideration was given to delaying the opening of the hospital despite the issues being faced with completion and operation."

48. Given that the Scottish Government did not know at the time of the opening of the hospital of the flaws in the water and ventilation system, and given that it was well understood that there is a general desire for public sector capital procurement projects to be completed 'on time' and 'on budget', we did not

[81] Glasgow 4 Part 3 - Witness Statements, Volume 2, Shona Robison, Document 3, Page 67.
[82] Bundle 52, Volume 1, Documents 38-42, Pages 733-770.
[83] Bundle 52, Volume 1, Document 38, Page 733.
[84] CTI Closing Statement, Glasgow 4, Page 293, Para 956.
[85] CTI Closing Statement, Glasgow 4, Page 250, Para 805.
[86] CTI Closing Statement, Glasgow 4, Pages 250 and 508, Paras 807 and 1650.
[87] CTI Closing Statement, Glasgow 4, Page 266, Para 864.
[88] CTI Closing Statement, Glasgow 4, Page 252, Paras 812-814.
[89] Bundle 52, Volume 1, Document 38, Page 745.

then consider that the existence of pressure to open the hospital on time was particularly remarkable and concluded that what was described in the note was no more than a reflection of that desire.

Further statements

49. Since the final oral hearing the Inquiry Team has obtained statements from Ms Aitkenhead, Mr Leiper and Professor Steele.

50. Ms Aitkenhead explained[90] that she undertook the meetings referred to in the note on behalf of the then Chief Nursing Officer, Ms McQueen, to understand the findings of the investigations conducted by Mr Leiper in 2018 into NHS GGC's handling of the DMA Canyon L8 Risk Assessments[91]. She was a member of the Oversight Board and prepared the "Timeline of Infection Incidents" produced as Annex F to the Oversight Board's final report[92]. The note summarises what she was told during the meetings. She was not provided with any additional documentation to supplement what she was told by Mr Leiper. She was never provided with Mr Leiper's earlier reports. Ms Aitkenhead explained that the reference to 'political pressure' is in the report as Mr Leiper said it. As far as she can recall, he did not expand upon what he meant beyond what is contained in the note.

51. Professor Steele cannot remember the meetings. He points out that not only does he not recall making a statement about pressure, but he would have no evidence to support it as he was employed by NHS Forth Valley at the time. However, he did accept that there would be significant pressure, generally, on all parties to achieve completion on time and within the financial allocations. This would have been even more pronounced for the QEUH/RHC project, given its scale, the arrangements for the Royal official opening and the concurrent migration plans for other hospitals to be closed to ensure seamless staff migration and clinical service commencement[93].

[90] Bundle 52, Volume 13, Sandra Aitkenhead, Witness Statement, Document 1, Page 4
[91] Bundle 8, Documents 34-37, Pages 150-171 and Bundle 23, Document 89, Page 872.
[92] Bundle 6, Document 37, Page 922.
[93] Bundle 52, Volume 13, Professor Tom Steele, Supplementary Statement, Document 3, Page 16.

52. Mr Leiper did remember the meetings. He was reporting information he had received second hand as part of his earlier reviews[94]. He did not have direct knowledge of the events of 2015, as he had been employed by NHS Fife and HFS when the hospital opened[95]. As he explained:

> "The reference … to 'political pressure' made by myself or Prof. Steele, was a reference to 'implicit' political pressure as a generality. There was no political pressure in the form of any specific written or verbal direction that I or Prof. Steele (I believe) was aware of, and I certainly think the statement provided was not offered in a manner to suggest a specific direction by any particular politician. I do not think it was intended to suggest anything other than a general pressure that is felt by everyone involved in any major capital project in Scotland to get the project delivered, 'On Time, On Budget and with Zero Defects'. Indeed, from memory, this was the congratulatory statement that was being made at handover …. That it had been delivered, 'On time, On Budget with Zero defects'."[96]

