SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 September 2021

Day 15
Tuesday 26 October
Morning Session

C O N T E N T S

	Pages
Cuddihy, Professor John (Sworn)	
Examined by Mr Duncan	1-103

10:04

THE CHAIR: Good morning. Mr Duncan, are we ready to proceed?

MR DUNCAN: We are, my Lord.

THE CHAIR: And it's with Professor Cuddihy?

MR DUNCAN: It is, my Lord.

THE CHAIR: Right.

(Pause).

Good morning, Professor Cuddihy. Now, before I go any further, I think it is appropriate that I acknowledge the fact that you and I have met before; I think on two occasions.

The more recent occasion was last year, at the stage where the secretary to the inquiry and I were speaking to a number of people, just to inform ourselves about the broad parameters of what we would require to be doing in relation to the inquiry; and you were one of these people, and we had a Zoom or Teams, I can't remember the technology, but it was a remote meeting where we had a general conversation. I think we were listening to you, rather than the other way round. So that was one occasion.

And the other occasion was a good number of years ago, and nothing to do with the inquiry; and the context was, you were giving evidence as part of your then professional duties

as a serving police officer at a hearing that I was conducting as a judge. As I say, a good number of years ago, nothing to do with the inquiry, but we have seen each other before.

Having acknowledged that, as you appreciate, you will shortly be asked questions by Mr Duncan. We will probably take a coffee break at about 11.30. Should you want a break at any other time, please feel free to indicate that.

Now, are you prepared to take the oath?

A I am, my Lord.

THE CHAIR: Can I ask you, just sitting where you are, if you raise your right hand and repeat these words after me.

Professor John Cuddihy

(Sworn)

Examined By Mr Duncan

THE CHAIR: Thank you very much, Professor. Mr Duncan.

MR DUNCAN: Thank you, my Lord.

Good morning again, Professor. Can I just begin with some formal questions and have you confirm that you are John Cuddihy, you are █ years old and that you live with your daughter, your son and your wife in

the [redacted] of Scotland; is that correct?

A Yes, sir.

Q Yes. And you have provided a detailed statement, setting out your experiences of your daughter's treatment within the Royal Hospital for Children and the Queen Elizabeth University Hospital, and you are content that that forms part of your evidence to the Scottish Hospitals Inquiry; is that right?

A That's correct.

Q Yes. But you have come along today to answer some questions in relation to some other aspects of that; is that correct?

A Yes.

Q And can I just check that you have a copy of your statement to hand?

A I do, yes.

Q Can we begin with some personal background; and as you are turning to your statement, you might as well turn to the relevant part. It begins at paragraph 12. I'm just going to take a bit of time to have you tell us a bit about your professional background.

Are we right in understanding that you originally had an engineering background?

A Correct, yes; many years ago.

Q Yes. And then you

became, as his Lordship just indicated, a serving police officer in [redacted] Police to begin with; is that right?

A Yes, sir.

Q Are yes. And did you retire from what was by then Police Scotland in 2015?

A Yes.

Q What rank had you obtained by then?

A Detective Chief Superintendent.

Q What particular department or area did you have responsibility for?

A I was the Head of Counterterrorism and Organised Crime for Scotland.

Q Now, can I ask you, please, to tell us this. Upon retiring from the police, what did you do?

A I've taken up a dual role on -- within the University of Coventry with the Centre for Trust, Peace and Social Relations, where I operationalise research into terrorism and organised crime; but I also act as a consultant for a number of organisations on areas of conflict and fragility.

Q Is one of those organisations the UN?

A Yes.

Q I think you mention that

at paragraph 15 of your statement. Can you just tell us a little bit about that work?

A So on my background, I operate on behalf of the UN within their counterterrorism framework and I offer advice, guidance, capability and capacity and training to a number of international organisations, predominantly the prosecutorial intelligence and law enforcement within particular countries.

Q And just thinking about that work and also the work that you do at Coventry University which you describe at paragraph 12 of your statement. Can you maybe describe the core lessons that you have learned, in particular, from issues like dealing with risk?

A Yes. So in order to identify, manage and mitigate risk, you first have to understand the threats and the threat environment in which you're operating; and we do that through the information from a variety of sources. And that information is the basis of intelligence; and it's that intelligence that allows us to make informed decisions that enables us to manage and mitigate those risks, whatever they may be.

Q Yes. I think you set this out at paragraph 18 of your statement;

and I think planning, preparation, communication, you identify as being critical features of how you manage risk; would that be fair to say?

A Absolutely.

Q And when you mention information and intelligence, are the same things or are those different things?

A Two different things.

Q Do you want to explain that a bit?

A Well, all intelligence is information, not all information is intelligence.

Q Now, let's move towards the core of your evidence today; and I want to begin with the story of the hospital. Now, we know from what we heard yesterday that Molly began to become unwell towards the end of 2017, and we know that your first involvement as a family with the Royal Hospital for Children is January 2018; is that right?

A Yes.

Q I want to go back to 2015. You will understand that was the year that the hospital opened; is that right?

A Correct.

Q I mean, at that time, did you have any reason to have any detailed interest in the construction or

the delivery of the Royal Hospital for Children or the Queen Elizabeth University Hospital?

A None at all.

Q I mean, in particular, and we'll come to look at the work that you've done as time has gone on, did there come a point when you discovered that in 2015, just to take one example of one thing that you found out, did you discover that in 2015 NHS GGC had received a report from a firm called DMA Canyon?

A Yes, sir.

Q Yes. Now, as I say, Professor, I will ask you later about the circumstances in which you came to investigate that. But very broadly, what was the nature of the report provided by that firm in 2015?

A My understanding is: this is a risk assessment relative to Legionella. It's a statutory requirement that was commissioned of DMA Canyon by the then manager of the estates at Greater Glasgow and Clyde, Mr Ian Powrie, commissioned the report.

Q Am I right in understanding, and should we understand, DMA Canyon provide a range of services, but those include consultancy services in relation to the management of Legionella and other

bacteria risk; is that right?

A That's correct, sir.

Q And if we were just to try and get a broad understanding of what NHS GGC would have learned from the receipt of that report in 2015. How would you describe that, just at a very broad and high level?

A It provided information that would enable the reader to make informed decisions with regards to the water and, more specifically, any risks associated with that water; and it detailed a number of those risks.

Q Yes. Was it your understanding that essentially, as you later discovered in 2015, NHS GGC had commissioned a wide scale risk assessment by this firm of their water supply; is that right?

A That's correct.

Q And is it your understanding that that identified a number of risks?

A It did.

Q Now, can we look at your statement, please, just to identify where you deal with this. It's paragraph 99, