SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 September 2021

Day 3
Wednesday 22 September
Afternoon Session

CONTENTS

12:00

THE CHAIR: LORD BRODIE: Ms Arnott?

MS ARNOTT: Thank you, my Lord.

My Lord, I'm going to read from the witness statement of Kimberly Darroch. The witness statement can be found at page 304 of Bundle 3. My Lord, Ms Darroch's daughter died at the age of 10 when she was a patient at the Royal Hospital for Children in Glasgow in August 2017. I propose to read extracts from Ms Darroch's statement.

My Lord, I will begin at paragraphs 3 and 4 of the statement, if you have those:

> "When my daughter was five years old in September 2012 she was diagnosed with acute lymphoblastic leukaemia. She was treated at Yorkhill Hospital in Glasgow and entered remission in 2015. She relapsed in January 2017 and was admitted to the Royal Hospital for Children on 16 January 2017 where she was predominantly an inpatient until her death. My daughter spent the majority of her time in Ward 2A and 2B of the RHC which are known as the Schiehallion Unit. I stayed with my daughter for the duration of her admission along with her father. My mother, Christine Horne, also helped out and came to the hospital with us."

My Lord, I will now read some extracts from the family background section of the statement beginning at paragraph 7:

> "I had a very close relationship with my daughter".

Continuing at paragraph 9:

> "My daughter had a wonderful personality and was a bit of a character at times. She had a great sense of humour. She had some temper on her and she had a death stare that would look right through you. She had loads of friends and she cared about everyone she met. She always had a big smile on her face. It didn't matter how she was feeling at the time, she had one thing, and that was to make other people feel better. She cared a lot. She was always reassuring her family and friends".

Moving on to paragraph 14 my

Lord:

> "She did love animals, especially foxes. She would often feed the foxes at night in my mum and dad's house. She also liked going out into the garden and finding snails. She loved life and was full of beans. She was a joy to be around".

My Lord, at paragraphs 16-18 Ms Darroch describes her daughter's treatment at Yorkhill Hospital between 2012 and 2015. I will read some extracts from that section beginning at paragraph 16:

> "My daughter was initially diagnosed with acute lymphoblastic leukaemia in September 2012 and she was treated at Yorkhill Hospital in Glasgow. She was treated as an inpatient and an outpatient and received chemotherapy and steroid treatment".

At the end of the paragraph Ms Darroch says:

> "But we got through all of that and she was in remission. Yorkhill Hospital was a really nice environment to be in and I wish it had never closed. We were able to speak with other parents and the kids were able to mingle in the play room. It was a lot bigger than the play room in Ward 2A in the RHC. There was a lot more to do and it was more age appropriate for kids. It was always really busy and the nurses would be enjoying time with the kids in the play room as well as in the ward and the bedrooms. Kids were able to go up and down the ward and speak to each other. My daughter used to enjoy going there.
>
> When we went to the new hospital it didn't feel as nice an environment. It felt like it was more for younger kids and the play room was smaller. There wasn't a lot of room to do anything. There was hardly ever anyone in it and if felt like more of a prison. We weren't allowed to congregate in the halls or the kitchen to talk to anyone and the atmosphere couldn't compare to Yorkhill. All of the children had to be kept in their own rooms".

My Lord, Ms Darroch then moves on to describe events following her daughter's relapse in 2017. She tells us that she called Ward 2A and they told her to bring her daughter to A&E. At paragraph 21 Ms Darroch says:

> "We were in A&E for a couple of hours and then Professor Gibson came and told us that my daughter had relapsed. I think this was on 15 January 2017 and Professor Gibson told us that my daughter could have one last night at home and then she would be admitted to Ward 2A on 16 January 2017 which is what happened. My daughter was aged nine when she relapsed".

In the next section, my Lord, Ms Darroch describes Ward 2A and I will take up the narrative again at paragraph 23:

> "All the bedrooms are single rooms and I think they were a bit better than the rooms in Yorkhill as they had fold away beds for the parents that could be put in a cupboard which was better than them being in the room the whole time.
>
> There was a playroom, but it wasn't as big and didn't seem to have the same facilities as there had been in Yorkhill. There didn't seem to be as many activities to keep the kids entertained. There were no arts and crafts, no small tractors or lights that could shine on the floor and dance around. It was a shame.
>
> There was a parents’ kitchen but it was often closed because there were infections going through the wardlike norovirus. The kitchen was closed to stop the spread of infections so a lot of the time we didn't actually use the kitchen. We would only go there to get water and then leave straight away.
>
> There seemed to be plenty of nurses around the ward all the time, although I did notice that there was a difference in the amount of time they were able to spend with the kids. When we were in Yorkhill the nurses seemed to spend a lot more time interacting and playing with the kids but in the new hospital they would come in to see the kids and then leave straight away. It was maybe because they had more paperwork to do.
>
> I was really happy with the care that my daughter was given by the nurses. They were really

good, and I don't have anything negative to say about them. I think they were specially trained in dealing with oncology and there were certainly ones who were trained to administer chemo and they were the only ones who were allowed to do it.

As I said, Professor Gibson was my daughter's consultant, but she wasn't on the ward as maybe she could have been. We saw her about once a week. There were loads of different doctors on the ward. A lot of them were just learning and they would change every six months.