53. The Inquiry Team also obtained a statement from Andrew Robertson, Chair of NHS GGC at the time of the opening of the QEUH/RHC[97]. We had not done so previously as there was no documentary evidence to provide a basis to think that he knew of the ventilation deficiencies, the Agreed Ventilation Derogation, issues with the water system or the substantive content of the 2015 DM Canyon L8 Risk Assessment at the time the hospital opened. When asked about the period from January 2014 to July 2015, Mr Robertson could not remember reporting any concerns or issues in respect of any aspect of the water or ventilation system of the QEUH/RHC to the Scottish Government. He had not been told of these issues by the time he stood down as Chair in November 2015. He was not aware of any pressure from outside NHS GGC (including from Scottish Ministers) for the Board to open the QEUH/RHC on the planned date. He did report a telephone call from Ms Robison:

> "Towards the end of May 2015, I was away from the NHS HQ when I received a personal telephone call from Ms. Shona Robison, the Health Minister. She was looking for an update on progress with reference to the transitional arrangements

[94] Bundle 8, Documents 34-37, Pages 150-171 and Bundle 23, Document 89, Page 872.
[95] Glasgow 3 - Witness Statements, Volume 10, Mr Jim Leiper, Page 190.
[96] Bundle 52, Volume 13, Mr Jim Leiper, Supplementary Statement, Document 2 Page 10
[97] Bundle 52, Volume 13, Andrew Robertson, Witness Statement, Document 4, Page 20.

for staff moving into the new hospital from other existing units. I sought updates from appropriate staff and was able to go back to Ms Robison assuring her that all was progressing as we had planned. She was happy to get this report and had no further comments."

3.3 Initial Intervention by Scottish Government

54. We covered interventions by the Scottish Government after opening in our Closing Statement following Glasgow 4[98]. In contrast with the prompt disclosure by the Medical Director and Chief Executive of NHSL of issues with the RHCYP/DCN to Scottish Government, whilst help was sought from HPS in late 2015 over Ward 4B, the simple fact is that NHS GGC failed to inform the Scottish Government that there were any widespread issues with the ventilation system of the QEUH/RHC during 2015. The Scottish Government was not told of issues with the water system as the Board did not know of them, due to the failures of the Board Water Safety Group, the senior named persons and the Estates Department, all as covered extensively in earlier submissions.

3.4 Why we did not call further Ministerial Witnesses

55. On 27 November 2024 the Chair issued Direction 9 which required CPs to identify to the Inquiry any witnesses they considered to be essential to enable the Chair to reach conclusions that addressed the Remit and Terms of Reference. In response, CPs did suggest that Ms Sturgeon and Ms Robison should give evidence. No CP suggested taking evidence from Mr Swinney.

56. We decided not to take a statement from Ms Sturgeon and to restrict our focus with Ms Robison to the decision by Cabinet to approve the FBC because:

    a. There is always likely to be a general pressure on everyone involved in any major capital project in Scotland to get the project delivered on time and on budget;

[98] CTI Closing Statement, Glasgow 4, Section 8.5.2, Page 525.

b. There was no evidence that the Scottish Government knew about any of the defects with the water and ventilation systems prior to handover or the opening of the hospital. Any 'pressure' that existed would therefore be in ignorance of this fundamental issue; and

c. We already knew from the Interim Report that, prior to 2019, there were gaps in how the Scottish Government obtained assurance and provided support to health boards on technical matters, and that NHS Assure was conceived to address these gaps. This was further confirmed by our investigations in Glasgow 4 into the procurement system then in place.

