SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Procedural Hearing on 11 March 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Substantive Core Participants'

Direction 10 Responses

Table of Contents

Scottish Hospitals Inquiry

Note by MDDUS on behalf of Dr Teresa Inkster, Dr Christine Peters, and Dr Penelope Redding for the Procedural Hearing on 11 March 2025

5 March 2025

Introduction

1. This Note is produced to comply with Paragraph 2 of Direction 5. In addition, the Note has been prepared to convey the position of TI, CP and PR to the Inquiry in advance of the Procedural Hearing due to take place on 11 March 2025, and in particular to set out our position on the matters set out in the Agenda circulated on 3 March 2025.

Agenda Item 1 - Publication of Closing Statements

2. Given the large amount of work which went into these documents and the significant public expense which was incurred in their production, we respectfully submit that the Chair should direct that all closing statements relative to the Glasgow III hearing submitted by Counsel to the Inquiry and all Core Participants should be published on the SHI website and, thus, made available to the public. We note that the Chair is already minded to do this (Agenda for the Procedural hearing on 11 March 2025, para 1.2).

3. Such a direction would ensure that the closing statements for Glasgow III are treated in the same way as all the closing statements submitted for all the other hearings held by this Inquiry and would give effect to the statutory obligation which requires that, subject to certain limited exceptions, the public be given access to Inquiry evidence.

4. Section 18 of the Inquiries Act 2005 provides that the Chair is required to take such steps as he considers reasonable to "secure" that members of the public are able to

obtain or view a record of evidence and documents given, produced or provided to the Inquiry. This obligation is limited only by a restriction notice or order imposed under section 19 of the Act. Other than the restriction order issued for witness 7 and redactions which would be required to protect the privacy of some patients and their family members, no other notice or order has been issued under section 19 which would prevent publication of the closing statements. Indeed, the closing statements are all based on evidence which was led in public.

5. Given the importance of the subject matter of the closing statements and the fact that any report by the Chair is likely to be well over a year away, publication of the Glasgow III closing statements should take place as soon as possible. This will allow the public to follow the progress of the Inquiry and to understand what it is doing to discharge its remit and to fulfil its terms of reference, all of which are being funded by the public purse.

Agenda Item 2 – Witnesses and Documents

6. We provided lists of witnesses and documents in January of this year. We note that whilst some of the witnesses that we suggested do now appear on the Provisional Witness List for Glasgow IV, many do not.

7. In particular, we would wish to note that we regard it as absolutely essential that Laura Imrie (Clinical Lead at ARHAI) be recalled during Glasgow IV (either during part 2 or part 3). We are disappointed that she does not appear on the provisional list. The need to recall her arises, at least in part, from the evidence which emerged after she was called at Glasgow III about recent cases of Cryptococcus at QEUH which have not been reported to ARHAI, and other recent concerns about reporting culture within the IPCT at QEUH.

Agenda Item 3 – NHS GGC Application, and

Agenda Item 4 – Practical Implications of the outcome of the NHS GGC Application

8. We consider that these two agenda items are inextricably linked. Accordingly, we deal with them together below.

9. TI, CP and PR maintain their previously stated opposition to the receipt of the evidence of Professor Hawkey, Dr Agrawal and Dr Drumwright in respect of their Report ("the Report"). Their position, as outlined in July 2024, was that the report came too late. Since then, more than 7 months have passed and the Glasgow III hearing has been completed. The claim that the report "represents crucial evidence" (application, para. 2.4) is belied by NHS GGC's inexplicably dilatory approach to seeking its admission into evidence. At no point has NHS GGC sought to expedite matters. They did not seek urgent disposal of their Judicial Review, nor did they seek to delay the holding of the Glasgow III hearing. The report, which was already "late" in July 2024, is now even more "late" given the passage of time and the procedure which has taken place in the Inquiry in the interim.

10. We have been provided with a copy of the Report, but not with any of the underlying data which inform its conclusions. Without this data, there is little that can usefully be done to interrogate the findings of the Report or to respond meaningfully to it. Without knowing the nature and extent of the data that has been considered by the Report it is also not possible to state a final position on what input would be required to allow us to respond. All that can be said at this stage is that it is likely that we will require to make an application for funding for the instruction of an expert epidemiologist. It is possible other expertise will also be required – it will depend on the data. If an explanation has ever been provided by NHS GGC for the fact that the data was withheld from the Inquiry until February of this year, then such explanation has not been shared with us.