I wasn't really aware of any specific protocols on the ward in relation to infection control. The only thing that stands out is that if my daughter was in an isolation unit which had the double doors, then the nurses would wash their hands and gown up and things like that, but if we were just in a normal room then they didn't do this. My dad made a comment that there didn't seem to be any barrier nursing".

My Lord, Ms Darroch concludes her description of Ward 2A at paragraph 33:

"My daughter was then admitted to a room on Ward 2A. I can't remember the number of the room. All the rooms were much the same. When you went into the room my daughter's bed was on the left-hand side and the bathroom was on the right. The bed that parents could sleep in was on the right-hand side of my daughter's bed and we just folded that down. I think they were smaller than the rooms in Yorkhill, and the first room we were in I don't think the blinds worked so we couldn't see out the window. I'm not sure if my daughter stayed in the same room during this admission or if she was moved about.”

My Lord, in the section beginning at paragraph 34, Ms Darroch describes the next phase of her daughter's treatment. I will read extracts from that section:

"The treatment plan for the relapse was chemotherapy and steroid treatment again".

Picking up in the middle of the paragraph:

> "I do remember that the doctors had a meeting with me before they started the treatment and said that the treatment was really intense. My daughter might not survive it so that was a bit of a shock, but she sailed through it. She wasn't really ill during that first admission.
>
> The doctors' main goal was to get my daughter into remission within that month with the chemo".

Continuing at the end of that paragraph:

> "Once they realised she had not gone into remission after this first round of chemo, they started trying to find a stem cell donor and they kept going with the chemo until they found one.
>
> My daughter's chemotherapy was administered through her Hickman Line. Her Hickman Line was inserted under general anaesthetic into her chest. I think she got this line put in the day after she was admitted and then the chemo started the day after that. I can't remember the specific dates.

> My daughter had a Hickman Line when she was treated in 2012. The nurses showed us how to look after the line and clean it. We were advised to change the plaster covering the line once every week, but we did it every day as my daughter didn't want to get an infection. Infections in the line were very common, but my daughter never had one until the fatal one.
>
> There was a plaster over the line where it went into my daughter's body to keep it covered. We would change that and then we had wee alcohol sticks that we would rub over it. We would then use another liquid to swab round where the line actually goes into the body as that can be quite gunky. Then we would cover the line back up again and with alcohol wipes we would wipe the end of the tubes and that was it. There were two tubes on the line and one would be used to administer chemo and the other would be used for fluids and other stuff. The tubes were loose and my daughter used to wear a wee bag, “wiggly bags” we called them, round her neck that her gran made her and the

tubes were put in the bag so they didn't flap about.

This first admission lasted until March 2017. I think my daughter got out for a week just before her birthday".

My Lord, I will move on to paragraph 40:

"I think my daughter was let out of hospital to give her a break from her chemo. She hadn't had a temperature, so she was well enough to go home. She would go back to Ward 2B for bloods to be taken and for antibiotics to be administered. She got those three days a week. The antibiotics were called Ambisome. Professor Gibson told us that it was because it was a new hospital. I'm sure that's what her words were. I never thought to question her about it any further. I trusted her. I think she said it was to protect against bacteria of some sort but I'm not quite sure. I do not know when my daughter was started on these antibiotics.

My daughter was also on another prophylactic medication. I think it was called Septrin. I think she was on this to protect her lungs. I think she was prescribed that in February 2017. She wasn't given it straight away. Any time her blood counts came down she would be taken off that one. I didn't know why she was on this or why she was taken off it if her bloods counts were down. I just accepted it, especially as she had been on Septrin during her treatment the first time in Yorkhill.

Throughout my daughter's first admission and during subsequent admissions my daughter would often have spikes in her temperature. There was a protocol in place if kids had a temperature as it could mean that they had a line infection. My daughter had a temperature, she would be put on to general antibiotics for 48 hours. There would then be some tests carried out. My daughter would get a swap up her nose, bloods and cultures taken, and then we would find out if she had an infection that needed antibiotics. That happened a couple of times. It wasn't always an infection that caused her temperature to spike, some of the time I think it was

> just because of her treatment.
>
> I don't think my daughter spiked that often during her first round of treatment in 2012, but she did seem to spike more often during the relapse treatment. If it was an infection, sometimes the doctors and nurses didn't really know what it was, and it was just one of those things that happened. I do remember that she had the norovirus but that was more sickness and diarrhoea. I think the doctors and nurses also mentioned the adenovirus and rhinovirus which is just the cold. Those were the most common ones I think".

My Lord, at paragraph 44 Ms Darroch describes a second admission to Ward 2A. I will read some short extracts from that section:

> "After her week at home, my daughter was readmitted to Ward 2A in March 2017. I think this was because her treatment was starting again. I think it was the same regimen as the first admission when she got chemo every couple of days".

Paragraph 45 Ms Darroch

continues:

> "My daughter's treatment was all done as an inpatient as it was so intense. She had no immune system so was at high risk of getting an infection. I think this round of chemo lasted for about a month".

At the end of that paragraph:

> "She maybe had a few temperature spikes but she wasn't really ill".