57. There was no evidential basis to obtain a statement from Mr Swinney and no CP suggested that we do so.

58. Whilst the Scottish Government did not know of the issues with the water and ventilation systems prior to handover or the opening of the hospital, it is not correct to say that these problems were contained entirely within NHS GGC and could not have been prevented by Government intervention. CEL 19 (2009), the Policy on Design Quality for NHS Scotland (particularly Annex A of the Policy), the Scottish Capital Investment Manual and the presence of civil servants on the Project Executive Board, still left wide enough gaps for the NHS GGC Project Team to fail to mention these issues at Gateway 3 Review or FBC. Mr Seabourne explained his position; "The business case is about selling something to the government who's buying something". and he saw the Agreed Ventilation Derogation as an "alternative design"[99]. Whilst NHS Assure will go some way to address these issues, we have proposed recommendations to address them in our Closing Statement following Glasgow 4[100] and in our paper in response to Core Participant Closing Statements - Glasgow 4[101].

59. The additional investigations described here confirm our understanding of the lack of knowledge of Scottish Ministers and the way that 'pressure' was understood. As a result, we still see no evidential basis to take evidence from

[99]Transcript, Mr Alan Seabourne, 29 May 2025, Page 71, Column 137.
[100] CTI Closing Statement, Glasgow 4, Sections 10.2.1, 10.2.2, 10.2.3 and 10.2.4, Pages 584-588.
[101] CTI Paper in Response to CPs Closing Statements, Glasgow 4 Paras 14-18.

Mr Swinney or Ms Sturgeon or further evidence from Ms Robison.

4. RECENT DEVELOPMENTS AT NHS GGC

60. Given the terms of the statement by the First Minister on 17 February 2026, a notice in terms of section 21 of the Inquiries Act 2005 was served on the Scottish Ministers, to provide the Inquiry with the two reports referred to, all correspondence between the Scottish Government and NHS GGC in respect of the reports and copies of all briefings and any other information supplied to the First Minister in respect of the production and conclusions of these two reports prior to his reference to those reports in Parliament on 12 February 2026[102].

61. By the time we received the response, the NHS GGC Board had considered the Assurance Summary Report at its public meeting on 26 February 2026. The material provided by Scottish Ministers has been bundled[103]. The Assurance Summary Report was provided by NHS GGC to Scottish Ministers on 10 February 2026[104] and on 26 February 2026[105]. As discussed below the two reports were included in the Assurance Summary Report. We also received Briefing for the First Minister dated 11 February 2026[106], an email dated 13 February 2026[107] and a letter from the First Minister to Prof. Gardner on 18 February 2026 in respect of the reports[108].

4.1 The Assurance Summary Report

62. The Assurance Summary Report comprises of a principal report and appendices, which include an Authorising Engineer Audit, (Ventilation) by M&M Compliance Training dated 17 December 2025 and an Authorising Engineer Audit, (Water) by Daniel Kelly dated 13 January 2026.

63. At the same meeting the NHS GGC Board approved the minutes of its

[102] A55496579 - Bundle 52, Volume 13, Document 9, Page 51.
[103] A55496579 - Bundle 52, Volume 13, Document 9, Page 51.
[104] A55643614 - Bundle 52, Volume 13, Document 13, Page 65.
[105] A55643615 - Bundle 52, Volume 13, Document 11, Page 60.
[106] A55725172 - Bundle 52 Volume 13, Document 15, Page 67.
[107] A55643611 - Bundle 52, Volume 13, Document 12, Page 64.
[108] A55643609 - Bundle 52, Volume 13, Document 14, Page 66.

meeting on 18 December 2025. Whilst the Inquiry understands from NHS GGC that the decision to approve its Closing Statement to the Inquiry was made in a private meeting of the Board on 18 December 2025, that the Board decided to consider that question in private on that date is not recorded in the public minute of the Board meeting on that date[109]. This appears to be contrary to Article 5.23 of the Board's standing orders[110] which require that where the Board meets in private "the minutes of the meeting will reflect when the Board has resolved to meet in private".

64. It is therefore all the more striking that the Assurance Summary Report contains no acknowledgement that NHS GGC now accepts both that there was an exceedance in the rate of environmentally relevant blood stream infections (BSI) amongst paediatric haemato-oncology patients in the RHC in the period 2016-2020 and that is it is more likely than not that a material proportion of these additional BSI had a connection to the state of the hospital water system. As far as we can see the Board has still not acknowledged this radical change of position in papers for its public meetings.