11. TI, CP and PR have considerable expertise in their own right and we therefore might be thought to be better placed to respond to the Report without the need for separate

input than some other Core Participants. There are two problems with that assumption. First, CP and TI both have full time jobs and have already had considerable burdens placed upon them by the Inquiry, with which they have cooperated fully and frankly over many years. PR, who has also expended considerable efforts in her full and frank cooperation with the Inquiry over many years, has retired but has significant family commitments, and her own health to consider.

12. Secondly, NHS GGC state in their closing statement for the Glasgow III hearing (at para 24) that TI, CP, and PR all feel "*deeply personally aggrieved*" and that all evidence given by them has to be seen in that light.

13. It is, therefore, reasonable to expect that if we attempted to make a submission about the significant shortcomings with the Report without the benefit of access to an independent expert to support our position, then NHS GGC will simply submit that such a submission should be afforded little or no weight because TI, CP, and PR's expertise is somehow nullified by their "aggrieved" state. The position adopted by NHS GGC, therefore, increases the likelihood of us requiring to make an application for funding to instruct our own expert.

14. This aspect of the closing submission by NHS GGC of course ignores the fact that many of their staff who don't share the views of TI, CP and PR, are likely to feel similarly "aggrieved" by the events giving rise to the Inquiry, and indeed concerned about their own personal and professional positions, including in relation to the ongoing police investigation. Despite this, it appears to be said on behalf of NHS GGC that only TI, CP and PR's evidence should be regarded by the Inquiry as being somehow tainted. All of this will require to be dealt with on another occasion.

15. We have carefully considered the timetable which NHS GGC have set out in their application. We doubt whether the timescales set out are realistic. However, we cannot provide a clear position on any proposed timetable at this stage given that we do not have the data and, therefore, cannot determine what, if any, external input will

be required to meaningfully respond to the Report. We have no idea how long it might take to identify and instruct any experts that are required, or how long it might take the Inquiry to consider the necessary applications for funding once expert(s) are identified.

16. Whilst the lack of the data gives rise to some uncertainty at this stage, two things do appear to be clear. First, the receipt of the GGC Report is likely to delay the final conclusion of this Inquiry by a year, and quite possibly longer. Secondly, the receipt of the Report will considerably add to the expense of the Inquiry. Both of these are significant considerations in the context of an Inquiry which was announced 5 and a half years ago and which had already cost over £23.5m as at the end of September 2024.

Agenda Item 5 – Matters arising from closing statements

17. We are specifically directed to consider two matters arising from the Inquiry's previously issued Directions:

Direction 9 paragraphs 2.1 – 2.3

18. Direction 9 provides as follows –

2.1. Where a Core Participant disputes the accuracy of the narrative or proposed findings set out in Counsel to the Inquiry's written closing statement, they identify the relevant passage or passages, and explain the basis of and reason for the dispute under specific reference to such documents and witnesses' transcripts or statements on which they rely;

2.2. Where a Core Participant proposes that the Chair should adopt a narrative or make findings additional to what is proposed by Counsel to the Inquiry, they set out such narrative or findings under specific reference to the documents and witnesses' transcripts or statements on which they rely;

2.3. Where it is proposed that the Chair should disregard any evidence heard or considered by the Inquiry in the three Glasgow hearings or within PPPs 5, 11, 12 and 14 a Core Participant set out clearly and explicitly which evidence should be disregarded and why the Chair should do so by reference to that evidence and any other evidence that is relied on;

19. We set out a detailed position on these matters, insofar as applicable, in our closing statement for Glasgow III. We have nothing to add at this point.

Direction 10 paragraph 6

20. Direction 10 paragraph 6 provides as follows –

> 6. For the avoidance of doubt a Core Participant granted leave to appear at Glasgow IV are granted leave to appear at all three parts of the hearing.

21. TI, CP and PR have been granted leave to appear at Glasgow IV. We note that this will now apply to all of the Glasgow IV hearing and we are grateful to the Inquiry for that clarification. We have nothing further to add on this matter.

Agenda Item 6 – Requests of CPs by CTI in relation to Glasgow IV

22. Should any assistance be required by the Inquiry in relation to the Glasgow IV hearings, TI, CP and PR would be very pleased to provide it.

Helen Watts KC

Leigh Lawrie, Advocate

Medical and Dental Defence Union of Scotland

Scottish Hospitals Inquiry

WRITTEN STATEMENT
TO THE SOLICITOR TO THE INQUIRY

ON BEHALF OF NHS NSS

in response to GGC's application and in relation to additional witnesses for Glasgow IV hearings
(per Direction 10 at paragraph 2)

1. GGC is applying to have its report received into evidence ("the Report"). On 3 March 2025, NHS NSS ("NSS") received a Provisional Witness List for the Glasgow IV hearings. Direction 10 at paragraph 2 instructs Core Participants to set out, in a written statement, any (i) submissions in response to the application by GGC, and/or (ii) proposal that the Inquiry should hear from additional witnesses.

I. Submissions in response to the application by GGC

2. If GGC's application is successful, NSS considers that it would assist the Inquiry to receive a commentary from NSS on the Report. NSS would be happy to provide such a commentary ("the Commentary").

3. The Commentary would be on the epidemiological content of the Report. It would be similar in nature to the responses that NSS provided to Mr Mookerjee's report, and would be prepared by Shona Cairns, NSS Consultant Healthcare Scientist.

4. For the avoidance of doubt, the Commentary would not address microbiology or whole genome sequencing. Nor would it attempt to redo – rather than merely commenting on – the analysis in the Report.

5. In order for the Commentary to be as meaningful as possible, NSS would need access to the data (both raw and final) used by the Report's authors when preparing it. In addition, it would need support from an external statistician, who would assist by

providing specialist input in respect of the methodology used in the Report (there are several statisticians who collaborate with NSS).

6. NSS notes the suggested timetable in GGC's application. With regard to how long it would take to produce the Commentary, NSS notes that it has not yet seen the data referred to above. But, on the assumption that the data is broadly as expected, NSS should be able to provide the Inquiry with its Commentary within 8 weeks of receiving that data.

7. In the event that Shona Cairns is provided with the data to enable her to provide the Commentary on the Report, she should be listed as an additional witness for Glasgow IV Part 2.

II. Additional witnesses

8. On 31 January 2025, following the Glasgow III hearings and receipt of the Closing Statement by Counsel to the Inquiry, NSS submitted a Closing Statement. NSS's Closing Statement referred to some matters on which evidence has not yet been heard. It was thought that these matters would assist the Inquiry.

9. NSS proposes two additional witnesses who will be able to speak to these matters in written statements:
    a. Laura Imrie, Clinical Lead at NHS Scotland Assure; and
    b. Shona Cairns, NSS Consultant Healthcare Scientist.

10. With reference to NSS's Closing Statement, Ms Imrie can speak to paragraphs 16 to 17, 37 and 40. Ms Cairns can speak to paragraphs 26 to 31, and 34 to 35.

11. NSS notes that Thomas Rodger, already a witness in the Provisional Witness List for Glasgow IV, Part 3 (see below), will speak to new matters raised in other paragraphs of NSS's Closing Statement.

III. Miscellaneous matters

12. In the section of the Provisional Witness List on Glasgow IV, Part 3, one of the witnesses listed is Jim McMenamin. He is described as "Head of Infections Service,

NHS NSS". In fact, Dr McMenamin is employed by Public Health Scotland rather than NSS.

13. In the same section, one of the witnesses listed is "Roger Thomas" (the Head of Engineering at NSS). This should be "Thomas Rodger".

7 March 2025

SCOTTISH HOSPITALS INQUIRY

WRITTEN STATEMENT

in terms of Direction 10

on behalf of the

SCOTTISH MINISTERS

1. This written statement is submitted on behalf of the Scottish Ministers in the following respects:
   1.1. in terms of paragraph 2 of Direction 10, in response to the application by NHS GGC;
   1.2. in response to the invitation in the Solicitor to the Inquiry's email of 3 March 2025, as regards publication of Counsel's and Core Participants' Closing Submissions on the Inquiry's website; and
   1.3. to note a further matter arising from the Closing Submissions of Core Participants, which have now been circulated.

Application by NHS GGC

2. The Scottish Ministers are neutral as to the outcome of the application.
3. They agree that the appropriate basis for the Chair's decision as to whether to accede to NHS GGC's application is ultimately section 17(3) of the Act, noting that that provision also requires express attention to the need to avoid unnecessary cost to public funds.
4. They also note, however, the observations of Lady Wise in her Opinion at [33] to [34], leading to her observation at [36] that the Inquiry must be enabled to make 'robust and defensible findings'. Those observations, of course, being made in the context of the Inquiry's Terms of Reference and the safety of the QEUH being matters of significant public concern.
5. If the Chair were minded to accede to the application, the Scottish Ministers would respectfully submit that the evidence should be heard in such a way and on such terms as to be fair to NHS GGC as well as other Core Participants, bearing in mind the stage that the Inquiry has reached and the potential impact on public funds.
6. With that in mind, the Scottish Ministers wish to canvass the possibility of NHS GGC's experts giving (at least part of) their evidence concurrently with other relevant skilled witnesses (that is, as it is colloquially known, by 'hot tubbing'), among whom the most directly relevant would appear to be the Case Note Review panel (whose methodology, reasoning, and conclusions are criticised by NHS GGC's experts). In that regard, the Scottish Ministers note the Inquiry intends to obtain supplementary written statements from the Case Note Review panel but not necessarily lead further oral evidence from them. The Scottish Ministers would invite the Inquiry to keep that intention under review, noting that the extent to which there may be differences between the NHS GCC experts and the Case Note Review panel has yet to be ascertained.

7. While “hot-tubbing” would require re-calling the relevant witnesses, it might allow for more immediate identification and potentially reconciliation of points of difference among these skilled witnesses than sequential evidence would; and it would be consistent with the non-adversarial approach of the Inquiry.
8. It is right to note that there may be other practical issues such as the possibility that the Case Note Review panel would need to be given access to the necessary data platforms; the Scottish Ministers have yet to speak to the panel, but do not envisage any practical issues as being meaningful obstacles to such a course.

Publication of Closing Submissions

9. The Scottish Ministers consider in principle that publication would be appropriate bearing in mind the need for transparency. If minded to order publication, it is important to note that the Closing Submissions are just that. That being so, the Chair may wish to indicate (or reiterate) prominently that, for example, there remains a significant amount of evidence still to be heard as to the Inquiry’s Terms of Reference, particularly as regards the Queen Elizabeth University Hospital, Glasgow (and perhaps including the expert evidence sought to be adduced by NHS GGC), which the Inquiry will consider fully before reaching a decision on what aspects of the Closing Submissions to accept.

Other matters arising from Closing Submissions

10. It is noted that NHS National Services Scotland suggests within its Closing Submission at paragraph 15 (pdf p.151) that more evidence will be needed if the topic of ongoing reporting of infections by NHSGGC is a matter of interest to the Inquiry. The Scottish Ministers respectfully associate themselves with this suggestion, adding only that this matter would appear to be directly relevant to the Inquiry’s Term of Reference 9.

SCOTTISH HOSPITALS INQUIRY

SUBMISSIONS ON BEHALF OF
MOLLY AND JOHN CUDDIHY
AND
EILIDH AND LISA MACKAY

IN RESPECT OF
(A) THE APPLICATION THAT THE INQUIRY RECEIVE THE EXPERT REPORT OF PROF HAWKEY, DR AGRAWAL AND DR DRUMWRIGHT DATED 24 JULY 2024
(B) ADDITIONAL EVIDENCE THAT THE INQUIRY SHOULD CONSIDER IN THE COURSE OF GLASGOW IV

1. INTRODUCTION

Direction 10 was issued by the Public Inquiry in respect of Glasgow III and IV Further Procedure. Direction 10 states at paragraph 2:

2. Core Participants who wish to participate in the Glasgow IV hearing who wish to make submissions to the Chair in response to the application by NHS GGC or to propose that the Inquiry should hear any other identified witness on the issues likely to be the subject of such evidence should set out that response in a written statement to the Solicitor to the Inquiry by noon on 7 March 2025.

This submission has been prepared on behalf of the Cuddihy and MacKay families in response to paragraph 2 above.

(A) THE APPLICATION THAT THE INQUIRY RECEIVE THE EXPERT REPORT OF PROF HAWKEY, DR AGRAWAL AND DR DRUMWRIGHT DATED 24 JULY 2024.

The Cuddihy and Mackay families maintain a neutral position in respect of the application by NHS GGC to have their Expert Report Received. However, in the event that the Report is allowed, we request that copies of the letters of instruction and all documents that were furnished to said experts in respect of their instruction to prepare said Report, be made available to all Core Participants at the same time as the Report itself.

(B) ADDITIONAL EVIDENCE THAT THE INQUIRY SHOULD CONSIDER IN THE COURSE OF GLASGOW IV.

(i) As noted in the written submissions for Glasgow III, we submit that the Inquiry would benefit from hearing from Mrs Lisa MacKay, Prof John Cuddihy and Molly Cuddihy. In the interests of fairness we believe that oral evidence in addition to Inquiry statements should be taken from each of these witnesses to facilitate Core Participants making Rule 9 applications.

(ii) In addition, we submit that the Inquiry witnesses to date and the proposed witnesses will result in their being a lacuna in the evidence around the issue of Governance.

It is respectfully submitted that, to date, a substantial body of evidence had been led of individual failures, including, failure to action the 2015 and 2017 DMA Canyon Reports timeously; failure to respond to early alerts of non-compliance with existing guidance on ventilation (email exchanges involving Dr Peters from the period 19th June 2015 to 1st July 2015 where she provides a checklist of the required specification for ventilation, the current state and action required, including access to the commissioning and validation data (Bundle 14, Vol 1, Document 15 pp327-328)), and failure to appoint appropriate personnel (AP and CP) in respect of ventilation and water and have appropriate testing regimes by qualified individuals in place.

Whilst there has been evidence of multiple individual instances of failure there has not been an exploration of how failures in NHSGGC Corporate

Governance may have materially contributed to an increased risk of infection for vulnerable patients. This governance failure represents a critical enabler that likely heightened the risk of harm.

To illustrate this point we refer to the systematic governance issues that arose in the response by NHSGGC to both Mycobacterium Chelonae and Aspergillus bacterial infections between 2015 and 2020. Key issues include, but are not limited to:

Delayed and Insufficient Response: NHSGGC identified mycobacterium chelonae in 2016, 2017 and 2018 but failed to formally report these to the Board or conduct water testing, despite its presence in patients being treated in the Schiehallion Unit and in ward areas such as showers. This lack of immediate investigation and testing contravened established infection, prevention practices.[1] [2]

Failure to Implement Immediate Identification and Testing: NHSGGC failed to collect water samples from outlets, storage tanks and mains supply for testing. They also failed to timeously use culture methods and molecular techniques like Whole-Genome Sequencing (WGS) following identification of bacterial infection, to link environmental and clinical isolates to determine nosocomial transmission.[3] [4] [5]

Non-Compliance with Standards: The 2015 Healthcare Associated Infection (HAI) Standards, which emphasise leadership, surveillance and robust infection control policies, were not fully adhered to. NHSGGC did not

[1] https://www.gov.scot/publications/queen-elizabeth-university-hospital-nhs-greater-glasgow-clyde-oversight-board-final-report/pages/4/
[2] https://hospitalsinquiry.scot/sites/default/files/2024-08/Scottish%20Hospitals%20Inquiry%20-%20Hearing%20Commencing%2019%20August%202024%20-%20Bundle%2021%20-%20Substantive%20Core%20Participants%20responses%20to%20Dr%20Walker%20Report%20-%20Volume%202%20(External%20Version)_0.pdf?utm
[3] https://pubmed.ncbi.nlm.nih.gov/33945838/
[4] https://research-repository.st-andrews.ac.uk/bitstream/handle/10023/25265/Inkster_2021_Investigation_of_two_cases_JHI_AAM.pdf;jsessionid=2A2B35E92DF1A8E9EC836945E4EBB81D?sequence=1
[5] https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0236533&utm

implement timely measures to identify and mitigate risks, as required by these standards. [6] [7]

Governance Failures: The absence of a coordinated organisational response, including water testing and risk management, highlights governance lapses. This undermines compliance with frameworks like National Infection Prevention and Control Manual (NIPCM)[8] and the Scottish Governments Blueprint for Good Governance.[9]

Delayed Recognition: The Case Note Review identified instances of Gram-negative bacterial infections in 2015 (Aspergillus is a GNB) that were not investigated at the time, suggesting potential gaps in early detection systems.[10]

