



# SCOTTISH HOSPITALS INQUIRY

**Hearings Commencing  
20 September 2021**

Day 1  
Monday 20 September 2021  
Morning Session

---

---

## CONTENTS

	Page
<u>OPENING REMARKS</u>	
The Right Honourable Lord Brodie (“The Chair”)	1
Mr Steve Love (on behalf of the 54 Core Participants)	6
Ms Clare Connelly (on behalf of Molly and John Cuddihy)	18
Mr Peter Gray (on behalf of the Greater Glasgow and Clyde Health Board)	27
 <u>GOUGH, Mr CAMERON</u> (Affirmed)	
Examined by Mr Alistair Duncan	38

---

**10:03**

**THE CHAIR:** Good morning, everyone, and welcome to the first day of the Scottish Hospitals Inquiry's first session of substantive evidential hearings. I'm very pleased that we've been able to begin these hearings in person with witnesses, who include many of the core participants and their legal representatives, present here today in the Inquiry's premises in Edinburgh. However, at the same time, we are very conscious of the continuing risks presented by COVID-19 and the health of all of you, and indeed all of those who will be coming to the Inquiry's premises is our first priority. I therefore ask everyone to observe the Inquiry's social distancing procedures and other health and safety recommendations, and we would ask you to follow these carefully for the benefit of all those involved. I'm aware that our audience includes not only those present in the Inquiry's hearing room, but many people, members of the public and press, who will be watching our proceedings remotely on livestream. It has been our object to ensure that, even in the current climate, the Inquiry's proceedings remain as accessible to as many people as possible.

Now, among those present this

morning are some members of the Inquiry team, and perhaps I can take the opportunity to introduce them. On my right in the middle is the lead Counsel to the Inquiry, Alastair Duncan QC, who will be responsible for questioning witnesses. He will be assisted in that by Victoria Arnott Advocate, who is also Counsel to the Inquiry. Samantha Rore is the Deputy Solicitor to the Inquiry and Instructing Counsel. On my left there is Umera Rashid, who is Assistant Solicitor in the Inquiry. Also present are, and will be, members of the Inquiry's Witness Engagement and Support team. I don't see anyone present at the moment, but we do have a member of the Document Management team, who will be providing support and assistance as required.

The plan over the next few weeks is to hear oral evidence from some 33 witnesses, concluding on, or possibly before, the 5th of November. We will not be sitting in the weeks between the 11th and the 22nd of October. The purpose of this initial set of hearings is to hear from patients and family members of patients who may have been affected by issues at the Queen Elizabeth University Hospital campus in Glasgow and the Royal Hospital for Children and Young People and the

Department of Clinical Neurosciences in Edinburgh. Witness statements and documentary bundles have already been circulated among core participants, and these will be published when appropriate on the Inquiry's website. We will also publish, within a few days of the relevant hearing, transcripts of the evidence that has been led. Any directions or orders, including restriction orders that I have made or may make, will also be available on the Inquiry website.

Now, hearings such as we are about to conduct require a great deal of preparation. In relation to that, can I, at this stage, acknowledge the help and cooperation that the Inquiry has had in the course of working with core participants, their legal representatives and with witnesses? I'm very grateful for that. I am acutely aware that many of the witnesses who we'll be hearing from and who will be sharing their experiences will be doing so having suffered from the really unimaginable distresses which are associated either with their own medical conditions or with the very serious ill health of a child, and in some cases, the death of a child. This is not something which I or the Inquiry team have taken lightly. We hope that, in the course of engaging with witnesses, we have

offered appropriate support and assistance and we are continuing, we hope, to do that. The offer of support and assistance continues through these hearings.

Before we hear from our first witness, which will be later in the morning, I will invite opening statements from three counsel on behalf of core participants. I will be inviting Mr Steve Love QC to make an opening statement on behalf of a group of patients and family members, I'll be inviting Ms Clare Connelly Advocate to make an opening statement on behalf of Professor Cuddihy and his daughter Molly Cuddihy, and I will be inviting Peter Gray QC to make an opening statement on behalf of Greater Glasgow Health Board.

Before going to these opening statements, can I remind everyone that the function of this statutory public inquiry is an inquisitorial one, and in carrying out that function, the Inquiry must, of course, always act with fairness? Our aim is to be as impartial and objective as possible. Accordingly, no inferences to a different effect should be drawn from anything that is said or done by a member of the Inquiry team or, indeed, myself, or appears to have been said

or done. The purpose of these hearings is to listen to the accounts of the witnesses who I have mentioned. These accounts will form part of the whole evidence which will be held by the Inquiry, and it is the whole evidence which I will have to consider before making final findings and recommendations.

Can I also say that no inference should be drawn from the length of time which is allocated to any particular witness? There's no judgment or prejudgment involved as to the quality and value of the evidence simply because the evidence may be, on the one hand, shorter or, on the other hand, longer. Witnesses will speak for various lengths of time for a variety of reasons. We are very grateful for every witness who has agreed to assist the Inquiry, and we will listen to each of these witnesses with the same care and attention.

Finally, can I remind you, as will no doubt be evident from the screen, that these proceedings are being livestreamed and recorded for the purposes of sharing with the wider public on the Inquiry's YouTube channel? Now, that means that it is possible that those in the room may be caught on shot, and you should be conscious of that. We have, today, a

camera operator as a result of a request to provide some background footage for the purpose of providing context to reporting. I don't anticipate that this filming will continue for very long into this morning's proceedings and will not be continuing when we get to the stage of hearing from witnesses or hearing from, probably, just our single witness today.

So, with that, by way of preliminary, can I invite Steve Love QC to come forward and to make the first of the opening statements? Mr Love.

**MR LOVE:** Thank you for that introduction, my Lord. I appear, along with my learned friend, Mr Thornley, on behalf of the 54 core participants represented before this Inquiry by Messrs. Thompsons Solicitors. Those whom we represent are either parents or family members of patients who were or are still being treated in the children cancer ward and at the neonatal unit at the Queen Elizabeth University Hospital in Glasgow. They formed the campaign group "Families for Healthy Hospitals", which influenced and framed the Terms of Reference for this Inquiry. On behalf of those who we represent, we thank your Lordship for affording us the opportunity to make this opening statement.

Your Lordship already has before him, I think, a document headed, "Opening Statement for the affected Core Participants: the parents and representatives of the children affected by their treatment at QEUH". That's a PDF document that runs to some 13 pages. What I intend to do today, however, is to provide your Lordship with a summary of what we see as the most significant points in that full opening statement. But for those that may be interested, the full text of the statement can, I understand, be found on the Inquiry's website.

As will become clear from the evidence that your Lordship is about to hear, the children of those we represent were admitted to hospital for treatment for serious illnesses, such as leukaemia and other cancers, as well as other serious medical issues, and they reasonably expected that the best possible medical care and treatment would be provided for their children in a suitably safe and clean hospital environment. Your Lordship will be told that what they in fact faced were serious infections, life-threatening additional illnesses and a catalogue of other problems as a result of the hospital environment, the hospital water supply and the conduct of some of the medical staff there. The Queen

Elizabeth University Hospital was proclaimed as a state-of-the-art or super hospital, with enough beds to hold in excess of 1600 patients. It opened for patients in April of 2015. The evidence from the parents and representatives which you will hear relates to their experiences and the circumstances surrounding the treatment of their loved ones at the Queen Elizabeth. A significant number of children suffered infections during the course of their treatment there and, tragically, some of those children died as a result.

In recent times, we've had the opportunity of reading detailed and lengthy statements taken by the Inquiry team from those we represent, and in many instances, they paint a harrowing picture. It seems, from what is said in those statements, that parents were frequently kept in the dark about the problems with the water supply and the ventilation at the hospital. They were not informed about the cause of the infections suffered by their children, although it appears that the hospital knew that many of the infections were, or may have been, closely connected to the water supply and ventilation systems. There is evidence about a lack of candour and a failure to obtain

informed consent about the administration of drugs, including the use of prophylactic antibiotics and their impact. There were significant numbers who suffered infection from 2017 onwards and of which the hospital must have been or, it seems, was aware. The parents of the children affected want answers for what happened, what went wrong and why. Many of them have lost all faith in the hospital as a safe place for their children to be treated.

Now, this Inquiry will, we hope, go towards establishing the truth of what happened and why, bringing any past and ongoing wrongs to light, learning lessons about the protection of patients and of families of patients who rely on the NHS for safe and appropriate treatment, exploring the duty of candour owed to patients and their families and its importance, and calling those responsible for any failings to account and providing them with the opportunity to acknowledge and accept the responsibility for any wrongs that were done by them or on their watch, and apologise for the failings and consequences of those failings.

The core participants appreciate the extent of which your Lordship and counsel to the Inquiry have made it

clear that the stories of parents and representatives should be heard at the outset of this Inquiry, and they welcome the opportunity to be able to speak about what, for many of them, has been a hugely traumatic period in their lives and for their children. They have been invited to identify and describe any particular problems that they encountered and to talk about the emotional impact on them and their children. There are accounts of parents being left with long-standing emotional illnesses as a result of their experiences.

They required to seek medical care of their ill, vulnerable children when they needed it most. They put all of their trust and faith in the NHS. They trusted the doctors and nurses to whom they turned, they trusted their expertise, they trusted their honesty. They trusted that their loved ones would receive the best care available in a safe environment. They were let down. Having a child treated in hospital is a stressful experience for any parent or family member at the best of times, and it should not be the case that it is made to be more stressful, more traumatic and more upsetting by the conduct and circumstances at the hospital itself. Parents could not believe that the

hospital environment was, as far as they were concerned, making their already sick children more ill. They were horrified by the conditions and feel betrayed by not being told what the problems were at the hospital and how those problems were affecting their children. For many of them whose child had, for example, leukaemia, the infections were worse than the cancer itself.

This Inquiry has been set up and its Terms of Reference have been fixed. It is recognised that there will be further substantive hearings in due course dealing with the Terms of Reference, and we, if advised, seek to make opening statements at the commencement of those hearings. The relevant facts must be established. We know that the Inquiry will ensure that the relevant facts are fully and fairly investigated, without fear or favour. Those relevant facts will be exposed to public scrutiny. Those whom we represent are aware that both individuals and organisations are responsible for what has happened to them. They wish to see the truth and to see justice done for themselves and for their loved ones. They wish those individuals and organisations to be held accountable for what they and their children experienced and had to

endure. The fundamental purpose of this opening stage of the Inquiry is for the experiences of and consequences for those who we represent to be heard and heeded. They need and deserve to be listened to, my Lord.

The individuals who we represent come from all walks of life, all social classes, all backgrounds and all age groups. Although their stories are different, they are united by some common themes or threads that I will turn to in due course. They have, as stated, been left with their faith in the NHS shattered as a result of poor communication, evasiveness, and a lack of openness, candour and honesty. They want answers. Why did they experience what they did? What could have been done to prevent those experiences? What can be done to ensure that nothing like it ever happens again? Patients and their families ought to have been protected, involved and given informed choices. They ought to have been told the truth. Your Lordship will hear that they were not. The impact of what they experienced has to be understood and appreciated. This Inquiry will provide an opportunity for individuals' stories to be told. Those we represent finally need that to happen for them to be able to move on.



We suggest that the Inquiry ought to pay attention to the following issues. Firstly, issues relating to the hospital itself. There were problems experienced with the supply of water, drainage, ventilation, levels of cleanliness and systems relevant to the issue of infection control.

Secondly, issues in relation to communication merit consideration. The level of communication from some of the doctors and nurses about what was happening with their individual child and how the issues with the hospital were adversely affecting them was felt by parents to be very poor. The lack of transparency and openness about the problems with the water supply and ventilation in the hospital, and the reasons for ward closures completely undermined the trust and confidence that the parents should have been able to have in the hospital, the medical staff and the treatment being administered. It seems children were being given antibiotics as a preventative measure without any explanation being given to the parents as to why this was happening. Parents felt they were talked to in a condescending manner if they asked questions or queried what was happening. When medical staff were questioned about this, there are

examples of parents being told that it was for their child's cancer treatment or for an underlying problem, which is shown to be false.

Thirdly, the nature, quality and suitability of the facilities available at the hospital for both child patients and parents alike should be explored.

Fourth, consideration ought to be given to the importance of the duty of candour. It seems, from the statements, that underlying much of the treatment of children and parents at the hospital is a failure to properly advise the parents about the treatment of their child and the reasons for that treatment. This goes to the heart of the relationship between doctor and patient and healthcare professional and patient. The Inquiry ought to give consideration to the issues of patient autonomy and the risks posed by a "doctor knows best" paternalism. Many of those whom we represent report they were made to feel stupid or overanxious.

The issue of complaints and how they were handled arises in many of the statements taken from those we represent. Those statements indicate that complaints made by parents have, on many occasions, been ignored, gone without response or been overlooked by the hospital. Parents do

not feel that their complaints were being listened to or treated seriously. That is a fundamental part of the process, and the failure of the hospital to properly address the complaints of parents is something that needs to be addressed and answered by this Inquiry. The statements of parents cover a number of other issues that includes the following: refusal or delay to provide medical records; staffing levels for both nursing and cleaning staff appearing to be inadequate for patient-appropriate nursing care and levels of cleanliness; lack of appropriately qualified and trained staff; provision of medication, which includes examples of over or under-dosing of patients as a result of staff being too busy with room moves, and which led to painful consequences for the child patient.

As already stated, it is appreciated that further substantive hearings will be held in due course, focusing on the Terms of Reference and issues such as the construction of the hospital and its associated amenities. This Inquiry will focus on past events with an eye to the future. It should be recognised that decision making must be understood from a patient's perspective. Those who we represent have fears for the future.

What happens after this Inquiry if their child relapses and has to go back to the Queen Elizabeth? Will they be treated worse? Will their child receive substandard care? How can this fear be allayed?

There must be transparency as to whether senior members of the NHS Board were feeding ambiguous or even false information to junior staff to disseminate to patients and parents with a view to alleviating concerns that were growing. Was there a deliberate cover-up? There must be an investigation into the response of the NHS Board and Scottish government as to the concerns that were raised about the operation of the hospital. Public confidence requires to be rebuilt or restored, and that can only be achieved if matters are fully, properly and openly investigated. There requires to be a specific apology in due course for what went wrong and the consequences. Healthcare professionals need to be reassured. They should be encouraged to feel able to voice concerns without fear of repercussion.

The 54 individuals who have asked us to represent them have engaged with this Inquiry process with confidence that it can, and the hope that it will, deliver on its Terms of

Reference and meet their objectives. If the Inquiry is not about them and people like them from all over Scotland, who is it about and who is it intended to benefit? Parents who have provided statements to the Inquiry have found the whole process to be extremely reassuring. It's been a clear demonstration of the Inquiry's commitment to exploring and discovering the truth. They have found that the statement-takers and Witness Engagement team have been supportive and kind, have given the families the time and space they need to discuss the most traumatic events in their lives, and have ensured that statements have been all-encompassing. For that, we are very grateful, my Lord, to the Inquiry team and the empathy and understanding shown by them in the course of their investigation. We are committed to and look forward to working with the Inquiry team further in this and subsequent substantive hearings, knowing that those we represent will, perhaps for the first time, see full investigation, transparency, respect, trust and honesty.

Thank you again, my Lord, for the opportunity to make this opening statement.

**THE CHAIR:** Thank you very

much, Mr Love. Thank you

**10:27**

**MS CONNELLY:** My Lord, I appear on behalf of Molly and John Cuddihy, and I wish to thank your Lordship for the opportunity to make this opening statement. It's fitting, my Lord, that the Inquiry opens with the evidence of patients and family members of those directly affected by the events at the Queen Elizabeth University Hospital and the Royal Hospital for Children. The Inquiry team have provided and created confidence in the Cuddihy family that this will be a thorough inquiry, and the compassion and understanding that has been shown by the Inquiry team in the course of taking statements from both Molly and John Cuddihy has been both impressive and has provided them with comfort, my Lord.

For any family, a cancer diagnosis is terrifying not just because of what the illness itself can do, but because of the brutal impact of treatment. The resultant immune-compromised state from chemotherapy treatment introduces an additional daily challenge that must be managed by any patient and their family. In the Cuddihy family, infection control became a collective responsibility in an attempt to protect

Molly from exposure to infection when she was so vulnerable. Molly and her family were not aware, however, that the hospital that she was attending for life-saving treatment was to be the source of her contracting mycobacterium chelonae and further adding to her health difficulties.

The Queen Elizabeth University Hospital and the Royal Hospital for Children were supposed to be state of the art. They were a hospital to treat a record number of patients, including child cancer patients. As evidenced in the statements of patients and families, a significant number of children suffered infections during the course of their treatment at the hospital, and several of those children died as a result. For those receiving treatment at the hospital, including Molly Cuddihy, it soon became apparent that there were problems with the water and other aspects of the hospital. Although patients were told initially that they couldn't drink the water, it continued to be used for showers. Further problems with ventilation, cleanliness and drainage became apparent, but these physical problems were not the only ones faced by patients. There was also a lack of candour, poor communication and an absence of effective corporate

governance. This was paralleled by media reporting of ongoing difficulties at the hospital estate. Against the background of poor communication by management and a lack of candour, this was a further source of stress and worry for families.

Molly Cuddihy was diagnosed on the 24th of January 2018 with metastatic Ewing's sarcoma of the rib. She was 15 years old. At the time of diagnosis, Molly's tumour had spread to her lungs and to one of her vertebrae. Shortly after diagnosis, she commenced a course of highly immunosuppressive chemotherapy, which was delivered to her as an inpatient in Ward 2A of the Royal Hospital for Children. Wards 2A and 2B are known as the "Schiehallion unit". Molly attended as an inpatient at the hospital throughout February, March, April and May 2018 to receive chemotherapy. When she attended in April 2018 she had a raised temperature, she experienced septic shock and required fluid resuscitation a number of times, and she rigoured.

In early May 2018, Molly was again admitted to Ward 2A. She had an infection once again and received a course of antibiotics. On the 30th of May 2018, Molly became very unwell and on the 31st of May was admitted

as an emergency patient to Ward 2A with febrile neutropenia, requiring multiple fluid bolus and IV antibiotics. Molly, again, started to rigour. A saline bolus was administered via her central line, with a second and third saline bolus subsequently administered. A new intravenous cannula was inserted into Molly's left hand, and blood cultures that had been obtained from Molly's CVL on or about the 16th of May were identified as containing mycobacterium chelonae. Molly underwent a cocktail of antibiotics, one of which caused her to develop an abnormal heart rhythm. Following cessation of intravenous antibiotics in June, Molly was advised that she required a further five months of oral antibiotics.

During the autumn of 2018, Molly was no longer admitted to Ward 2A as both Wards 2A and 2B had been closed as a result of the incidence of hospital-acquired infection amongst patients. Molly was scheduled to undergo surgery in October 2018 to remove her originally infected rib and to provide two final sessions of chemotherapy. However, on the morning of her surgery, it was found that she was, once again, very ill and mycobacterium chelonae was, again, isolated from cultures. Again,

Molly was started on a cocktail of antibiotics and given prophylactic antibiotics due to ongoing issues with the water in the hospital. Molly had to undergo a number of surgical procedures to replace central lines. Molly was extremely ill and remained as an inpatient on Ward 6A, receiving antibiotics until her discharge on the 21st of December 2018. Molly's surgery to remove her rib finally took place in January 2019. The delay in Molly's surgery and the disruption to her cancer treatment caused great distress to Molly and her parents, Maria and John Cuddihy, and her brother, [REDACTED].

Samples subsequently taken on Ward 2A on the 14th of April 2019 identified the presence of mycobacterium chelonae at four sites, two of which were rooms that Molly had occupied. Subsequent testing at the hospital also found mycobacterium chelonae, but the records of this do not specify where it was found.

Separate from the physical trauma of surgical procedures and the effects of delayed cancer treatment, Molly also suffered psychological, emotional and social trauma. Each individually has been significant, but collectively has had a major impact on her continued psychological and

emotional wellbeing, necessitating a requirement for sustained psychological support. For Molly, whilst the diagnosis of cancer was traumatic, contracting mycobacterium chelonae further reduced her already compromised quality of life and also directly affected her options of treatment when she relapsed. Molly wishes to know what consideration was given by those within the hospital to the impact on patients of the problems with the water supply and drainage, poor infection control, ward closure and the resulting prophylactic use of antibiotics, together with the provision of antibiotic cocktails to very sick and vulnerable patients. What assessments were considered and what measures were identified and implemented to minimise the effect on patients like Molly? What measures were implemented to assess the impact on patients from the closure of Ward 2A, an environment specifically designed to be suitable for young cancer patients who may require prolonged hospitalisation, together with disruption in education and other aspects of their lives? What measures were implemented to assess the impact of the temporary closure of Ward 6A, and what measures were implemented or was it even

considered the impact of the relentless reporting that the hospital was unsafe?

This experience has left Molly emotionally scarred, frightened and afraid to go to the very facility designed to help her in time of greatest need. Molly has told me, "I know I will need the hospital, but I am not at all comfortable with the environment or the management." Whilst there may be an impression to those watching and now following the Inquiry that this Inquiry is examining issues that arose historically, the view of the Cuddihys is that that is not accurate. For Molly and John Cuddihy, the failures in corporate governance that contribute to a crisis in patient safety are not just issues of the past to be reflected upon. They are of the view that corporate governance failures continue to this day.

This, for them, is particularly highlighted by the fact that a particular report that the Inquiry will, in due course, be asked to look at is by DMA Canyon. It was a report produced in 2015 on Legionella Risk Assessment. This report was not made available to those who required it to ensure effective infection control and proper water sampling. This report is referred to as the "lost report". Within this "lost report", it states:

“At the time of the assessment, there is no formal management structure, written scheme or communication protocols and there were significant communication issues between parties involved.”

There are also emails from 2015 requesting water sample results for microbiologists involved in infection control and, most recently, a 2021 report, which considered a Paediatric Trigger Tool review of patients at the Royal Hospital for Children in NHS Greater Glasgow and Clyde. That report advises on expert findings on adverse events. The recommendations of this report are still not published, despite instruction to do so by the then Chief Nursing Officer and the Cabinet Secretary.

For the Cuddihys, this evidences ongoing problems with effective governance and knowledge sharing with patients. The 2015 DMA Canyon report should have been a critical report considered prior to the hospital opening. The 2021 report on the Paediatric Assessment Tool, which

has still not been published, is yet another example of there being knowledge collated and analysed by experts. It has not been placed in the public domain for either patients’ knowledge, and there isn’t evidence it’s in the domain of clinical or other staff who are required to run the hospital. For Molly and John Cuddihy, there’s an ongoing fear and lack of confidence, as there is still no evidence of effective corporate governance that puts the welfare and treatment of patients at the centre of management and delivery of care.