65. We have four concerns about the Assurance Summary Report.

Lack of clarity about the standards being measured.

66. The report does not explain to the Board members that there is a difference between the standards for the design and specification of a building system set out in Part A of the relevant SHTM, and the standards for the management of a building system set out in Part B. A water or ventilation system can be managed in a manner compliant with Part B of the relevant SHTM, whilst not meeting the standards set out in Part A.

67. In respect of the ventilation system this is exactly the situation for most of the hospital because of the Agreed Ventilation Derogation. The single rooms and general wards of the QEUH/RHC were not built in accordance with Part A of SHTM 03-01. They are not compliant with it. If Board members are not told of this distinction, it is difficult to see how they can deal with the risk

[109] A55793344 Bundle 52 Volume 13 Document 19 Page 176
[110] A55793361 Bundle 52 Volume 13 Document 18 Page 163

management issues that may arise from a largely non SHTM 03-01 compliant ventilation system, especially for immunocompromised patients.

Lack of acknowledgement of previous microbial proliferation

68. Section 3 "Water – The Domestic Water System in QEUH & RHC" fails to acknowledge the history of the biofilm, microbial proliferation or widespread contamination that was found at the start of the Water Incident in March 2018, and that most of the measures taken were introduced in response to those findings and the infections they likely caused. Figure 1 describes the approach being "undertaken to maintain water safety". That is not the whole picture. The Water Technical Group (and those who followed it) fitted a chlorine dioxide dosing system at the hospital and improved the management of water system to address the biofilm, microbial proliferation or widespread contamination found in 2018 (and likely developing for years). If Board members are not told of this fact, it is difficult to see how they can deal with the risk management issues that arise from operating a formally contaminated water system.

Limit of focus on the ventilation systems to "Critical Air Systems"

69. Section 4, "Ventilation in QEUH & RHC", reports that "Ventilation systems are managed in line with SHTM 03/01" without explaining to the Board this refers to Part B. The report explains how the ventilation systems in QEUH and RHC can be broadly split into two categories, General Air Systems and Critical Air Systems.

70. The reporting of the operation and management of Critical Air Systems appears consistent with the evidence that the Inquiry has already heard. Chapter 4 of SHTM 03-01, Part B[111] only requires annual verification of critical ventilation systems[112]. The NHS GGC definition of 'Critical Air Systems' as including Ward 4B QEUH, Ward 2A RHC, Theatres, ITU, PICU and Endoscopy[113], but excluding wards other than 4B in the Tower[114], is not

[111] Bundle 46, Volume 3, Document 3.1.2, Pages 663, 688.
[112] Bundle 46, Volume 3, Document 3.1.2, Page 663; Section 4.4, Page 688.
[113] Glasgow 3 - Witness Statements, Volume 7, Professor Tom Steele, Page 560, Question 52.
[114] Levels 4 to 11 in the QEUH.

inconsistent with the definition of a critical system in the SHTM[115]. Indeed, Professor Steele explained that what are 'Critical Air Systems' is identified by 'the Clinical Team'[116].

71. The report correctly notes that, in contrast with the Critical Air Systems, the "General air systems are not subject to annual verification requirements". It obscures the fact that the ventilation systems of the wards and rooms of the hospital not built in line with SHTM 03-01 Part A are not subject to the same intensity of management as the more limited ‘critical air systems’.

72. We are concerned that Board members and other readers of the report:

    a. Might well conclude that the ventilation system of the QEUH/RHC is compliant with SHTM 03-01, when that is clearly not the case in respect of the general wards and single rooms in respect of the Air Change Rate standard set out in SHTM 03-01, Part A; and

    b. Will not appreciate that the ventilation systems of the hospital were never validated against either the specification in the Agreed Ventilation Derogation and the M&E Clarification Log or the standard set out in SHTM 03-01[117].