Moving on to the end of paragraph 46:

> "She got home after the round of chemo in April 2017 around Easter time".

In the next section, my Lord, Ms Darroch describes a third admission to Ward 2A, and that is set out between paragraphs 47-49. I don't propose to read that out.

My Lord, I will pick up the narrative again at paragraph 50 where Ms Darroch describes her daughter's admission for a stem cell transplant in June 2017:

> "Once we knew that we had a donor for my daughter's transplant, she was admitted so that her body could be prepared for the transplant. My daughter was admitted on 4 June 2017 for this to be done.
>
> We got a letter from the hospital explaining what the stem cell transplant was as well as the risks. I think Professor Gibson probably had a discussion with us about it, although I can't remember that. We decided to take the chance. The transplant did work."

My Lord, I will move on to paragraph 57:

> "My daughter got her stem cell transplant on 15 June 2017. She was in the isolation room and it was done intravenously through her Hickman Line. Once it was done, the nurse stayed with her for three hours and checked her blood pressure every 15 minutes, then they came in every four hours to check her and carry out observations, then after that we were just left to see if to worked. My daughter remained in isolation. The expectation was

> that she would remain in isolation for about eight weeks, although it was only about 15 days before my daughter got her first neutrophil which was a sign that her body was accepting the transplant.”

My Lord, I will pick up the narrative again at paragraph 59 and read this section almost in full through to paragraph 71:

> "On 16 June 2017 my daughter experienced some respiratory difficulties. I don't know what caused that, although I thought that it might have had something to do with the transplant. I think they maybe gave her an injection to boost her neutrophil counts. That was something she was given quite a few times.
>
> On 20 June 2017 my daughter was given antibiotics as she was unwell. She was having temperature spikes and she was given the antibiotics. I don't know if she had the adenovirus infection at that point.
>
> My daughter had blood cultures taken on 28 June 2017 and on 30 June it was confirmed

that she had adenovirus. I think Professor Gibson and maybe another doctor, Mark, told us about the infection. I think they told me that it is quite a common infection, and it lives in everybody. Obviously with my daughter having no immune system, it just appeared and made her unwell. I don't remember if I was told how they thought she had caught it. She was given antibiotics and she improved.

On 6 July 2017 my daughter's fever had settled and about a week after that she was allowed out of the hospital. This was the second week in July 2017. She was allowed out on a few occasions. She was allowed to go home for a couple of hours, although she wasn't too keen about this as she still didn't feel great".

Moving on to paragraph 63:

"On the ward my daughter was still in the isolation room with the double doors but she was no longer in isolation. She was allowed out. She mainly stayed in her room and played her

PlayStation and watched the iPad or TV. She didn't really use the playroom because she didn't want to. As I have said, it wasn't really for her age group. She didn't really interact with any of the other kids but there wasn't really an opportunity for her to do so.

The Friday before my daughter's Hickman Line was removed she was complaining that it was sore around where the line went into her body. She never complained, so it must have been sore. I mentioned it to the transplant nurse. I don't remember his name. He had a look at it and said that it was fine and that was it. There was nothing obvious, the infection must have been in the line. Nothing else was done at that point.

Around about this time, my daughter was spiking quite a few temperatures and she was telling me that she was feeling rotten. She was still telling me that her line was sore. Blood cultures were taken again on 25 July 2017 and they found that she had a line infection. My daughter's dad was in the hospital that day. He was told that her line was infected and that she needed to go to theatre to get it removed. We were never told what the infection was. In fact, Professor Gibson kept telling us that they didn't know what the infection was. She said it might have been adenovirus or it could have been because of the chemo. I don't know when she first said that they didn't know what the infection was, but the hospital staff maintained throughout my daughter's treatment for the infection that they didn't know what it was.

My daughter was taken to theatre on 25 July 2017 and they couldn't get her temperature under control. Her blood pressure was either high or low, I think maybe low. But they got the green light to go ahead and take the line out. This was after blood cultures had been taken from my daughter and they showed that she had a stenotrophomonas maltophilia infection in her line although we were not told that at the time. I actually thought I was going to lose my daughter that day after the line removal. Whilst they

were removing the line there was a septic shower from the line and the PICU doctor explained to us afterwards that it was the infection running through my daughter's blood. On 26 July 2017 my daughter had further blood cultures taken from her and they were still positive for stenotrophomonas although we weren't told that at the time either.

After the surgery to remove the line we thought that my daughter should have been admitted to the Intensive Care Unit but she wasn't. She was taken back to Ward 2A and was being monitored closely by the nurses. We were told that she would be admitted to PICU if her lactate levels fell below a certain number, although even when the numbers did fall she wasn't admitted.

My daughter wasn't admitted to PICU until 4 August 2017. She had just been at the toilet and her lips were blue. One of the doctors came into her room and saw her and it was then that the decision was made that she should go to PICU.

The decision to admit my

daughter to PICU was made because she was blue in colour and her heart function was at 17 per cent. Her lungs weren't coping either. She had severe infection in her lungs which I didn't know about either. I wasn't told anything about why she was so unwell. I put it down to her heart function and her lung condition. I remember when she went that PICU and she was ventilated, Professor Gibson came down and I asked her if my daughter would survive. She said she didn't know. So at that point I knew it was serious. But I was still under the impression that they didn't know what was wrong with her.