Thank you for the opportunity, my Lord.

**THE CHAIR:** Thank you very much, Ms Connelly. Thank you. Mr Gray.

**MR GRAY:** My Lord, I, together with my learned friends, Ms Toner and Mr Broome, appear on behalf of Greater Glasgow and Clyde Health Board. As my Lord is aware, an opening statement has been lodged on behalf of Greater Glasgow and Clyde Health Board, and in those circumstances, I do not seek to make a supplementary oral submission this morning. What I would seek to do, with my Lord’s leave, is simply to read out the opening statement which has been lodged, in order that all those

following these proceedings who may not have seen that statement have a clear understanding of Greater Glasgow and Clyde Health Board's position at this stage.

My Lord, turning to the statement which has been lodged:

“On 03 July 2015, the Queen Elizabeth University Hospital and the Royal Hospital for Children in Glasgow were officially opened by Her Majesty the Queen, a historic date which represented the realisation of the cornerstone of Greater Glasgow and Clyde Health Board's, ('NHS GGC'), Acute Services Strategy, one which had initially been formulated in 2002. That strategy had at its heart the delivery of the highest standards of healthcare provision to the community it served, within 'state of the art' hospital accommodation designed to ensure the safety and well being of

all patients whilst receiving medical treatment.

In these circumstances, it has been a matter of the utmost concern to the Greater Glasgow and Clyde Health Board that, since both hospitals opened to the admission of patients in 2015, certain issues have come to light, which may have adversely impacted on the specific needs of some patients, including the young and very vulnerable.

NHS GGC have the greatest sympathy for the suffering and anguish that has so obviously been experienced by patients and families alike and, against this background, welcomed the announcement made by the then Health Secretary in September 2019 that there would be a Public Inquiry into the issues, which have arisen. NHS GGC is



determined to ensure that the issues which have required to be addressed in both hospitals do not arise in other future NHS infrastructure projects, and it will provide all the assistance that it can to the Inquiry to enable it to fulfil its vitally important remit.

The safety and welfare of its patients always has been, and remains of paramount concern to the NHS GGC, and it is committed to seeking to improve the service which it provides to patients and their families wherever possible. If this Inquiry should find, in due course, that there may be any lessons to be learned on the part of NHS GG& C in relation to any of the Inquiry's Terms of Reference, both the Inquiry and the public should be in no doubt that comprehensive steps will

be taken by NHS GGC to address those matters robustly and promptly.

It is recognised, of course, that the purpose of this evidential hearing to commence on 20 September 2021 is a limited but, nevertheless, vital one -- ”

As my Lord has already indicated.

“ -- to enable patients and their families to share with the Inquiry their respective experiences, and perceptions of how the issues being investigated by the Inquiry impacted upon each of them. NHS GGC will listen carefully and sympathetically to the evidence to be led and will, in its submission at the conclusion of the Inquiry, provide comment, where appropriate, in order to endeavour to assist the Inquiry in its consideration of that evidence.

At this juncture,

however, on behalf of NHS GGC, I would merely wish to conclude this brief statement by providing reassurance to all patients and families who have experienced distress, anguish and suffering that, wherever possible, NHS GGC will continue to provide support to all those whose lives have been impacted by the issues to be explored in this Inquiry, and that, as previously indicated, NHS GGC will assist the Inquiry to the fullest extent it can.”

My Lord, beyond that, I have no further submission to make at this stage.

**THE CHAIR:** Thank you very much, Mr Gray.

Now, before turning to Counsel for the Inquiry, perhaps I should just record that, in addition to the written opening statements from the core participants who have addressed the Inquiry this morning, the Inquiry has received a written opening statement on behalf of Lothian Health Board and

a written statement on behalf of NHS National Services Scotland. Now, both these core participants are represented this morning by Mr Barne for the Health Board and Mr Ross for National NHS National Services Scotland. But, as I understand the position, they have not requested to make an oral opening statement. But, first, they can be assured that I have read and will read again these opening statements and they will be available on the Inquiry website.

So I now turn to Mr Duncan, Counsel to the Inquiry.

**MR DUNCAN:** Thank you, my lord. I make no opening statement as such. I will let the evidence speak for itself and, at this point, I say only this: as your Lordship has indicated, we begin today what will, in effect, be about five weeks of evidence, in which we will hear from the patients and families who have had experience of the Glasgow and Edinburgh hospitals and, in particular, experience of the issues that the Inquiry is required to investigate. The focus of their evidence will be the impacts of those issues. The context which is necessary to understand the perceptions of those issues is, in most cases, the treatment of children with life-threatening illness, and so we will

hear quite a bit of evidence about that too. As is already obvious from this morning, this evidence will be upsetting for us to listen to and, certainly, for the witnesses to give.

During the first three-week diet, my Lord, we will hear from witnesses whose experience is of the Glasgow hospitals only, and we will begin with our first witness, a Mr Cameron Gough, who will be present with us later this morning.

Thank you, my lord.

**THE CHAIR:** Thank you, Mr Duncan. Now, what I propose is a fairly short adjournment. The length of the adjournment may, in fact, be determined by Mr Gough's travelling plans. If I remember correctly, he may have been asked to be here at 11.30, but because of the well-presented opening statements, as it were, we may be a little bit ahead of our timetable. So what I propose is an adjournment of a minimum of 20 minutes. It may be a little longer if Mr Gough is yet to attend, I don't know. Have I got Mr Gough's timetable correct?

**MR DUNCAN:** My Lord, the aspiration was that we would start at 11.30 and that Mr Gough would be with us from shortly after 11, I think, but we can update core participants

and representatives.

**THE CHAIR:** Or maybe the default position becomes 11.30, but if we're able to resume earlier than that, core participants, legal representatives will be advised. But, for the moment, we'll adjourn.

**10:57**

(Short break)

**11:14**

**THE CHAIR:** Before I ask Mr Gough to join us, can I just say something about reporting, and, in particular, the need to respect the anonymity of children who are involved?

As counsel to the inquiry has explained, and as have other counsel have acknowledged, we are going to be hearing, during the course of these hearings, the evidence of patients and family members of patients, and that evidence is going to be concerned with the medical treatment provided to children.

The starting point, of course, is that this is a Public Inquiry to which the public, the press and other media should have as full access as is reasonable and practical. That is the reason why we are livestreaming our proceedings, and why, as I have already said, witness statements and documents will be posted on the

Inquiry's website. So, should those listening to the evidence, either here in the room or, indeed, on livestream, wish to communicate about the proceedings on social media, they are free to do so, subject just to this; there is a two-minute delay between what is actually said in this hearing room and its going out on livestream, so if anyone is communicating on social media from inside this room, could I ask you to respect an equivalent two-minute delay between anything said by a witness and the repetition of that on a social media feed.

At risk of repetition, some of the evidence that we will hear, I anticipate, will be distressing, and the Inquiry doesn't wish to unnecessarily exacerbate that distress, and we felt it appropriate to recognise the importance of the privacy of certain sorts of information.

Broadly speaking, we've taken two measures. Now, the first is that I have granted specific restriction orders under section 19 of the Inquiries Act 2005 in response to applications that were made by particular individuals. The information subject to a specific restriction order will be redacted from documentary evidence, and the related oral evidence, which is subject to restriction order, will be heard in a

closed hearing, so these will not be hearings which will be open to the public or the press. Copies of these orders are, I think I have already said, posted on the website and I would urge you to have regard to them because, as you are aware, there are legal sanctions available should anyone breach an order.

The second measure that we've taken is to publish a statement of intent on redaction. That, again, is available on the website, and it sets out certain categories of information, personal information, that the Inquiry may redact from evidentiary documents, witness statements and transcripts, and one of the key elements in that are the names of children under the age of 16, and when I use the term, "Redaction", I simply mean taking a black pen through the information which should be kept anonymous.

I would ask for your co-operation in ensuring that these redactions and the anonymity that they're intended to achieve be respected. There is a balance which we've attempted to achieve in carrying out redactions between the wish to protect privacy which I have referred to, but also, of course, the need to be as transparent as possible, but in the course of giving

oral evidence I think it is inevitable that witnesses will disclose some redacted information. I mean, particularly the name of a child, surely it is unreasonable to expect the parent of a child to not refer to that child's name, but that is an example of personal information that we would wish be kept anonymous.

So, can I ask you that instances such as that, in other words, names or other information that could identify children or the other content of redactions not be published. When I say that, I mean not disclosed on social media or otherwise published, and this is directed at the members of the public, to the press, legal representatives, and, indeed, anyone watching on the livestream. As I say, I would be grateful for your co-operation in trying to achieve that.

I think we are now at a stage where it is appropriate to invite Mr Gough to join us. Yes, by all means, Mr Gough.

(After a pause) Good morning, Mr Gough. The first thing is to settle down, be comfortable, which I think you have probably achieved. You have met, I think, counsel to the inquiry, Mr Duncan, and as you appreciate, it is Mr Duncan who will be asking you questions.

Can I just say we plan to sit until about 1 o'clock, take a lunch break of about an hour and sit again at 2 o'clock, but if, for any reason whatsoever, you want to take a break, please just give me an indication, catch my eye, and we will take a break. You don't need to explain why, but just feel free to do that.

Now, before I ask Mr Duncan to ask you questions, I think I would ask you whether you are prepared to affirm.

**A** Yes.

**GOUGH, Mr CAMERON**  
**(Affirmed)**

**THE CHAIR:** Thank you very much, Mr Gough.

**A** Thank you.

**THE CHAIR:** Yes. Your microphone is picking you up.

**A** Is that any better?

**THE CHAIR:** If there is any problem with that, I will leave it to those better able to give you useful instructions than myself.

**Examined by MR DUNCAN**

**THE CHAIR:** Mr Duncan?

**A** Thank you.

**MR DUNCAN:** Good morning, Mr Gough.

**A** Good morning.

**Q** Mr Gough, can I just begin by having you confirm that you are Cameron Gough and that you live with your wife and three children in Renfrewshire? Is that correct? And you're here today to give evidence in particular about your son who is currently ten years old?

**A** Ten years old.

**Q** Now, I will ask you more questions about this presently, but just to get a sort of overview, as it were, your son, I think, was diagnosed with cancer in July 2018.

**A** Yes.

**Q** And he received treatment at the Royal Hospital for Children and also the Queen Elizabeth University Hospital between 2018 and 2019. Is that right?

**A** Yes.

**Q** And you have provided a detailed statement about that experience, and am I right in understanding that you're content that that statement forms part of your evidence to the inquiry?

**A** Absolutely.

**Q** But you've also agreed to come along today to answer some

more questions about aspects of that. Is that correct?

**A** Certainly.

**Q** Now, if at any point -- I think you have your statement next to you, is that right? If at any point you want to look at it, just indicate and we can do that, but I was going to take you through your evidence without doing so apart from one or two parts, and, again, can I just reiterate what the Chair has said, that (inaudible) as the eldest. Is that right?

**A** Yes. Yes. ■.

**Q** Can we begin by having you describe him to us? What sort of person he is?

**A** Cracking. He's a wee boy. He's, aye, great fun. We couldn't wish for a better son, to be honest. He's quite cerebral, so he loves building things, great fan of Lego and building and drawing and, you know, he's just a nice, well-balanced son. Obviously, I don't say that to his face, but ... but no, he's really good fun and he is -- we've been amazed throughout this process how well he's coped with it; being quite rational and being able to reason things, having an engineering outlook on life, we were very lucky that we could discuss with him and go through these things and rationalise quite complex and

unpleasant situations that he had to go through, and I have so much respect.

I couldn't have done what he has done, full stop. There's not many people I know that could have done what he's done, so I have so much respect and have so much -- do you know, he's incredible, and we thank the National Health Service for giving us our son. That's really what my thoughts are. He's a great wee boy.

**Q** Just to, then, sort of move towards the events that this evidence will be concerned with, I think your son became unwell on holiday in July 2018. Was he seven years old at that point? And in short (inaudible) hospital, and I think he was booked in for an MRI (inaudible) of that?

**A** The MRI scan, I lose track, there were so many scans, and this is why the timeline is a fantastic thing. The first scan was at Paisley Hospital that we got, showed a huge tumour had taken over one of his kidneys, basically, so there was this thing that was the size of my fist strangling around his kidney which, aye, that was a bit of a shocker, not what you expect, but it had caused the symptoms of -- that had run up to that, so that was immediately after that happened, it all kicked off, and that

was us in the system, and moving forward, but that was-- --

**Q** Yes. In your statement you describe it as, "Everything flipped".

**A** Yes.

**Q** What do you mean by that?

**A** The first symptoms that presented were ■ having blood in his urine, and, you know, never Google anything about your health, but when you Google you look down the list and as you get further down you see things that could be this, could be that.

Cancer is right at the bottom of the worst-case scenario. Cancer is there, you know. Kidney infections, then you have got stuff like kidney failure, and right at the bottom you have got cancer and you don't expect that, and it's the thing that we all worry about, it's the thing that you don't think about, it's the reason why all the cancer charities use the images of the kids with the bald heads and the feeding tubes, because it's the worst case scenario that people don't want to happen, and that's why life flips, because you suddenly realise, "My goodness ..." and, I apologise, I'll try not to say the exact words that went through my head, but, my goodness, there's no way to vocalise. Life -- it's not what you expect, and the

ramifications of realising that there's every possibility you're going to lose your child to this. It's tough, and you then go into that environment where everyone is running around doing their best and doing fantastic jobs trying to stop the worst thing happening, but yeah, it's a shocker. You don't expect it. I pray no one has to go through it. It's not good.

**Q** Thank you. Shortly after that, your son was admitted to the Royal Hospital for Children to begin treatment, and I think from now on we will just call that, "The Children's Hospital"?

**A** Fair enough.

**Q** And what I want to do with you, Mr Gough, is just to try and take your evidence chronologically. I will begin by looking at August 2018 and we'll try and get a kind of overview of things, and then what I might ask you to do as we go through that is just to look at one or two bits of it.

**A** Certainly.

**Q** Let's start at the beginning, as it were. What was the treatment plan?

**A** The British Treatment Plan, or the European Treatment Plan for Wilms tumours, which is what ■ had, is you go in hard with chemotherapy. It uses two different

types of drugs. So, you have daptomycin and vincristine, used one week as vincristine and daptomycin and then the next week it's just vinc, and he gets hammered for four or five weeks of this. As soon as that's done the thought behind this is it shrinks the tumour to an extent that it can then be removed as safely as possible. Once it's removed, it's then sent to the labs. You have different types of tumours. There's a good Wilms tumour and a bad Wilms tumour. You wouldn't have thought that there's good and bad types of cancers but there is one that's more difficult to deal with, so they need to test what type of Wilms tumour it is, so after four weeks they remove the tumour and then they continue, depending on the results of that, depending on your ages, they will then produce a different set of protocols to move forward through the treatment. ■ was quite unusual because Wilms generally affects much younger children, so I think the figures are around 70 children in Britain. With Wilms, most of them are young, and all the protocols -- and I'm sure you'll hear lots of things about protocols here -- but the way they decide protocols is a lot of statistics. What people are trying to do is minimise the impact of chemotherapy drugs, because



chemotherapy drugs are really nasty. The nature of the drugs is when they're being administered, people that administer them have to wear plastic protective clothing because it burns your skin, so that's what's getting put into your child, which is fine, because if they don't, they die, full stop. It's kind of a Hail Mary. So, the protocols are built up to try and minimise the use of these drugs which have often been developed for adults rather than children, but they're trying to use these chemicals as little as possibility, so they work on statistics.

The nature of ■ is because he was in a small pot of numbers, it was a difficult process to actually decide his process, but he ended up having continuation of vinchristine and daptomycine post tumour removal.

**Q** So the plan is: hammer it, remove it, examine it and then take it from there?

**A** Yes. Yes.

**Q** Okay. At the beginning of August, I think in order to enable the treatment to take place, your son had a Hickman Line fitted?

**A** Yes.

**Q** Now, can you tell us what that is?

**A** You tend to use different terminology, so if I call them,

"Wiggles", because they wiggle, so I ended up calling them, "Wiggles". Going back to the point earlier on, to administer meds, to take meds, it needs to be into a main line, so having this direct access makes life a lot easier, rather than trying to put cannulas and such like in, so that was the purpose of this. Because it's hanging outside, it's really easy to access, so for younger children there's not the battle, you're not constantly trying to fight to hold down children to try and get needles in, because no one likes needles, particularly children, and that's the purpose. It's like a direct line into your blood system, and in principle it's a great thing, you know. It dials straight in there.

**Q** So, something that's fitted by a surgeon?

**A** Yes.

**Q** Under general anaesthetic?

**A** Yes.

**Q** It has one or two tubes hanging out from the skin, essentially?

**A** Yes. I have forgotten what ■ had, I think he had only one, but depending on the nature of them, there was -- it wiggles down, there's a wee loop that is under the skin because, obviously, you don't want to get pulled out, particularly with

younger siblings that -- that wouldn't be fun, but yes, so it's stitched in, put under general anaesthetic, stitched in, and that allows free access.

**Q** And I think, just to pick up on the terminology, I think ■ referred to as his, "Wiggly". Is that right?

**A** Yes. Yes.

**Q** And you describe it in your statement. You said something about it having a green cap on it?

**A** Yes. The protocols within dealing with these lines -- the big concern, and I'm sure you will hear an awful lot about this -- is line infections. Because you're dealing with chemotherapy drugs -- sorry to such an egg -- but chemotherapy drugs hammer your immune system as well as a lot of other things, so normal ways of working are out the window. You need to be hypersensitive about these children because they've got a suppressed immune system, therefore there's protocols built around trying to keep this environment as clean as possible so that the caps weren't just little caps that closed off, I think they were antiviral or antibacterial. I can't remember the exact -- I never actually read the packet but one of the things that the Schiehallion nurses who were very, very good at us in sharing

information, very good in general.

Doctors and nurses were incredible, full stop, and I will say that again.

Doctors and nurses in Schiehallion were incredible, absolutely incredible. One of the things they impressed on us was always has to be a green cap, because that's the special one that keeps things clean. You know, it's not the old school type, and they're always looking to update and move the process forward to make it as safe as possible for the children.

**Q** Thank you. Now, ■ was admitted to Ward 2A and that's within the Schiehallion Unit that you've just referred to in The Children's Hospital?

**A** Yes.

**Q** And I think my understanding is that your timeline is that he was discharged on 8 August 2018 and then I think the plan was that his chemotherapy would be essentially from Ward 2B which is also part of the Schiehallion Unit?

**A** Yes.

**Q** And, effectively, that was to be as a day patient. Is that right?

**A** Yes. Yes.

**Q** But I think, in fact, soon after he started his chemotherapy he went through a pattern of spiking temperatures?

**A** Yes.

**Q** I think you say that's something that happened quite a lot?

**A** Yes.

**Q** The way you put it is that he really, "Bounced in and out", of Schiehallion over that first month, and I think was the position that, in effect -- I think we see in your statement -- every second weekend that would happen. Aside from temperature spikes, how did ■ cope with this chemotherapy over this period?

**A** We saw a deterioration in him. It transpired that -- usually, and it was a good thing -- but the chemotherapy was very effective in killing the tumour. So, by the end of it the tumour was dead, which actually made things a bit more difficult because they couldn't test it post event, but it killed it. By killing it, he had this thing the size of my fist inside a wee boy's body that's dying and letting out ... plus all the chemodrugs, so it wasn't a fun period for him, but he did incredibly well, and the staff really helped us through that period. They were incredible, and he was incredible. We were kind of just sat back in awe of all the people working together to try and reduce the effects of both the chemo and the cancer and things dying within his system.

**Q** Thank you. What I would like to do now is still just trying to keep us within August 2018, is to now look at some points of detail, and I think the obvious place to start is actually with the hospital itself.

**A** Certainly.

**Q** I think what I would like to do at this point is look at some images of the hospital and Mr Castell who is sitting at the table behind you is going to help us with that. Could I ask you, Mr Castell, if you could put up from Bundle 2 page 7? Mr Gough, these images will come up on the screen that's immediately in front of you, and I think Mr Castell will potentially control it from where he's sitting.

Thank you, Mr Castell. So, we were at the right page. If you go back to the photograph? It is, I think, page 7 of the bundle. It was the one that you pulled up immediately. That's it. The numbering on the top right-hand corner, page 7, we've got a picture of the Royal Hospital for Children in Glasgow.

So, for those who have not seen this before, just to try and orientate ourselves a bit, the cross-shaped building in the middle of the photograph is what?

**A** That's the adult hospital.

**Q** Yes, and to its left the building that's shaped like a race track, give or take, that's what?

**A** That's The Children's Hospital, so that whole area is The Children's Hospital.

**Q** And each of these, am I right in understanding, has got its own main entrance?

**A** Yes. So, the adult hospital, if you look at the top of the screen, and similarly with The Children's Hospital, it's, again, at the top of the race track and along the bottom, the sort of flat building to the right-hand side of the bottom of the race track is A&E access.

**Q** Is your understanding that the emergency entrance for both of the hospitals is towards the rear?

**A** I think so. Touch wood, I haven't used the adult one yet, and let's hope not, but certainly I used the kids' one a fair bit.

**Q** If we look at the cross-shaped building and the point that's at 7 o'clock, is that a helipad we see on the top of the-- --

**A** Yes. Yes.

**Q** Now, if you were to head towards the top of the photograph -- in other words, if you were to start

walking towards the top of the photograph and you kept going, would you eventually hit the main road?

**A** Yes. You walk up there and at the top there's the main road, there's a car park here and on the left-hand side there's a load of sewage, you can actually see it on the top left, these long dark part, there's a huge sewage treatment plant there which also carries on over here, was a tip as well, so there's a lot of industrial work. A lot of work in that area.

**Q** Yes. On the other -- so again, just heading towards the main road, on the other side of the main road there is some kind of water treatment works. Is that right?

**A** Yes.

**Q** And I think you are also directing us to what look like five channels in the top left corner of the picture.

**A** Yes.

**Q** You understand that's part of the-- --

**A** I think so. I think so.

**Q** Were these water treatment works something that you were aware of during your visits to the hospital?

**A** Depending on the location, certainly going in and out of the hospital you are very aware of

smells and odours which was problematic because one of the symptoms of chemotherapy is that to makes you unwell, it makes you vomit, so he was very aware of them. He was like a wee sniffer dog.

Some of the rooms, because we bounced around and because Schiehallion itself bounced around so much, we ended up in different positions, and depending on where the room was you could certainly smell it, and I'm an ex-smoker, so my smelling is appalling, and, you know, if I can smell it, it wasn't very pleasant.

**Q** And without putting too fine a point on it, what was the smell?

**A** Poo, to put it bluntly. It was sewage, you know. It wasn't very pleasant, but yes.

**Q** When you talked about ■ a moment ago, did it make ■ feel unwell?

**A** Yes. There were times with his nausiousness which we became better at managing -- is that a word, "Nausiousness"? Whatever, sorry if I have got that word wrong -- it did, you know, flare up. The smell didn't help him. That wasn't nice for him.

**Q** Thank you. Mr Castell, could we go on a bit, please, to page 10? Just scroll down to page 10.

That's great. Stop there. You see a number of photographs, and I think these are all pictures that date from August or the summer at least of 2015.

**A** Yes.

**Q** I mean, just having a look at those just now, do these look like how the hospital looked when you attended?

**A** Largely. I think there were slight changes to the hospital while we were there, I think, but largely. There was an awful lot of work going on on the exterior while we were there as well, so that the entrances we could access were different, so ...

**Q** Yes, and, maybe, just to be clear, when I referred to, "The hospital", these are pictures of The Children's Hospital? Is that right?

**A** Mm-hmm.

**Q** And, Mr Castell, if we just scroll down a little bit further to the pictures that are on page 11 -- those ones, thank you -- pictures 4-6 I'm thinking about, and in particular the photographs at Slide 4 there.

**A** Yes.

**Q** Are these scenes that you are familiar with?

**A** Aye. I think they had different seating and some of the interactives weren't as open, that's the main waiting area, so they had a row

of seats down the centre, and they had some interactives on the left-hand side to keep you entertained while you were waiting in that area. I think the seats have changed, some of the interactives have closed down, but it has that feel to it.

**Q** This is the reception and waiting area in The Children's Hospital. Is that right?

**A** Yes. So, you would have clinics off each side of this down the corridor there.

**Q** And when you refer to, "Interactives", what are you referring to?

**A** Toys to keep the children occupied. So, solid, fixed toys.

**Q** Was this an area that you visited on a regular basis?

**A** Tried to avoid it, to be honest. We would occasionally use it at weekends because it was a space that we could -- there was no one there because we were concerned about diseases and bugs. We couldn't use that space unless we cleaned it first. When we did use it at weekends there was no one there, and we cleaned the areas before we used it because we always had to be hyper careful about bugs because the implications were that that would be bad for ■.

**Q** Thank you.

Mr Castell, could we go on, please, to page 19? Now, we were looking a moment ago, I think, at what was the ground floor of The Children's Hospital and we are now looking on the top half of the screen at page 19, we are looking at a floor plan of the second floor, and if we concentrate, really, on the right-hand side of that, does that set out the floor plan of the Schiehallion Unit, essentially?

**A** Yes. I'm just zooming in here because my eyesight is not great. Sorry about this.

**Q** If I reassure you that we are not going to have to look in granular detail at the individual rooms on this slide, at least, it was just really to get the general layout. Have you finished buffering?

**A** Yes. Yes. We are all good. Thank you.

**Q** So, do we see delineated in yellow is that Ward 2A?

**A** Yes.

**Q** And that -- as we see there it curves round?

**A** Mm-hmm.

**Q** And as part of that delineated in green, in the top half, is that where the Teenage Cancer Trust was?

**A** Yes. So the ward itself was kind of split in two, which is a really fantastic thing, because, if I remember rightly, The Children's Hospital deals with children up to 18 years old and the issues in dealing with a two year old are considerably different from dealing with a 14 year old. Therefore, and a genius idea here, having a separate place for teenagers where teenagers -- because teenagers aren't just coping with cancer, they're coping with puberty and all the other stuff that's going on which means that having a space (Inaudible), so really the ethos in Schiehallion in general was a space where children could be children, not just cancer patients, and, really, having a specific place where children could be children and teenagers could be teenagers, as well as being cancer patients, was fantastic. That was what was so lovely about this environment, was you weren't defined by your -- ■ wasn't defined by his sickness. He was -- I want to use the word, "Normal", but that was it. You know, if you are in a room full of children with no hair and feeding tubes, there's nothing unusual. You know, it takes the big scariness away for not just him but for the parents as well, and, similarly, having the teenage area

there was fantastic. I don't know, because ■ wasn't allowed to go in there. You had to be a teenager. I can't really describe it that much more.

**Q** We are going to look at the floor plan in a bit more detail in a moment and we might pick up on some of that. Just the final area I was going to notice is the one delineated in blue.

**A** Yes.

**Q** That would be the day case unit at Ward 2B. Is that right?

**A** Yes.

**Q** Where was the entrance to Ward 2B? Are you able to see that on the -

**A** Yes. If you go down to the bottom right-hand side there's a corridor there and to the left you go along to Ward 2B and to the right you go along to Ward 2A, and also if you go up from there there's a bank of lifts and a staircase that we used to access these -- and from my understanding we were the only people who were allowed,

generally, to use these (Inaudible). I could be wrong, but there was a bank of -- I'm sure it was that one because the other one was further down.

**Q** So just picking up on the detail of that a little, in terms of the

entrances to each of 2A and 2B, you are indicating the area that is effectively between the blue line and the yellow line.

**A** Yes.

**Q** And you turn in one direction to go yellow and one direction to go blue?

**A** Yes.

**Q** And so you therefore don't need to go through 2B to get to 2A or vice versa?

**A** Absolutely. In theory, if you are going into day care, you are either going in to flag up something that is wrong or you are going to get chemotherapy. You would go in there if there was an issue, if you had a spike during the day, or you would go and get your chemo or go and get your MOT just to check that you were okay, whereas if you are in Schiehallion for something generally, you know, you were dealing with it. You had a spike or you were only moved across there if there was a reason for doing it, so keeping the two separate meant that there was no cross-contamination or any issues there, and that worked well.

**Q** And the lifts that you mentioned, those would be a little further up on that channel that we see between the blue and the yellow. Is that right?

**A** Yes.

**Q** And your recollection is that those were lifts for that unit?

**A** Yes. I can't remember whether -- certainly they weren't signposted as the lifts, the main lifts were further down the building, so you had to know that they were there. I can't remember whether they were specifically only for Schiehallion or there were other people using it, but they were very much the tradesmen's entrance, but that was the -- there were public lifts and then these were the non-public lifts.

**Q** And what was the advantage, if any, in that?

**A** Because you are immunocompromised children, it is socially distancing. We were all now experts on socially distancing and no one was then. No one understood that, actually, you sneeze near my child and my child could end up in hospital, or worse. You know, your child has chickenpox, well, my child doesn't have an immune system so that could be very bad. We are now very much aware, we've got to keep our distances and wash our hands, but that wasn't the case then. Having systems, protocols, set up where we were kept away from the snotty kids was great, to put it brutally. Those



snotty kids could make our children quite sick.

**Q** Now, I said we would look at the floor plan in a bit more detail and if Mr Castell could take us down on the page to page 20 of the slide, we can already see it, but I wonder if we can just move it up a little. Again, I don't think you will need to increase the focus on it, but do so if you need so.

You've already told us about the entrance and the exit, so I will not ask you too much about that, but I just wanted to try and identify particular areas on it. I think there was a play room.

**A** Yes. So you came in through the front door, come round and then sort of the curve of the D, which is across from Room 26, there is -- you go straight from Room 26 travelling out towards the right-hand side, there is the reception desk where -- that was the focal hub of all the doctors and nurses, mainly nurses and from there if you carry on you will see a play/dining room, but it was just a playroom, so that was an area where we could go and play with our children and other children who were undergoing treatment. The protocols within those rooms were really, really robust. Phenomenally robust. You

could only go there as a child if you were undergoing treatment, so you couldn't take in siblings or anything like that, for the protection of the children. The cleaning regimes within the room were phenomenal, so there was nothing porous. Everything was handed to you and then once it was taken from you it was either cleaned or binned, so they had an awful lot of packs that they broke open and you would do some colouring in or -- doing something. We had access to electronic equipment, but, similarly, we were issued with them by the play worker who cleaned them first, and, really, everything that went out was cleaned within an inch of its life, and everything that came back either was able to be cleaned or binned, and there was nothing there that could potentially infect the children. It was set up as a safe zone.

**Q** Did ■ like the playroom?

**A** It was fantastic. It was great. It was a place where he could be a wee boy, not a cancer patient. Children become defined by their cancer and the only way to reduce that is put them in a room full of other children that don't have cancer, and ■ dealt with it very well, you know, better than I would have dealt with it, but having an opportunity to be round

children and normalise it -- take the big, bad scary cancer away because that's what it did, and also there was a camaraderie between the children. So, for example, when ■ got his wiggly in, you couldn't go into each other's rooms, there were very stringent protocols about spaces that you could mix, and the playroom for the children was where they could mix, and one of the children had communicated about -- they have got a wiggly, and the easiest way to communicate about this wiggly is to go, "Aye, look, there's a wiggly here", and he thought it was great because he had got a wiggly, and ■ was like, "That was a great wiggly", and just seeing kids interact and having a giggle about it, whereas all the parents are going ... (makes noise) ... "what the heck's going on here", and I don't underplay that. They're just balling to bits and the kids are just standing round comparing their wiggles. That just -- that what needs to happen. To makes it normal, you know? And they can laugh about it which is fantastic, and that's what that space was for and that's why it was so important to have that space.

**Q** It is probably self-evident from what you've already said, Mr

Gough, but do you consider that the playroom was a vital part of treatment?

**A** Phenomenally. Again, looking at this post COVID time where we all talk about mental health and mindfulness and, you know, where we are all very aware of it now, but, really, creating an environment where children are happy and content, not only does to make them feel better, because you know yourself, if you are sad, you feel worse, but also we are asking the children to do really crappy stuff, excuse my language. I could use stronger words, but we are asking them to take really nasty chemicals to save their lives. We are asking them to do horrible procedures to save their lives, and it is a testament to just how wonderful the staff, and not just the doctors but the nurses, the cleaning staff, the play staff, the auxiliaries, the cooks, it is a testament to how good they are that they can get the children to go through these processes, but if you create an environment where it's normalised, where it's fun, and the people that are doing it are the experts, then it's so much easier. You know, if you've got to stick a line into a kid and the kid's happy, it's easy to do, whereas if the kid's not happy you've got to pin the kid down and that's brutal, but the child has to have the

medicine or the child will die. You have to get it in. If they're happy, it is a lot easier, and if they're not scared, it is a lot easier, and that's what Schiehallion does. Schiehallion takes the scariness away from cancer, which is incredible, because it is scary.

**Q** Another room that might have served a similar sort of function but for children -- well, not for children, for teenagers -- ■ wouldn't have been using, would be the Teenage Cancer Trust room. Can we see that on the-- -

**A** Yes. So that's just across from Room 10. Now, when we stayed we were in Room 10 quite a lot. We never actually went into that room because we weren't teenagers and so we weren't allowed and that's fine. That's not our place, but that's where that was.

**Q** Thank you. I want to then, still looking at this diagram, go on to think a bit about the actual rooms that ■ was in. I think when he was first admitted that was Room 10. Is that right?

**A** Yes.

**Q** And we see that at the top of the diagram. Is that right?

**A** Mm-hmm.

**Q** And when he was admitted later, I think there was a

particular incident towards the end of August where he experienced something called, "Rigour".

**A** Yes.

**Q** And he was admitted to Room 2. Is that right?

**A** Possibly. Maybe.

**Q** Or a room similar to Room 2?

**A** Yes. It might have been Room 24, vaguely. Certainly on that side it was a vac room. To be honest, we were bouncing in and out of rooms all over the place, but it was possibly. I lose track.

**Q** Okay. I want to just pick up on some of that in a wee bit more detail.

Room 10 is not a vac room. Is that right?

**A** No. No.

**Q** If we go, then, to Room 24 which I think you identified and hopefully you are able to see this, we see that Room 24 seems to comprise the room itself, but also an outer lobby.

**A** Yes.

**Q** And is what you call a, "Vac room", a room that has a lobby?

**A** Yes, and the purpose of a vac room, and, apologies, you probably want an expert here to explain it better, but it blows air out so

there's -- the purpose of a vac room is if a child is -- you are trying to make it as sterile as possible so if you blow air out, if you raise the pressure of the air within it, there's a push out of air so bugs can't swim upstream, so it's unlikely that any airborne pathogens can come in. That's the purpose of the double doors, as it is really to stop the bugs swimming upstream of the air currents.

**Q** And in both rooms there would be an en-suite bathroom. Is that right? **A** Yes. Yes.

**Q** Okay. Just maybe pausing there, an important point not to lose sight of is, when ■ was in 2B or in 2A, particularly, maybe, when he was in 2A, who accompanied him?

**A** At nights you could only have one person. There was only one night where we were both in together because it was not a fun night, from what I can remember, I lose track, but generally during the day it was both of us for the first four-week period. When this all kicked off, my two girls were through with my mother-in-law and father-in-law because they were doing something through there, so we left them there for the four-week period, which was when the thing was rotting and getting hammered with chemo, we were there together pretty much all the

time, and then we would take turns of an evening. Once the girls came back we needed to get some normality back because sometimes you forget about - - it is important not to forget about the other siblings as well which can be very easy because you do put your focus on the child that is most sick, but when that four-week period was finished, and after he had had his surgery, we then brought the girls back and then went into a tag team, so we were very good at doing changeovers in car parks and we just took turns around, you know, Collette's shift, my shift, and we generally did do four hours on, take four hours off, and it seemed to work well enough.

**Q** And were there facilities within the room in 2A to stay overnight in the room?

**A** Yes. So 2A was really well thought out. It was designed for adults to be sharing with children. So the bed for the patient was the middle of the room, depending on which side of the room the bed was, they also had a fold-out bed for the adults which you folded out at night and put away but it was a proper fold-out bed which makes such a difference. See, particularly when you are not sleeping, sleeping well and getting woken up through the night having something

that is vaguely comfortable for yourself, because you also have to be vaguely with it, the facilities were very well set up for there. They had storage facilities to hang jackets and all that.

Also, depending on the type of treatment, you quite often found that kids would stay in for quite a wee while, so it was set up to cope with long-term stays. It wasn't just a bounce in, bounce out for a couple of days, as you would if you were getting your tonsils out, you know. Kids could be in for weeks, months, so it was very much set up to be a wee home from home, and not just for the children but for the adults because it was recognised while it is always important -- you know, the key focus is on the child, they also were aware that the parents needed a bit of help as well, and having a bed that was vaguely comfortable was useful, because you didn't sleep. It was good. They had it very well set up.

**Q** That was something I was about to ask you about was, actually, the experience of parents in the ward.

**A** Yes.

**Q** What support was there for parents on Ward 2A?

**A** The most important thing -- they had facilities, so they had the beds that worked for the parents, they had a parents' coffee and tea place where you could go and cook food, make yourself a cup of tea, which -- it is amazing how important a cup of tea is, and I know that sounds silly, but a cup of tea -- see, at 4 o'clock in the morning, when you've been watching your child go through rigour or whatever, whatever bad night you are having, just to be able to nip along, literally nip along and get a cup of tea, or get something to eat, was a saviour. The other nice thing about having a parents room is that it became a focus for parents. It is important that it's normalised for the children, but it's also important for us as parents to normalise it, because, yeah, it is -- someone telling you, "Your child has cancer", it is one of the worst -- not the worst, I'm sure there are worse things that someone can say to you, but someone saying, "Your child has cancer", is ... it just comes out of nowhere, and having parents round about you that have gone through that, who will support you, is phenomenal, and they had set up spaces having a tea room where you could go and chat, and heat up food because you don't get to eat when your child has got

cancer because getting food into them is really important because they have to be healthy. Having that space where you could go and just shoot the breeze is a phenomenal therapy. You know, I remember walking in to the play room on the first day and two or three children were there, all no hair, tubes, and the two mothers in, and the compassion and empathy in their eyes was, you know, knowing that -- for me was a huge solace, just having them there, and do you know, within a week, we were part of their world, battle hardened, and we were looking at the next people coming in, and just having people round about you that have walked the walk is just phenomenal, and the nurses and doctors and play leaders and cleaners and auxiliaries also were very aware of the parents' needs as much as the children, so they would come and chat and -- because you are stuck in a room with your child all day. You can't move because if they're having a spike, or they're not well, you can't go away because that's important you stay with your child, and that's fine. I'm not complaining, but they always knew to come and stick their heads and say, "Hiya, how's it going?" And they always asked about you as well as the child, and it wasn't just the doctors and

nurses. It was the -- you know, auxiliaries, the cooks, everyone just really pulled together, and the best way I can describe it, and really what sums it up to me was an incident where ■ was having a spike. He wasn't doing well. He was having a really crappy time of it, and his meds had run out and he was shivering and he wasn't well and he was just struggling. He wasn't doing well, and one of the cleaners came in and gave ■ a box of Lego, and -- because she knew that ■ liked Lego, and that gave us enough time, that gave us two hours to the next meds. That was better than medicine, that's better than play. Everyone was on it, and, you know, it brings wee prickles up my spine just thinking about it now, that here is a person that -- you know, we all, quite rightly thank doctors and nurses but this was everyone. Everyone, top down, were on it, and they all worked with such compassion. They didn't get battle hardened, they worked with such compassion to make your stay as easy as possible primarily for the child but also for the parents. They're great. I can't thank them enough.

**Q** I want to just look at two other slides on this, Mr Castell, just to complete this part of the evidence, Mr

Gough, so if we could go on, please, to the photographs at page 24, first of all?

**A** Mm-hmm.

**Q** I think you've got those in the front of you, Mr Gough. I think we see that photograph 1 seems to be photographs of the Teenage Cancer Trust lounge which we mentioned earlier but wasn't a feature of ■'s care. To the right of that, photograph 2, it may be a little difficult to see, but either side of that, as it were, inlet area, it has been described as a, "Touchdown base", either side of that it indicates isolation rooms. Are these what you referred to as, "Vac rooms"?

**A** Yes. I think if you look at 23 you almost see on the left-hand side of that doorway there's almost another doorway you see in there, and that's your -- the corridor within.

**Q** Yes. Am I right in thinking in fact actually you can see in 23 that you go through a lobby and you can see, in fact, a chair?

**A** Yes.

**Q** That would be a chair that would be within the actual bedroom itself? Is that right?

**A** Mm-hmm.

**Q** And I think if we go on, please, to look at page 25, if we could scroll just a wee bit down, please, Mr

Castell, we see a number of pictures again from the ward. If we look at photograph 12, accepting that it's got a cot in it which wouldn't have been a feature of ■'s care is that similar to the layout of the rooms that ■ was in?

**A** Yes. So you see on the -  
- going into that image in the middle beside the window there's what looks like a wardrobe but that's actually the pull-down bed. On the left of that we have a door with a door handle that's through to the toilet. Quite light on furniture. There would be a lot more furniture there. They have a lot more storage which was necessary, because you would be living in there for a wee while. You see where the red chair was? Generally you had bedside cabinet on one side, quite often two sides, and a lot of the machinery of keeping your child well, so the beepy machines and the oxygen and all that were -- technical phrase there, "Beepy machine" -- were all alongside on one side or the other, normally on the door side of the bed, because it allowed the doctors and nurses to access it quietly, because they were really good at being able to take meds, take obs and give meds without waking the child.

**Q** I will come on to that in a moment, Mr Gough, but just staying

with the room, are you indicate, then, that the room is a bit more sparsely furnished?

**A** Yes.

**Q** And there's a sort of arm above the cot with a screen attached to it. Are you able to see that?

**A** Yes.

**Q** Is that something that would have been in ■■■'s room?

**A** Yes. So they all had televisions.

**Q** And then maybe just one final thing to say about a number of these pictures that we've looked at. Have you any observations to make about the colour schemes or the decorations?

**A** It was all very bright, all very child friendly. I can't remember whether they were specifically these colours because, as I say, we did a lot of different wards and different wards had different colours, so it was a bit bright, but it tried to be nice and vibrant without being too patronising. Sometimes in these things they can over do it, and it was just nice. It was a nice environment for kids to come into. It wasn't scary, but it wasn't trying too hard. It was very well pitched. If you've got to go to hospital, that would be the one I would want to go to.

**Q** Mr Castell, we can put these production to say one side for now.

Now, Mr Gough, I want to go on. I'm still in August 2018, and I want to now -- I think we've seen a bit about the environment, the infrastructure. I want to now have you give your reflections on your experiences and ■■■'s experiences within Wards 2A, 2B over that initial period.

**A** Mm-hmm.

**Q** And I thought I might approach it this way; something that you speak about at a number of points in your witness statement, and you refer to it as, "The Schiehallion umbrella", what is that?

**A** The nature of being immunosuppressed, immunocompromised, is that children have to be treated in a specific way. Like anything, if you've got a broken leg you need a plaster on, if you've got a heart condition you need specific things, but for children that are undergoing chemotherapy they need a specific set of -- they have a very stringent way of treating them to stop them getting sick, because any bug that comes along will slam into them. Also, the nature of the medicine means that there's only specific things -- because their systems are



suppressed, limits how you can deal with temperature spikes. For example, unless their counts are at a specific level you can't give them ibuprofen, so if you are managing a temperature spike on a child, normally you would have four doses of paracetamol and three doses of ibuprofen and they would put them together and you could manage a 24-hour period, and that's great, but whereas with a child that can't use ibuprofen you've got to manage -- there's a which go gap that you have to -- so the Schiehallion nurses, doctors, cleaners, were set up to create an environment that was specifically tailored for children who have cancer and are undergoing chemotherapy, so from a basic level the level of cleanliness was through the roof. The staffing level of cleaners was up here, and I suspect the training was up here. It was always immaculately cleaned, and they took a huge pride in their work. So hats off to them. The ratio of doctors to nurses to children were much higher because the nature of -- of course, go back to go forward, one of the key concerns about children being immunocompromised is they get infections, and the nature of the infections is they can go wrong really quickly, so they run a much higher

level of doctors and nurses per patient because they need to be able to react faster. They also are much more reactive to the patient, so -- they're on it. That's the only way I can describe it. They're very much on it all the time, so they create this umbrella of being specialists in their field.

They also, understanding that it is a long slog, it's not just a, "Go and get your arm fixed and back out again", and there's nothing wrong with having a broken arm, I hasten to say, I'm not putting anyone down that has a broken arm, but it is a different set of skills, needing to treat that broken arm as it is to treat an oncology patient. The level of care is very much tailored to these children, and both of the child and of the parent, and they're very good at trying to deal with the emotional fallout not just of the child but of the parent as well, so it's really creating an environment that is tailored specifically to these children's needs and also including us in the process, because it is such a long, long haul, you know, you may be there for three years dealing with it, so it's not just a quick thing, so it is about everyone working together and we were amazed with the level of care and also the protocols that they follow are much more stringent, so how they do things,

you know. I suppose the way I would put it is there's a sort of general standard, gold standard, then Schiehallion standard, and they were - that's them, you know, up here. Climb to the top of the castle, you know, high enough. Their standards were phenomenal because it was necessary, but the problem is, and I'm sure you will speak about it later on, when we went to other areas who weren't maybe as -- Schiehallion had an awareness of this because they were dealing with this and they were highly trained in this. If you are not dealing with this on a daily basis, if you don't see children crashing in half an hour, going from being healthy children to circling the drain, putting it brutally, you know, half an hour, 40 minutes, that's how quickly it can go wrong. The Schiehallion doctors and nurses were set up to deal with that. You are not used to this, then, you know, or not trained in that, then maybe not as quick to react, and that's fair enough, I'm not decrying anyone's skill or -- because everyone has different skill bases and different training but Schiehallion doctors and nurses were just on it. That's the only way I can describe. They were on it.