IPC Management

73. Section 5 of the report states that "NHSGGC hospitals consistently perform in line with or better than the Scottish Government Indicators for Healthcare Associated Infection". There is no acknowledgement of the lack of trust in the NHS GGC IPC Management Team in respect of HAI Reporting disclosed by NHS NSS witnesses in the Glasgow 4, Part 3 hearings that resulted in a significant intervention by the Director General Health & Social Care[118].

74. In Section 5.6 the report claims to recognise “professional tensions" have developed. It is difficult to imagine a less clear acknowledgement of the

[115] Bundle 46, Volume 3, Document 3.1.2, Section 4.7, Page 663.
[116] Glasgow 3 - Witness Statements, Volume 7, Professor Tom Steele, Page 600, Question 164.
[117] CTI Closing Statement, Glasgow 4, Section 8.3.17, Page 507.
[118] CTI Closing Statement, Glasgow 4, Pages 532-533, Paras 1721-1722.

systematic failure of NHS GGC to listen to Dr Redding, Dr Peters, Dr Inkster and others over the last decade, short of entirely ignoring the issue. This section is not entirely consistent with the acceptance of that failure in Prof Gardner's evidence on 9 October 2025 and is inconsistent with the position taken by NHS GGC in its Closing Statement after Glasgow 4.

75. Section 5.7 contains a report that since Quarter 1 2022, the QEUH has consistently had a lower crude mortality rate than NHS Scotland. This sounds reassuring but ignores the tight focus of the harm caused by the water system and the board's response on small numbers of immunocompromised patients. There has been a pattern of NHS GGC relying on its performance against broad measures of harm when the issues with HAIs were focused on a small number of patients. The most extreme example was Appendix 1 to the second NHS GGC Positioning Paper[119]. Given that NHS GGC now accepts that there was an exceedance in the rate of environmentally relevant blood stream infections (BSI) amongst paediatric haemato-oncology patients in the RHC in the period 2016-2020, it is difficult to see how broad measures of mortality across the whole hospital can provide assurance to the NHS GGC Board.

4.2 December and January AE Audit Reports

76. The two reports referred to by the First Minister on 12 February 2026 are attached to the Assurance Summary Report. They are annual Authorising Engineer Audits (commonly known as AE Audits), one for each system. In the Glasgow 3 hearing we heard evidence from Mr Kelly about the role of the Authorising Engineer and the nature and scope of an AE Audit[120]. Mr Poplett's reports for Glasgow 4, Part 2 are rather more comprehensive AE Audits[121].

77. In respect of the water system, the AE Audits from 2020 to 2023 demonstrate clear progress in management of the water system from 2018 onwards, describing the delivery of the required risk reduction processes as "virtually complete". On the basis of Mr Poplett's 2025 AE Audit[122] these steps have

[119] Bundle 25, Document 10, Page 367.
[120] Transcript, Dennis Kelly, 27 August 2024, Pages 62-68, Columns 120-131.
[121] Bundle 53, Documents 3 and 4, Pages 14 and 40.
[122] Bundle 53, Document 3, Page 14.

been adequate and effective[123]. In our view the key issue for the water system is not the current management of the system as a whole, but the eventual removal of the Point of Use Filters ("POUFs"). This will pose real issues for NHS GGC in terms of maintaining the confidence of patients, staff and the public[124]. Whilst the POUFs do not appear to have been addressed by Mr Kelly in his most recent water AE Audit dated 13 January 2026[125], his conclusions sit in the same continuum of improvements in management of the water system over time described in his earlier reports[126].

78. The recent ventilation AE Audit, (Ventilation) by M&M Compliance Training dated 17 December 2025[127] appears to reach broadly similar conclusions as Mr Poplett's AE Audit (Ventilation)[128]. We do not need to reiterate our submissions on the safety of the ventilation system[129]. This latest AE Audit (Ventilation) does not remove those concerns.