Building and Design Issues: Concerns about ventilation systems and water quality were raised before and after the hospital opened, indicating potential oversights in the construction and commissioning process.[11]

Consistency in Outbreak Management: There were inconsistencies in how cases were defined, identified and reported during outbreaks, which could impact effective management and analysis.[12]

Whilst the Inquiry has focused on specific incidents and technical deficiencies, broader system issues, such as the lack of robust 'Board to Ward' accountability framework have not been sufficiently explored. This

[6] https://hub.careinspectorate.com/media/1211/healthcare-associated-infection-hai-standards.pdf?utm
[7] https://www.nipcm.scot.nhs.uk/?utm
[8] https://www.gov.scot/publications/queen-elizabeth-university-hospital-nhs-greater-glasgow-clyde-oversight-board-final-report/pages/4/
[9] https://www.publications.scot.nhs.uk/files/dl-2019-02.pdf
[10] Provisional Position Paper 5 – History of Infections Concerns

[11] Provisional Position Paper 5 – History of Infections Concerns

[12] https://www.nipcm.hps.scot.nhs.uk/media/2261/2024-02-08-healthcare-infection-incidents-and-outbreaks-in-scotland-v-21.pdf

was a critical finding in previous Inquiries, e.g., Vale of Levan Hospital Inquiry, which highlighted how governance lapses compromise patient care environments.[13] It is of note that Professor Angela Wallace, during her evidence to the Public Inquiry, repeatedly referred to the NHSGGC 'system', with an assertion that it was effective[14]. We believe that it would assist the Chair to the Inquiry to hear the evidence of an expert as to the effectiveness of the systemic governance of infection prevention and control practices in QEUH/RHC. This should involve consideration of the organisational; transparency and responsiveness of NHSGGC to the crisis as it developed. We believe that addressing these systemic governance issues is crucial to fulfil the Terms of Reference and, if appropriate, to identify recommendations to ensure sustainable improvements in patient safety.

For the sake of clarity, we regard effective governance within NHS GGC as applying across several key areas (listed below) to ensure the delivery of safe, effective, and person-centred healthcare. These areas align with the principles outlined in the Healthcare Quality Strategy (2010), the Blueprint for Good Governance (2019), and other statutory frameworks.

Key Areas for Effective Governance

1. Clinical Governance
   - Ensures the quality and safety of patient care by embedding continuous improvement in clinical practices.
   - Includes monitoring clinical performance, addressing risks, and ensuring compliance with national standards.
2. Financial Governance-
   - Focuses on the responsible management of public funds, ensuring transparency, accountability, and value for money. *(with regards to the decision around the Horne Optithern Taps, was finance a factor?)*

[13] https://hub.careinspectorate.com/media/1415/vale-of-leven-hospital-inquiry-report.pdf

[14] Professor Angela Wallace - Witness Statement

- NHS Boards must regularly evaluate financial performance and align spending with strategic priorities. (*aligning financial performance and the decision not to increase the resource allocation model within Facilities Management & Estates and ensuring appropriate funds used to upskill and train staff thus safeguarding patients and staff - ultimately at what cost to patient & staff safety)*

3. Staff Governance
    - Promotes a culture where staff are well-supported, valued, and empowered to raise concerns safely. (*evidence provided that this has not been the case in relation to IPC and Communication and Engagement*)
    - Includes adherence to policies such as whistleblowing and workforce development initiatives. (*reference can be made to the independent review by WB Commissioner in her report into GGC)*
4. Information Governance
    - Ensures the secure and ethical management of patient data and information systems.
    - Aligns with legal requirements like GDPR to protect confidentiality and data integrity.
5. Integrated Governance
    - Combines clinical, financial, staff, and information governance into a cohesive framework that supports decision-making and accountability.
    - Encourages collaboration across NHS GGC Board and Integration Joint Boards (IJBs) to meet health and social care integration goals.
6. Governance of Change
    - Guides NHS GGC Board in managing reforms or service redesigns effectively while ensuring stakeholder engagement.
    - Emphasises adaptability in response to evolving healthcare needs, such as move from Schiehallion Wards to Ward 6A and thereafter to CDU.
7. Assurance Framework
    - Provides mechanisms for NHS Boards to evaluate risks, monitor performance, and ensure compliance with Scottish Government policies.

- Includes regular self-assessments and external audits to identify areas for improvement.