**Q** That's helpful. Now, what I would like to do is maybe just

look at some aspects of that. An overall aspect I take from what you've just said is that there was an experience and an expertise. I think one thing, for example, you mentioned in your statement, a number of points, is that your impression was that there were no first year doctors?

**A** No. No. Doctors have to learn, not decrying that, doctors have to learn, we all need to learn. We all need to be -- we are all learning, but there are people to practice on and there are people not to practice on, and with these children that are so sick, they shouldn't have been practised on, and they weren't practised on, so you had the top end people, you know, so you didn't have the first year students in using your kids at pin cushions. No one wants that, and also trying to get a vein on a child that is immunocompromised and in shock and all this, you know, it's not easy.

**Q** I will come on to that in a minute. I wanted to look at some other aspects of what we are calling, "The Schiehallion umbrella", what you are calling, "The Schiehallion umbrella", and just a number of aspects of that. I think one aspect, for example, that you bring forward is the actual administering of the medication itself.

**A** Yes.

**Q** I think particularly in relation to those on Ward 2B, I think, you noticed that that was an expertise in itself?

**A** Very different skill base, and what I understood, a lot of Schiehallion moved over to -- there's a crossover between the two. You had Ward 2A and 2B and they could jump in between each other but, as you say, administering the meds was very specific thing. They had two people to administer it, all the numbers were checked and double-checked, and they were all suited and booted and it was a fine art of maths as much as medicine, because the chemicals are nasty. The chemicals

**Q** And when you say, "Suited and booted", you mean --

**A** Yes, so the full plastic gowns, because the stuff burns you, if you get it on your skin it burns you, and that's really -- I -- you know, we are using chemicals that burn children's skin because it is better than the cancer.

**Q** A second aspect that I kind of detected in what you said in your statement on a number of points was the management of temperature, and what you say in your statement, and you've already touched on this just

now, is that it was tailored to ■'s needs.

**A** Absolutely.

**Q** And I think you've said this twice now, I think, and responsive to what could be a rapidly deteriorating situation. Is that right?

**A** ■ runs hot, so ■ having a high temperature is not a huge thing, a concern for us. When he was very young he was, I remember, over 40 degrees, as a young person, oh, scary, scary, scary, and that's normal, he didn't go into febrile convulsions, and that was -- we spoke to the -- because we took him to A&E at the time, and they said no, when he gets sick, it is a very high temperature and that's -- it is not great, always come to see us, but - - so we were kind of not complacent, but when ■ was 39.5 degrees, it's not great, but we were used to it, him sitting there, 38.5 is, aye, that's him just having a wee snuffle. The first -- sorry -- second week we were there, third week, I lose track, maybe third week, ■ got a temperature and started to go into rigour, shaking, shivers --

**Q** Can I just pause you there? Because we've had the term, "rigour", a few times this morning already. I was going to ask you about this. I think in your statement you say

there was an incident, I think it was on 24 August --

**A** Yes.

**Q** -- and you describe how |  
's temperature spiked?

**A** Yes.

**Q** And he then went into something called, "rigour"?

**A** Yes.

**Q** What is that?

**A** Your body goes into shock and you see kids shaking, so it's like -- you know in yourself when you get a fever, a really bad fever, you go into those shakes, and that was -- and we had seen ■ having these before when he had a very, very high temperature, it wasn't great, but we were kind of used to it. We flagged it and the nurse who we had flagged it to was, like -- all hell broke loose because it was something -- and we -- and the nurse was great because actually afterwards we felt a bit guilty because we felt, "Should we have flagged this?" And again, this shows the level of -- how it was very much tailored to Schiehallion kids was, "No, no, it's okay, you weren't to know, but from now on if that happens ..." and they went through all the procedures of -- he goes through this -- and, you know, we had to be taught about

cancer, and that's what Schiehallion did.

So when a child goes into rigour, it is not a good thing because it is potentially a function of line infections and such like, so, yes, all heck broke loose, and it is about managing the temperature, because you've only got four doses, the strategies that they developed, and it was strange, because there was wee tweaks that, you know, paracetamol only lasts for four hours, so you've then got two hours before you can -- in theory you've got to make it last six hours, so you've got two hours without him having meds, so you are trying to do stuff to work out how to make that -- to reduce the impact of those two hours drug free, and they were great.

So they were giving him IV paracetamol sometimes helped, or delaying it, do you delay it or do you punch it up to the front, or actually, are his meds good enough so that he can have ibuprofen, so they were very, very -- they were on it, you know. They could tailor everything exactly and because they knew the implications of your blood counts not being correct or being too low, then they could tailor the medicine to the child, and accept that it was a moving target, and that was the other thing, is,

it was a moving target, and I remember on that occasion he wasn't doing well, because he was still getting -- he was in the first four weeks, and the nurse in question stood outside the room, waited, you can't give it within four hours, waited, literally, almost there, five minutes, five minutes, three minutes, bang on four hours, came in and gave ■ the meds, and that's the level of, you know, standing outside the room with the syringe going, "Aye, yes, we can go and do that now", so it was all about doing it as efficiently as possible to get his temperature down.

**Q** I mean, I take it seeing ■ go through rigour was something that was distressing for you.

**A** Aye. That wasn't fun. That was -- aye. It wasn't -- the two hours --

**Q** Were you scared?

**A** It was -- yes. There's no other polite way to put it. I was scared. I think I became more scared after the line infection because --

**Q** I will come on to that later, Mr Gough. If we just stay with this incident just now, but you do emphasise in your statement the intensity of the care that was provided to the patient in this incident. You talk about the counting down of the clock,

and I take it close observation was also a part of that?

**A** Yes. They tailored the obs -- they tailored all the care to the requirements of the patient which was great, because when you are in -- you hope that with ■ we found that the first 24, 48 hours were the worst, and during that period they were on it, they were on it throughout the whole time, but as his temperature came down and things stabilised, observations and such like, maybe weren't as regular, but it meant that they could -- we were always really impressed with the fact that they could tailor -- they managed the ward as well as each individual, so they could give -- you know, they could give the resources where it was needed, and that was great, you know, because for them it's not just one patient, it's 24 patients, it's 30 patients, and they did that incredibly.

**Q** Yes. Now, I'm going to go on later to ask you some questions about experiences on other wards, and I'm going to ask you in particular about the extent to which the Schiehallion umbrella, as it were, followed ■ around the hospital.

**A** Yes, yes.

**Q** Just taking matters at a general level at this stage, so without going into the detail, necessarily, when

went to other wards, was this management of temperature in particular something that was always evident?

**A** No. No. There was -- well, fundamentally they didn't have the numbers of staff so they were automatically fighting an uphill battle, and that's trying to be as positive as possible about this, if you are running with half as much staff, or you've lost a third of staff ratios, then you are automatically going to have a third few obs done or reaction times, so you were automatically hamstrung. There wasn't -- it depended on the ward, it depended on the ward, but because wards dealt with high-risk patients, so, for example, cardie, you know, they can have a heart attack, that's what they were dealing with, so they were on it, but -- so they were on it and very quick to react to situations, but generally we were -- aye. Schiehallion was the gold standard for us, and to a certain extent, as part of the process of induction, we were -- Schiehallion were great because they kept on telling us what they were doing. We had to learn as parents about this, not just to make sure that we knew what was going on, and to allay some of the fears to take the scariness out of it, but also I can't remember how it was

communicated, so my apologies, but it was very much kind of alluded to that this is gold standard. It might not be it in other areas, and as I say I can't exactly remember how it was communicated, but, you know, be aware that this is what the level is, and you need to make sure that this is the level that it stays to, because, you know, you need to watch as much as everyone else, because -- you need to be eyes, which I'm glad they did, and it was a great thing that they --

**Q** And you indicated in your statement, you just alluded to, that essentially you were warned that that would not be available everywhere in the hospital?

**A** Yes. It was -- different people have different skills, and to be very diplomatic here, but -- yeah.

**Q** As I say, Mr Gough, we will look at these other wards in more detail, I just want to get an overview at this point.

Staying, then, with the management of temperature within Wards 2A and 2B, I just wonder about this; would a relevant consideration from your point of view at this point have been your experience of the temperature within the hospital? Did you have any issues as regards that?

**A** Yes. Aircon in Room 10 -- 10 sticks in my head because we spent a lot of time in Room 10 -- didn't work, and it was always proper hot, which, when you are trying to deal with children that are spiking is not easy.

**Q** What did you do?

**A** We ended up having cold flannels and just wet towel on the head, wet towel on the head, and just trying to cool him down that way. We were limited in what we could do. We couldn't use ice blocks and such like and I can't remember why. Could be wrong. Depended on one ward. There are bits of it that are a blur because we did bounce in and out, but we -- I do remember using cold, wet towels on his head.

**Q** What about when you were in a vac room? Easier to control the temperature there?

**A** I think from memory the vac room -- there was one -- we were in one room, the temperature was slightly better. I could be wrong. I'm sure the room, Room 24 -- possibly. Speak to my wife. She was better on this than myself, but I'm sure 24 might have been a better room. I certainly remember 10 was like an oven. That wasn't fun, and other rooms we went to weren't as bad as Room 10, but 10

wasn't fun. That wasn't nice, to be in for a kid that's spiking.

**Q** The third aspect of what I take you to be grouping under the heading, "Schiehallion umbrella", was the way in which the Schiehallion staff were able to take blood from ■■■. I think in one point in your statement you say, "They could find a vein in a rock"?

**A** They were great. Literally you could stand at the other end of the room and just go -- just great, because they're used to dealing with kids that are difficult to find, and they were -- again, had protocols for doing it, so the process was, you know, come up and check the hand first of all, and that was (Inaudible) spending a bit of time looking over the hands, going that's a good one, that's a good one, that's a good one, stick on Emla cream which was an -- numbs the area, and then come back, but they did investigative work first, just to see where they were going, but great - - and it wasn't just putting in cannulas, it was putting in wiggles, it was accessing, and I'm sure you will ask about different types of ports later on, but they did it every day, you know? And, therefore, were experts at it, and that was a key part of it, and -- yeah. You knew if you needed to access

ports and lines and you were with these people they would always get it, and if they didn't get it there was an issue, so they were great.

**Q** What is a cannula?

**A** Cannula, catheter, this one in your hand, so you will have all had them in your hand where it is finding your vein, but the issue with kids is that, you know, if you all do it, do that on your hand, you start pulling a vein up, whereas, because these kids weren't well, it was difficult to find a vein in the kids quite often, certainly for ■ there were times when it (Inaudible).

**Q** I think in your statement you indicate in fact in Schiehallion they tended to avoid cannula?

**A** Well, that's the advantage of a wiggly is you were straight there, so you only needed an external line, if there was an issue with this one. There was a point when there was an issue with the line that we needed to put a line in, but generally we avoided that because it's nasty, you know. You don't want that in there. That's why you've got these things.