My daughter had to be put on a ventilator on 6 August as her lungs weren't functioning. We were told this by the PICU doctors. We rarely saw Professor Gibson once my daughter was in PICU and I think she was away on holiday until the week before my daughter died. The PICU doctors were amazing but they still didn't say my daughter had stenotrophomonas. They were telling us everything they were doing for my daughter.

They were giving her lung massages and they were clearing out her lungs as well. The doctors were telling us that they were trying to find out what the infection was and even checked to see if her leukaemia had returned. Kept trying her with different medication when she was in PICU. One of them they had to get from America. I can't remember what it was called but they thought it was this other infection that they were going to treat her for, kept telling us that virology was involved, and all these different doctors, infectious disease doctors, but if they knew what the infection was, I don't understand why they would tell us these things. Maybe the PICU doctors didn't know. I don't know. Somebody knew but maybe they didn't.

On 12 August 2017 my daughter was put on the ECMO machine which is a heart and lung by-pass machine. It takes all the blood out of the body and does the work for it. Just after she was put on the ECMO machine were the Gibson and the head of PICU spoke with me, my daughter, my daughter's dad and

> his wife. They told us that my daughter was very poorly and was the sickest child on the ward and they didn't know what the outcome would be."

My Lord, in paragraph 72 Ms Darroch describes the end of her daughter's life. I will read some extracts from paragraph 72:

> "After that they were just trying to keep her comfortable. They tried taking her off the ECMO one night. She was okay and then they put her back on it again".

Moving forward a couple of lines, my Lord:

> "They took her off her medication which had sedated her and she was able to speak to me a couple of times. It wasn't much but it was nice. At one point we were told they were looking into getting her a heart transplant down in Newcastle. They were always giving us hope. There was always something that they could do. Then they said that they couldn't do the heart transplant because

> she was so poorly. I think that it had already been established that if she couldn't have the heart transplant then there was nothing more to be done. My daughter passed away. At the time of her death we knew that the stem cell transplant had been successful and the leukaemia had gone".

My Lord, in the next section Ms Darroch describes events after her daughter's death. I propose to read extracts from it beginning at paragraph 73:

> "After my daughter died, one of the doctors in the PICU certified her death".

Moving on a couple of lines:

> "I didn't look at the death certificate until about five or six weeks after my daughter had passed away. I saw the stenotrophomonas infection on the death certificate and I had never heard of it before. I Googled it and saw it was an infection found in water but I never thought anything untoward. Maybe I should have at that point but I had just lost my daughter

and I trusted everyone in the hospital. I didn't expect an infection found in water to have killed any daughter. I didn't ask any questions at that point. There was no further information from the hospital about my daughter's death.

I didn't start to question the information about the infection until everything came out in the press in November 2019. I had heard about Ward 2A closing in September 2018. I did have a niggling feeling at that time. I'm not the sort of person to go out and get answers. I'm actually quite shy.

In February 2018 Professor Gibson and one of the outreach nurses from Schiehallion, Karen Marshall, came out to my house to meet with me. My mum was there too. I was in touch with Karen quite a lot and I think I had had a card sent to me by Professor Gibson saying she would be happy to talk to me. So I told Karen I thought that would be a good idea and she arranged it. They came out to see if I was okay and if I had any questions. I did say to Professor Gibson that I had Googled the

stenotrophomonas and thought it was found in water, but she didn't take the conversation any further. I think she just nodded her head and that was the end of it. We didn't really discuss my daughter's death at all. Professor Gibson was saying how lovely my daughter was and what a nice family we were. She was just really sorry that my daughter had passed away. She seemed to be particularly affected by my daughter's death which I thought was strange. I remember that Karen told me that Professor Gibson hadn't gone to the memorial service held in September 2017 for all the children that had died. She was too upset about my daughter.

After this meeting in February 2018 I didn't really have much communication with the hospital. I kept in touch with Karen now and again and I raised some money for the ward. I used to get invited to the memorial service I just mentioned. I didn't go in 2017 as it was too soon after my daughter's death, but I did go in 2018. I also went to the Christmas event held by The Children's Hospital charity and I went to a few counselling group meetings. After everything came out in the press I wasn't invited to anything else".

My Lord, I will move on to paragraph 78:

"Around November 2019 I must have seen something in the press about the hospital which made me think that the issues at the hospital were linked to my daughter's death. As a result of that I emailed the Health Minister, Jeane Freeman's office. I think this was in September or October. I was asking whether there was a link between the issues at the hospital and my daughter's death. I had a suspicion that something wasn't right. I did get a response from Jeane Freeman's office about three or four weeks later which said that someone would be in touch in due course, and then I got a further email to say it was being looked into. By that time the press articles had come out about the whistle blowers and the water contamination and I instantly knew that the child they were talking about in the press

was my daughter. The press article came out in November 2019. I didn't have any meetings with Jeane Freeman as a result of my email to her.

After all the information appeared in the press, no one from the hospital contacted me.”

My Lord, I will continue the narrative at paragraph 82:

"The only line infection that my daughter had was the one linked to her death. We knew that it was a line infection. That was the reason that she had to have her line removed and that led to the septic shower.

At no time were we told what the line infection was and, as far as we were concerned, the doctors had no idea what it was. The death certificate was the first we knew that the infection was stenotrophomonas and was related to my daughter's death. The case note review says that there is a record that this infection was discussed with us as her family. That did not happen. We have never discussed the infection with the hospital at the time, or in the

> aftermath of my daughter's death. No one in the hospital has ever discussed with us the cause of my daughter's infection."

My Lord, at paragraph 84 Ms Darroch mentions again the prescription of antibiotics to her daughter. She says:

> "I am aware that my daughter was prescribed Ambisome as a prophylactic when she was admitted to Ward2A in January 2017. Professor Gibson told me that it was because it was a new hospital and mentioned something about bacteria but that was all I was told".

My Lord, in the next section beginning at paragraph 85 Ms Darroch describes her interaction with the case note review and the work of the oversight board:

> "My daughter was one of the children who was included in the case note review and I have her individual report. The review states that my daughter's infection was linked to the hospital environment. The case note review report states my daughter caught an infection on 23 July 2017 and it was caused by stenotrophomonas maltophilia. The report states, “*Based on the information available to us we consider that this infection was probably related to the hospital environment.”* They refer to another case of the same infection which occurred in the same ward ten days earlier and they mention that my daughter had been on Ward 2A for seven weeks prior to contracting this infection in support of their view. They state, on balance that they believe that the stenotrophomonas infection must have made a contribution to my daughter passing away. There is one comment in the Review that is false. It says that there was a meeting between us and the doctors and the infection was discussed. The only meeting we had was the one where they told us that my daughter was really poorly. That was the meeting with Professor Gibson and the Head of PICU. My dad was there too and neither of us remember stenotrophomonas being mentioned. It's something that we would have remembered,

especially when we saw it on her death certificate. I was quite into all the medical side of things, and I would Google everything as I always wanted to know what was happening and what things were, so I am sure I would have done this if I was told at the time.

This information was in the Review as one of the questions I had asked the Review team, through the Oversight Board. It was why my daughter's parents had not been told about the stenotrophomonas infection. In the Review, it says: "*The case records document that stenotrophomonas infection certainly featured in discussions with members of the family once Ms Darroch's daughter had been admitted to Paediatric Intensive Care. It's not exactly clear when the issue was first raised with the family after the blood culture was confirmed on 25 July*." That never happened.

I haven't had any further discussions with the panel who were involved in the Case Note Review. They did offer to speak with me, but I didn't feel able to. I asked them questions through the Oversight Board prior to the

Review concluding. I met with Fiona McQueen to do this. She was helpful and we had quite a positive meeting and I felt she wanted answers as much as I did. She took all of my questions back and they have all been answered in the Case Note Review, although not all accurately. I haven't heard from her since that meeting. I did find the Oversight Board and the Case Note Review to be helpful processes.

I also had some email contact with Professor White. He would email now and again with things that we needed to know or things that came out, and I did find that helpful, but I haven't heard from him in a while, certainly not since the meeting I had with the Oversight Board. I thought he would have emailed once the Case Note Review was out but he hasn't."

My Lord, at paragraph 89, Ms Darroch makes some short observations about the hospital building. She says:

"When we were in the hospital with my daughter, I was not

> aware of any issues with the building. I was not aware of any work being done in the building. I wasn't aware of any issues with the water or the drainage in the bedrooms, the ward, or elsewhere else in the hospital and none of the staff ever mentioned anything about the water."

My Lord, in paragraphs 90 to 92, Ms Darroch summarises her experience of communication at the hospital.

> "When my daughter was in the hospital, I didn't have any issue with the communication that I was getting about my daughter's infection, but now, knowing what I know, they should have told us what it was at the time.
>
> I don't think that any of the staff on the ward knew at the time that there were any issues with the safety of the hospital or the buildings. I think that if they had they would have said something as I'm pretty sure none of them would have wanted a child to be in any danger.
>
> I feel really let down by the hospital. My daughter didn't need to die. When she was in the hospital, we kept getting told that we needed to keep her clean. I would have been happy for her to have been dirty if it meant saving her life. The bottom line is that I believe that she caught the infection from a shower or bath as that is the only time her line was near water. Since the link between the water and my daughter's infection all came out, I think that the hospital has been burying its head and hoping it all goes away. They're not communicating with the families at all. They keep saying in the media that they are more than happy to meet with families but they've never once invited me personally to have a meeting with them. So their communication, or lack of communication, is absolutely shocking. I think it would be really good for them to meet families that have gone through this unnecessary pain but they're staying away from all of us as much as they can."

And, at paragraph 94, Ms Darroch says:

> "I would have preferred that

> the hospital staff had been honest and told me about the infection at the time. Instead, I found out about it in the press. I would have preferred it was not public knowledge. I think it could all have been dealt with better.”

Finally, my Lord, Ms Darroch’s concluding comments are contained at paragraphs 96 and 97:

> “My view is that the hospital should be closed. I don't think it's safe. I've since heard other reports from nurses that there's fungus growing in walls and adult patients are now dying and they're covering that up. I feel like the health board need to be punished for all of this. In my eyes, what happened to my daughter is murder. She should still be here and I am trying to come to terms with that after coming to terms with losing her initially. I don't know that I'll ever be able to. I would never go back to the hospital, never.”

For completeness, my Lord, you will see that Ms Darroch makes a declaration of truth at paragraph 98.

My Lord, I propose now to read

some short extracts from the witness statement of Christine Horne, who is the mother of Kimberly Darroch. Mrs Horne has provided a witness statement to the Inquiry, which is included in Bundle 3 at page 332. My Lord, I propose to begin with some excerpts in which Mrs Horne describes her granddaughter, and these begin at paragraph 8.

> “My granddaughter loved animals. She wasn't a girly girl and played in the garden with all sorts of insects and love doing that. She had her own wee bit in the garden. She would collect snails and name them.”

And at paragraph 10, Mrs Horne says:

> “My granddaughter usually stayed with us a couple of times a week. She was always here one night at the weekend. Whenever she came, she would stay for the night. We had midnight feasts and watched television until midnight. She made me watch all of the Disney films, but she would watch anything, even films you wouldn't think a girl would watch; spy

films, Jaws, everything. She watched anything to do with an animal, it didn't matter what kind of animal it was. There was Jurassic Park too. It didn't matter how scary a film was. We usually sat up late at night.

My granddaughter could give you the look … if she wasn't happy with you. She didn't have to say anything, you just got the look. She was very witty too. We miss her very much. We miss her terribly.”

My Lord, I will take up the narrative again at paragraph 18, where Mrs Horne describes Ward 2A of the Royal Hospital for Children.

“The RHC was a super hospital. It was a big hospital and it was absolutely beautiful. Inside they had loads of things for kids to do. This was at the front entrance of the hospital. There were lots of things for kids to do while they were waiting for clinic. There were novelty mirrors which made you look much bigger or much smaller and there was a ball game. On the ward, the bedrooms were a good size. They were bigger than Yorkhill ones and they had the fold down bed, so you weren't squeezed in as much.

Down the right hand side of ward 2A were the transplant rooms. I can't remember how many transplant rooms there were. There were two in the old Yorkhill, but I think there might have been four in ward 2A. They’re maybe a little bit bigger than the usual bedrooms and they have filtered air. There is the bedroom where my granddaughter would be in her bed and then the parent bed as you were still allowed to stay with them. There is a door from the bedroom into an outer room with a big sink and the medicine cabinets. There's a stand because you've got to put your coat on as you can't walk into the bedroom with your outdoor coat on. Your shoes have to be changed and you've got to scrub up. There is then a door from this outer room onto the ward. If the door from the bedroom to the outer room is open, then you can’t open the door that goes onto the ward. You would have to wait until the bedroom door was closed. It's like an airlock.

The cleaners go in and they clean the room before you move into it. I think it's a spray or something like that and then you were allowed to go into the room."

And, at paragraph 23, Mrs Horne says:

"After the transplant rooms, you had rooms to the side where you took the toilet and things, yucky things, like bedpans. And then there was the laundry room and after that there was the desk where the nurses sat. When my granddaughter was well enough she actually sat with the nurses at night. There was a wee nurses' bit outside my granddaughter's room too. It was a wee box thing that came in front of her room. We never went past this because that was the teenage area."

And, at paragraph 26, Mrs Horne says:

"I never really passed my granddaughter's door. One time I took her up to the teenage area as she was desperate to see what the teenagers had. They had everything she didn't. They had their computers and everything all set out, and they had a great big room to be in. I took her up to see it but that's the only time I was up there. Most of the time, we were in my granddaughter's room. I can't recall any of the numbers of the rooms that we were in."

At paragraph 30, Mrs Horne says:

"We never wandered up and down. The ward wasn't quite like Yorkhill, where they would go out and play in the corridors. Some of the kids did go up and down on the wee toys. I saw this in Yorkhill Hospital and the RHC but I saw this more frequently at York Hill. I agree that it's best to have kids in their own rooms but I also think that if they're well enough and they've not got an infection, then they should have another bit to mingle and play in."

At paragraph 34, Mrs Horne says:

"My granddaughter was getting laser treatment on her mouth ulcers because it was really, really bad and it was incredibly painful. She was feeling really crap. I spoke to the doctor who was doing the laser treatment, and told her that if she had a dog she should talk to my granddaughter about that and she would have a friend for life. The doctor did this, and she was fantastic. After that they would always talk about the dog. It was just the simple things like this that could make it so much easier because my granddaughter actually trusted her then.

There were special protocols in place if my granddaughter was in the transplant room that I have already described, and, as far as I know there were protocols in place for infections more generally on the ward. There was always supposed to be barrier nursing if there's an infection. But obviously nurses go in and out rooms. That's a hard one to call, to be honest with you, because when you're coming in and out of rooms you don't actually see if the nurses have gone and scrubbed. They'll come and wash their hands but you don't know if they're dealing with somebody else that's maybe had another infection. It wasn't as good as Yorkhill. No one had any masks on, and the cleaners and nurses would come in and out of the rooms. No one was wearing gowns. That was the main difference we saw between Yorkhill and the new hospital. The first month my granddaughter was in York Hill, everybody was gowning up. We didn't see this as much in the new place."

My Lord, I will take up the narrative again at paragraph 55, where Mrs Horne describes the events shortly after her granddaughter's death.

"We had no idea what the infection was that caused my granddaughter to become unwell. We knew that it was from her line, but we were never told what it was and there was never any indication that it was related to the water in the hospital. Nobody said anything about what had caused the infection."

And, at paragraph 58, Mrs Horne continues:

“We weren't there when my granddaughter's death certificate was being issued. It was her mum and dad. They had to go back to the hospital the day after my granddaughter passed away and Derek took Kimberly in. We were just functioning. We weren't taking anything in. We did see the death certificate but I don't know when we saw it and I didn't know what it said. They were all big words to me. I couldn't have told you what any of the infections were. Nobody has ever said it was from the water or anything. When we read it, we just thought she had an awful lot of infections.

As far as we are aware, there weren’t any meetings with anyone from the Schiehallion just after my granddaughter died. Usually, Kimberly would tell us if there was anything but I can't remember her saying that she was going to meet with anybody until Professor Gibson and an outreach nurse from the Schiehallion came out but that was a while after my granddaughter had died. I think it was a few months later, as I was back at work, possibly February 2018. I had to get time off my work to be with Kimberly for the meeting with Professor Gibson. During this meeting, Kimberly did ask about the stenotrophomonas infection but it was brushed away as a hearsay question. She was asking about this infection because it was on the death certificate, I can't remember exactly what she said, but I know that Professor Gibson brushed it aside. It wasn't answered. Professor Gibson didn't elaborate on any of the questions. She was just asking things like, “How are you coping?” I can't remember fully what was said but Kimberly was trying to find out what that infection was and we didn't get any answers. I expected more from the meeting, even after all those months. The big question is why were her parents not told face-to-face what the infection was and how my granddaughter got it? We didn't know about some of the information at the time but the infection actually started before my granddaughter got her line out. I did not find this out until I read this in the independent case note review report. The report was prepared by a consultant who reviewed my granddaughter’s medical records. Then she had the septic shower. I can't believe that it has actually gone on and they hadn't told us. Why not tell us? They're always going to say it was an infection. We didn't know what kind of infection my granddaughter had. We knew it obviously had to be a line infection or something to do with the line because when it was removed, that's when she started to go downhill. Nobody said anything about what caused it.”

Moving on to paragraph 61, my Lord, Mrs Horne says:

“Until this actually came out in the papers, we had no idea at all about the water and it hit us like a ton of bricks. After the meeting in February 2018 the next thing I was aware of was when Kimberly phoned me at work saying it was in the papers. Anas Sarwar had gotten in touch with her and told her about these whistle blowers. Kimberly said it was a water infection that my granddaughter had. This was November 2019 so a lot of time had passed. It

just brought absolutely everything back and then we were worse than what we had actually started with; all of a sudden, we realised my granddaughter could be here. It brought up so many emotions, we were so angry and disappointed with the hospital. At this point there was no name in the papers but Kimberly knew it was my granddaughter. She just instinctively knew it was my granddaughter they were talking about when they said a child had died. She knew instantly. It is thanks to the whistle-blowers that this was all brought to everyone's attention because they don't want to live with feeling that they're letting something go. It's understandable but I wish they'd done it earlier.”

And, at paragraph 64, my Lord, Mrs Horne continues:

“When I heard about the ward being closed, I had my suspicions that this maybe had something to do with my granddaughter. We were also hearing about the infections from the pigeon droppings too and when we started to put things together and

> form a picture of what was happening; we realised things weren't working in that hospital. We started to think; “Why, all of a sudden, are they closing and not opening up again?”. There must have been problems. There must have been a big problem.”

My Lord, at paragraph 68, Mrs Horne describes her impression of the new hospital building.

> “The building was brand new and it was immaculate. I did notice that there was always some work being done on ward 2A. They were always fixing things like the doors: the doors coming into the ward and things. It's a new build, so you're always going to get wee problems and wee things that have got to be sorted. So I didn't really give it any thought.”

My Lord, I will take up the narrative again at paragraph 73, where Mrs Horne describes the impact of discovering the potential link between the infection her granddaughter had and the hospital environment.

> “The grieving process, when it

> started in 2017, was bad enough. We supported Kimberly every way we could. She's our daughter. So, we're trying to do this, support her and grieve all over again. That's what has happened. The grieving process has started again, and it brings it back every time we talk about what happened to my granddaughter. It's not that we don't talk about my granddaughter. We talk about her like she's still with us, but it's stories of my granddaughter, happy stories before she passed away.
>
> We’ve not had any communication from the hospital. There should have been communication. The hospital should have been open and transparent. I wish they told us right from the beginning all about the infection and not kept it to themselves. At the end of the day, they've got to live with this. We are living through it. They've got to live with it for the rest of their lives. Somebody has made a big mistake. Somebody's passed something that they shouldn't have passed. Somebody’s not checked things

> that they should've checked before that hospital opened."