8. Community Engagement
    - Ensures that local needs and expectations are reflected in healthcare planning and delivery.
    - Promotes transparency by involving patients and communities in decision-making processes.

By exploring whether NHSGGC employed robust governance across these areas, the Chair of the Inquiry will be in a position to establish if NHS GGC upheld its commitment to deliver high-quality care while maintaining accountability to Scottish Ministers and the public. In the event that the expert report highlights systemic failures in corporate governance, it should shed light on how each contributed, individually and collectively to increased risks from infections thereby impacting patient safety.

Ineffective governance, such as inadequate oversight by hospital boards, poor interpretation of infection control data, or a lack of accountable mechanisms, can lead to systemic issues that exacerbate infection risks. Additionally, governance gaps such as insufficient risk assessments, delays in reporting on such, and poor communication between key stakeholders have been linked to preventable harm and adverse outcomes in patients.

CONCLUSION

We respectfully invite the Public Inquiry to instruct an expert report on Governance to fill a current and future lacuna in evidence. We have identified a suitable expert with whom we have no connection and can provide details of same to the Inquiry.

Clare Connelly, Advocate

6th March 2025

THE SCOTTISH HOSPITALS INQUIRY

NOTE on Direction 10

from the affected Core Participants: patients and the parents and representatives of the adult and child patients affected by their treatment at QEUH

1.1 We have been invited in Direction 10 to indicate whether we wish to make submissions to the chair in response to the application by NHS GGC to receive the evidence of their experts or to propose that the inquiry should hear any other identified witness on the issues likely to be the subject of such evidence.

1.2 We are disappointed albeit not surprised by the decision of Lady Wise, particularly given the likely consequences for the elongation of this Inquiry. We offer no view on the receipt of the joint report of the experts instructed by NHS GGC on the evidence of risk of infection from the water and ventilation systems. Receipt at this desperately late stage, with all its consequences, remains a matter entirely for the Chair's discretion.

1.3 We would observe that the report came very late and without explanation for its lateness. At the hearing in July 2024 on the question of receipt of this report, we asked: why a report of this nature, likely funded by the Scottish tax payer, did not materialise years ago when patients and families were being affected by the ongoing problems and infection issues at the hospital; where this report was when medical practitioners were giving evidence at the Glasgow II hearings about the QEUH when they were highlighting what they considered to be high infection rates; why the report did not materialise after the 2021 Case Note Review and why that review was not challenged at the time (or certainly long before it was). It remains the case that none of these questions have been acknowledged or answered.

1.4 It should be obvious that it is simply not possible for us to indicate at this stage whether we would like the Inquiry to hear from further witnesses, if so whom on what matters and when it might be available.

1.5 We have not been provided with access to the supporting data and evidence referred to in the NHS GGC expert report.

1.6 The issues that are engaged are complex and intertwined. The supporting data and evidence is voluminous.

1.7 We have previously been granted authority to obtain expert input from various expert witnesses on the water and ventilation issues set out in the detailed reports by the experts instructed on behalf of the inquiry. We do not have permission to obtain comment from the experts instructed by us on the NHS GGC expert report and its content. Without reasonable remuneration being provided to allow us to obtain comment from our own experts, we are simply not in a position to advise the inquiry whether we would like them to hear from further witnesses.

1.8 If the Chair grants the application of NHS GGC then we will require to seek funding from the Inquiry to allow our instructed experts time to consider and advise on the NHS GGC expert report and its findings.

1.9 It will be accepted that if the NHS GGC report is received into evidence, issues that ought properly and fairly to have been put to witness who have already given evidence were not put. In connection with paediatric oncology, for example, Professor Gibson was not asked to comment on the question of whether, as the NHS GGC expert report offers, infection rates at Yorkhill Hospital were higher than those encountered at QEUH/RHC. At the very least, Professor Gibson should be recalled to give further evidence in that regard. It will be a matter for the Chair to determine whether the approach to infection rates taken by the expert panel instructed on behalf of NHS GGC is borne out by the oral and documentary evidence in that regard. There are material inconsistencies between the content of the NHS GGC report and other sources of evidence that will require to be scrutinised and evaluated by this Inquiry.

SCOTTISH HOSPITALS INQUIRY

Bundle of documents for Procedural Hearing on 11 March 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow Substantive Core Participants' Direction 10 Responses

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