**Q** And again, just to get your general position on this, just now, we will look at the detail in a minute, but are we right to understand from

your statement that this expert and careful approach in relation to the taking of blood was, again, not something that you always saw on other wards?

**A** It depends on the person. There was a consistency of high quality care with Schiehallion, so it didn't matter who you got. You could get anyone from that ward and you knew that they would always get it.

**Q** And outwith the Schiehallion ward?

**A** Outwith the Schiehallion ward there was very good people, very well-trained people, but you also had people that were trainees. You also had people that didn't get the opportunities to use these unusual -- not so much the wiggles but the subdermal ones that it was -- you know, they weren't time served.

**Q** The subdermal ones being ports?

**A** Yes. Yes.

**Q** We will speak about that later.

**A** But, you know, A&E nurses and doctors were great at finding lines because they do it every day and that, you know, other ones were maybe not so good or trainees weren't so good and that's fair enough, people have to learn, but not on ■.



**Q** One maybe just last aspect of the Schiehallion umbrella, again, it is implicit in everything you've said so far, and something you emphasise in your evidence about your experience on the Schiehallion ward was the communication between staff and parents.

**A** Yes. It is a big scary thing, cancer. Chemo is a big scary thing, and both 2A and 2B, they were very, very good at just keeping us in the loop, and just telling us, "This what's going on, this is why we are doing this, this is why we are choosing this protocol", and particularly with ■■■, where it was an unusual case within an unusual case, you know, there was -- while it was always going to be the doctor's decision what happened, they were very good at keeping us in the loop, and it transpired that having that information was fantastic because it kind of skilled us in dealing with -- when we weren't in the Schiehallion umbrella.

**Q** Thank you. Now, I want to, just in the minutes we've got left before the lunch break, I want to just try and, if I can, complete your evidence in relation to August 2018 and, in particular, your evidence about experience on Wards 2A and 2B, and I'm going to ask you about a couple of

matters in your statement which indicate some less positive reflections. The first one I'm going to ask you about is water safety, and what I want to know is was there ever anything that suggested to you that there might be some doubt about whether it was safe to either drink or use the water in the Schiehallion Unit?

**A** When we -- first four weeks particularly were a bit of a blur, so timelines, you know, I might be a day or two off, but when we first arrived you went into the room and there was just a normal room and all the taps and everything were just normal taps. The next time we went into Room 10, so maybe a week later, they all had filters fitted because it had been flagged that there was an issue with the water supply, so it would have been roughly a week or two later. I can't remember exactly how far it was, but within that four-week period it went from being no filters to filters. When we went in, we were communicated at the start, "Don't drink the water, we will give you water". Within the parents room it was communicated, we had a wee induction on several occasions because -- and, again, while dates are a bit fuzzy, the staff were very good at telling us things more than once, because they knew, to put it brutally,

we've just been told our kids have got cancer, our heads aren't anywhere that can remember information, so they tell us the same things over and over again which is great. So actually I couldn't remember whether it was the first time or third time, but they communicated on, I think, the first time, the parents area, that, you know, this is the drinking water, this is where you get the water from to drink, don't drink out of the taps, that when you are washing any dishes they need to go into the dishwasher. Don't wash the dishes in the -- using water from the taps. You shouldn't brush your teeth with the water from the taps, brush your teeth with bottled water. Don't spit water down the sinks, I think we were told spit it down the toilet because -- or I could be wrong, but something I remembered, don't put anything down the sinks because sinks are just for washing your hands, but we were communicated that because there had been a wee issue with the water. I can't actually remember exactly the conversation but it was communicated, issue with the water, don't drink the water, don't brush your teeth in the water. Don't make tea and coffee with the water, don't wash your dishes with the water, and very quickly we got filters on the taps.

**Q** Did any of that cause you concern?

**A** A wee bit, but we were kind of caught up in the cancer and, you know, I think there's only so much your head can cope with, and my thoughts were more on cancer. It was a wee bit concerning. It wasn't high on my radar at the time. It became much higher a few weeks later when it all kicked off, and retrospectively, it was about oh, you know, did I drop the ball there, should I have been more, you know -- but at the time it wasn't --

**Q** What do you mean, did you drop the ball?

**A** When ■ got an infection the bug itself was poo bug, for lack of a better phrase. It was a drainage bug. Now, when this was communicated to us, fairly soon afterwards communicated that this was a hospital-acquired infection, but there was a wee period where you don't assume that your child is going to get poisoned by a building. You don't assume that you are going to get a bug from the hospital, so you automatically personalise it. Have I done something? Is my child circling the drain? Did I almost kill my child because I didn't clean the bathroom properly? You know, that's not --

**Q** We are going to come later to that particular incident, but before we do that, let's maybe just look at one other aspect, then, of your experiences in Ward 2A in August, and you describe this in your statement, and there was an incident involving use of the shower.

**A** Yes.

**Q** And I think you say it was 26 August.

**A** Yes.

**Q** I wonder if you could describe that to us please?

**A** ■ -- cancer kids lose their hair. Shave it off. That's generally the way people deal with it, so we decided, ■ and I, to both cut our hair, so he could cut my hair and have a bit of a giggle -- still kept short here, still going -- but -- so we did it in the bathroom. Now, cut his hair, cleaned it all off, so that was the important thing, that the area was all cleaned off, and because the nature of his wiggly, easiest way to wash ■, because we wanted to keep this area clean, was to get into the shower with him and wash him. The infrastructure of the bathrooms, they were wet rooms so the purpose of a wet room is that the floor naturally tapers to the drains in the centre of the room, which is great, you know, so in theory if you drop

water anywhere in that room it all ends up down the drain.

The install of that room had been done incorrectly so that you only had a very small footprint that drained. Outwith that, any water that didn't fall within -- it was about a metre square, probably less than that, straight underneath the shower, any other water that splashed stayed out, and actually, because of the rake of the floor, ran out, and it would run along the sink, underneath the toilet and out into the room, so when we showered the room flooded and then it flooded outside so all the water -- now, bearing in mind that we had cleaned -- the drain wasn't blocked, it was just water bouncing off us, because you know, there was no curtains round about the room, so any water that -- and funnily enough, speaking to a parent yesterday about it, "Oh yeah, Room 24, we flooded that room as well" because -- and it was just a really badly designed room. The floor hadn't been installed properly, because the whole point about having a wet room is that it all drains into the centre, and the concerning thing there was not only did it floor the room but it flooded it by -- the water track was round about the toilet, so any nasties from round about

the toilet would get washed into the room.

**Q** Yes. Now, helpfully you've provided us with a drawing of this event, and Mr Castell, I think it is in Bundle 3, page 81, it is the very end of your statement, Mr Gough. I would quite like to have a look at that just to--

**A** Certainly.

**Q** -- assist with your description of this incident.

**A** So if I had known I was getting like there I would have done a really good job of it rather than just a wee rough -- I would have got out the paint.

**Q** To my point it is quite impressive as it stands. It is certainly better than anything I could manage.

**A** (Inaudible) was designers as well. They could have made it look really pretty. I'm not seeing anything at the moment.

**Q** Page 81 of Bundle 3. That's the bundle with all the statements in it. Do we have it? Have you got that in front of you Mr Gough?

**A** Yes. If you go to the top left of that, it had a wee drain.

**Q** So that's the drain under the shower?

**A** Drain under the shower. Now, that footprint, I would guess, was

maybe eight foot square of the room, ten foot square, no, maybe a bit bigger than that, but in theory, any water that landed in there should have gone down the drain. There was no -- the shower head itself was right above the drain. There was no curtain round about the shower because curtains are just bacterial mingy things so when ■ showered it was -- if you go less than - - probably about a quarter to a third along the top edge, and similarly down was the footprint that actually drained into the drain. After that, there was a ridge. The only way I can describe it is that there was a taper and a slight levy, and it flattened off down again, so any water that bounced outwith that metre, and I'm being generous there, that metre square ran away from it, so you couldn't even -- couldn't brush it in because there was a slight lip, and when it flooded, it flooded down, and it eventually went out the vac room, so it wasn't great. We were most apologetic, and we mopped up and the hospital staff were very helpful about it, and they were like, yeah, this has happened before.

**Q** Forgive me, I should know this, but can you remind me whether, in the bathroom, there's also a sink?

**A** Yes. So the sink is just in the corner. If you go left from the toilet and down from the drain, the sink was underneath there.

**Q** And your recollection of events is that the bathroom area was inundated to the extent that the water was in the proximity of the sink and also the proximity of the toilet?

**A** Yes. So it flowed down and then out the door.

**Q** And out into the vac room or lobby area?

**A** Yes.

**Q** Without putting too fine a point on this, Mr Gough, are you able to say that vomiting and diarrhoea are fairly regular problems for children who are going through chemotherapy?

**A** Yes.

**Q** Would it be fair to say that the bathroom probably bears a fair amount of the brunt of that?

**A** Yes. Yes.

**Q** I mean, did it cause you any concerns that this event had happened?

**A** I was amazed that the room -- coming from a technical background, going -- you wouldn't let that happen. Angry, to be honest. Someone signed that off. Someone -- you know, if you had a bathroom, a bath that ran uphill and the drain was

at the top of the hill, you would kick off merry old heck. You know, someone has installed a wet floor that not only doesn't function but makes matters worse. Someone has signed off a wet floor and flooded the place. You know, if that was in your house there would be all heck breaking loose. You wouldn't accept that. That's not fit for purpose, and you show that to any flooring or -- you know, having worked in watersport centres, if someone had installed a floor like that in my water --

**Q** Were you the person who discovered that there was this problem?

**A** It was -- they had had this problem before in that room.

**Q** Did you ask about that, when you reported this incident? What was said about whether this was a one-off or a regular incident?

**A** "Oh, that's happened before". There was a comment, or something like, "That's not the only room", again, it was one of those side comments, and again, we were kind of more dealing with the incident rather than the mechanics of the room, but I was amazed at that happening, and I suppose I wasn't so much angry at the time, but retrospectively, when you start seeing you've got a bug that is a line infection that occurs because of

poo, and you have a room that floods, sends potentially pooy water all across the room. I'm not saying that there is a direct link, but A plus B normally equals C, and even if it didn't get caused there to ■■■, someone else could have been -- you know, that's not acceptable in any infrastructure. That's not acceptable.

**Q** In your statement I think you say that discussions with, I think, nurses indicated that this was not an isolated incident?

**A** No, be it in the room or in other rooms that have flooded.

**Q** Yes, and did this lead to you and your wife to have some concern about cleanliness within the rooms?

**A** We were -- we developed systems of dealing with rooms, so we would get a bank of towels, make a wee levy that stopped flooding when that happened and you needed to go in and shower with ■■■, so we needed to cope with it, so we developed systems of cleaning up. We were -- I would say that we became more concerned about cleanliness when we -- we were very concerned about cleanliness but the real nail in the coffin for us was when we went into -- when ■■■ had his surgery and things -- because

Schiehallion was cleaned, whereas going into wards that beds still had matter on them we became hyper and at that point we cleaned the room, any room we were in top to bottom. That was the first job we did when we went into it.

**Q** Well that, in fact, is what I was proposing to ask you about next. My Lord, that would be a new chapter, so I wonder if that is a convenient moment?

**THE CHAIR:** All right. Well, we will take a break for lunch. I make it 1.05. If you could be back, Mr Gough, for 2 o'clock, if that's okay, and I plan to sit again at 2 o'clock. Thank you.

**13:05**

(Lunch adjournment)