Moving on to paragraph 76 and 77. My Lord, Mrs Horne concludes by saying:

> "We hope one day we'll get the truth. I think the Health Board have just crossed their fingers and are hoping for the best. It's not been the best for us. I think they've all known that there were issues and they've just kept going and hoped it would maybe clear itself. My granddaughter is no longer here. That's the main thing. She should be here. The hospital building was at fault. That's it, as far as I'm concerned. She should be here with us now."

Finally, my Lord, you'll see that Mrs Horne provides a declaration of truth at paragraph 78. My Lord, I am conscious it's five to one. I'm proposing to read in some extracts from Mr Horne's statement, but they will be very short, and I'd anticipate finishing either at one or shortly thereafter.

THE CHAIR: Right. I'm in your hands. I think, clearly, if we can conclude, even if it means sitting a bit beyond one o'clock, that would seem to make sense.

MS ARNOTT: Thank you, my Lord. My Lord, I want to finish by reading a few short extracts from the witness statement of Derek Horne, Ms Darroch's father, and husband of Mrs Horne. Mr Horne has provided a witness statement to the inquiry, which is included in Bundle 3 at page 354. My Lord, I will begin at paragraph 6, where Mr Horne describes his granddaughter:

> "My granddaughter, even the name says it all. A fun-loving girl, beautiful and wild and loved mixing with other kids. She was intelligent and sharp and was clever at school. Everybody seemed to enjoy my granddaughter's company and liked her. She was never away from our door, and we had holidays in the caravan on a regular basis. She was just a normal, fun-loving girl. She seemed to love nature and was never out of the garden."

And at paragraph 8:

> "She wasn't a girly girl. She played in the garden with all sorts

> of insects and loved doing that, to be honest. It's horrible, but snails, believe it or not. She loved the snails in the shells. Not slugs, snails. She’d collect them and feed them and things. We had a wee bit in the garden, and her wee brother is now looking after that. Her brother tells me, ‘Papa, look at this. Look at the wee stones with my granddaughter's name on it and my name on it.’ My granddaughter would have loved that, to be honest.”

And at paragraph 11:

> “My granddaughter’s always in our thoughts every day. She never goes away. I'm always thinking about her and missing her. We couldn't have asked for a better granddaughter, to be honest. Just perfect. I miss her so much.”

My Lord, at paragraph 14, Mr Horne goes on to describe what happened just before his granddaughter's death:

> “Late on in August, when my granddaughter was in the PICU,

> Kimberly and I got called into a side room. The times and dates escape me. Professor Gibson and another consultant took us into a room and basically told us that my granddaughter was a very sick girl. They didn't go into great detail of the outcome, but that was their comment. We were shellshocked at the news, and I can't remember exactly what was discussed. At that time, we knew that my granddaughter had an infection. We weren't told what the infection was, and there was never any mention that it was a waterborne infection.”

My Lord, I will take up the narrative again at paragraph 16, where Mr Horne makes some observations about the hospital:

> “At the time, there was nothing obviously wrong with the hospital building. It was a brand-new building. The ward looked immaculate, the room looked immaculate, and the facilities looked immaculate. It looked the part. I think the infection control was quite basic, what I noticed. No one was wearing masks or

anything like that. Cleaners, even nurses were coming in. You'd think, when treating someone with their immune system being so low, infection prevention and control policies would have been better than that, to be honest. We certainly scrubbed up when we came in, the family did.

This is what I observed when I was in the hospital: it wasn't as good as other hospitals we've been in. When my granddaughter was in York Hill, all the staff would gown up. But we didn't see that much in the new hospital. Knowing what we know now, they shouldn't have opened the hospital when they did. The things that are on my mind were whether the tests carried out on the water systems, gas systems, electrical systems were done right.

It then leads you to think about why the Edinburgh Hospital was closed for another year. Why bricks fell down at that primary school. And why Grenfell happened. All that stuff seems to be going the wrong way. To look at it, it’s a super hospital, but there's obviously other issues

that they're covering up. The whistle-blowers have come out, and there are various stories going around about. If it's a waterborne infection, the first question you ask is, “Where did it come from?” There must have been an investigation done. There must have been some readings taken.”

Finally, my Lord, Mr Horne makes some concluding comments at paragraphs 21 to 23:

“The hospital was a super hospital, is a super hospital, and at the time my granddaughter was in, we didn't think anything else other than that. When my granddaughter became seriously ill, it goes through your mind, “Could it have been this? Could it have been that? Why were they doing this? Why were they doing that?” You don't think for a minute that it's been a coverup. That's how you're feeling.

The whistle-blowers have opened a can of worms. We don't know where it's going to end, but we're looking for the truth, and for somebody to admit that it was the water that's

> caused this. Whatever happens, my granddaughter is not going to come back, but we have to get the answers we're looking for and help other people and hope they don't go through what we have.”

And finally, my Lord, you will see that Mr Horne makes a declaration of truth at paragraph 24. My Lord, that concludes the reading in of the statements from Miss Darroch and from Mr and Mrs Horne.

THE CHAIR: My understanding is we don't propose any further proceedings (break in audio) day. We would hope to sit again at 10 o'clock tomorrow. Although, I understand that the transmission may be remote. Well, thank you very much. We will convene again tomorrow.

13:00

(End of Afternoon Session)