79. Whilst it is welcome that these AE Audits confirm that the water and ventilation systems of the QEUH/RHC are being managed in accordance with Part B of the relevant SHTMs, such compliance does not address any non-compliance with Part A of the relevant SHTM. Given that the large parts of the hospital ventilation system were built and remain not in compliance with SHTM 03-01 Part A[130], any statement that the ventilation system is compliant with SHTM on the basis of the latest AE Audit (Ventilation) or the Assurance Summary Report betrays a fundamental misunderstanding of the guidance.

4.3 The Safety and Public Confidence Oversight Group ("SPCG")

80. In light of the statement of 3 February 2026 by the Cabinet Secretary about the establishment of the SPCG, the Inquiry sought further details from the Scottish Government.

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[123] CTI Closing Statement, Glasgow 4, Section 5.12.5, Page 340.
[124] CTI Closing Statement, Glasgow 4, Para 1834 & 1835, Page 569.
[125] A55643278 - Bundle 52, Volume 13, Document 17, Page 82 pages 131-160
[126] CTI Closing Statement, Glasgow 3, Chapter 5, Page 515, Para 1030.
[127] A55643278 - Bundle 52, Volume 13, Document 17, Page 82 pages 107-130
[128] Bundle 53, Document 4, Page 40.
[129] CTI Closing Statement, Glasgow 4, Section 7.3, Page 396, Section 9.13, Pages 570-571, Paras 1837-1842 and Section 10.2.3, Page 587.
[130] CTI Closing Statement, Glasgow 4, Chapter 7.3, Page 396.

81. It is not clear whose initiative the SPCG is. In a letter to the Inquiry of 5 February 2026[131] the Cabinet Secretary seems to imply he created it, but in response to formal questions[132], the Scottish Ministers provided a response on 3 March 2026[133] in which it was stated that:

> "The Safety and Public Confidence Oversight Group ("the [SPCG]") has been established by NHSGGC as part of its internal governance. The Scottish Ministers understand that the [SPCG]'s terms of reference and membership are yet to be finalised. Accordingly, the Scottish Ministers are unable to provide the Inquiry with the documentation sought ….
>
> The Scottish Ministers understand that the [SPCG] will report to the NHSGGC Board (executive and non-executive members) and to the Scottish Government (via the Chief Operating Officer, NHS Scotland).
>
> The Scottish Ministers understand that the [SPCG] is established under NHS GGC's powers to regulate its own governance as an independent health board constituted under the National Health Service (Scotland) Act 1978.
>
> The Scottish Ministers do not understand the Group to be independent of NHSGGC. The [SPCG] is not under the direction or control of the Scottish Ministers."

82. Accordingly, whatever its origins, SPCG is not independent of NHS GGC. It is a Board group.

83. Section 6 of the Assurance Summary Report explains:

> "… the new Safety and Public Confidence Oversight Group (SPCG) .... will involve co-participants of SHI including Families and Whistleblowers, External Experts, NHSGGC Colleagues, Partnership Representation, NHS Assure, ARHAI, Healthcare Improvement Scotland, members of the public as well as representation from NHSGGC Executive and Non-Executive Director members."[134]

[131] A55790756 Bundle 52 Volume 13 Document 23 Page 221
[132] A55496579 - Bundle 17 February 2026 section 21 to Scottish Ministers]
[133] A55643605 - Bundle 52, Volume 13, Document 10, Page 58
[134] A55643278 – Bundle 52, Volume 13, Document 17, Page 82 (Section 1.1.7)

84. So far none of Dr Redding, Dr Peters and Dr Inkster or any of the families who are CPs have reported any engagement with the SPCG to the Inquiry Team.

85. In our submission there would be considerable value in the Inquiry contacting Professor Sir Lewis Ritchie and asking him to write to the Solicitor to the Inquiry in the final week of May 2026, setting out what the SPCG has done in the period since its establishment, what role the families and whistleblowers have played in its work and what he considers it has achieved in that period. Such a letter would, in our submission, assist the Chair in reaching his final conclusions on a wide range of issues, particularly Terms of Reference 4, 6, 7 and 9.

4.4 Recent HIIAT Red in Ward 4B

86. At First Minister's Questions on 5 March 2026 the First Minister explained that on 26 February 2026 the HIIAT amber alert regarding Ward 4B (which cares for bone marrow transplant patients) was upgraded to red. On 12 March 2026 the Cabinet Secretary reported that mould growth had been found. The Inquiry has not investigated this incident, but in the Glasgow 3 Hearing we heard evidence about leaks and mould growth behind ceiling tiles[135] in Ward 2A in 2017. Proper management of the water system according to SHTM 04-01, Part B is not a complete answer to risk of repetition of such incidents. The management of risk and rapid response to leaks before mould can grow is a joint responsibility for ward staff, IPC and Estates and requires effective joint working and a willingness to listen to concerns.

87. It should be acknowledged that in her supplementary statement for Glasgow 4, Part 3, Dr Peters raised the issue that regular water leaks were still occurring in high-risk clinical areas including Ward 4B[136]. We decided not to lead further evidence of leaks, as a line had to be drawn after which investigating fresh incidents would require the recall of more and more witnesses and prevent the Inquiry reaching a conclusion in anything approaching a reasonable time. However, if the latest incident does involve

[135] CTI Closing Statement, Glasgow 3, Pages 290-291, Paras 302-307 and Section 6.6, Page 540.
[136] Glasgow 4, Part 3 - Witness Statements, Volume 4, Dr Christine Peters, Page 446, Paras 19-21.

water leaks it suggests NHS GGC needs to listen to Dr Peters. In addition, while it is understandable that public statements focus on steps taken to protect patients following this discovery, we have previously pointed out that finding out why mould has arisen may be equally important.

5. CONCLUSION

88. It was not until 2018/2019 that the Scottish Government first understood that NHS GGC had decided in the Agreed Ventilation Derogation to build this flagship hospital not in compliance with Scottish Government guidance. The Scottish Government did not know about the problems with the water system until 2018, but then neither did the senior management and board of NHS GGC due to failures to provide sufficient resources and lack of oversight by those responsible for the water system. Any 'pressure' from the Scottish Government to open the hospital on time and on budget was made in ignorance of both issues. The Scottish Government systems to manage the procurement of this hospital it paid for were inadequate for the task of ensuring that it was built to technical standards the public and Scottish Government as funder should have expected.

89. As NHS GGC has consistently explained, the management of infection risks from healthcare acquired infections is multifactorial. For the hospital to be suitable for safe, patient centred care of immunocompromised patients, four different elements must work successfully together to achieve that goal and to hold public confidence. In our submission they are:

    a. Patients and the public will rightly expect that the water and ventilation systems are managed in accordance with Part B of the relevant SHTM. Where ventilation systems do not meet the standard set out SHTM 03-01, Part A this alone is not a sufficient assurance.

    b. Patients and the public will rightly want to know that the water and ventilation systems of the QEUH/RHC comply with Part A of the relevant Scottish Government guidance. Where they do not there must be validation that systems meet their design specification and that any derogation has been subject to risk assessment. This has yet to happen.

c. Even once these first two requirements are met, it is necessary to be confident that the Infection Prevention and Control team in NHS GGC is alive to risks to patient safety from the hospital environment. Such confidence can only be earned by an IPC Management Team that is open about failures in the past, demonstrates a willingness to learn and change, regains the trust of NHS NSS on HAI reporting and treats whistleblowers with respect. Section 5 of the Assurance Summary Report does not suggest that much progress has been made.

d. These elements will be more difficult to deliver, and public confidence will not be regained, without the Board itself embracing changes of the sort set out in Section 10.3 of our Closing Statement. From the evidence of the "Assurance Summary Report" this has yet to start.

Fred Mackintosh KC
Craig Connal KC

20 March 2026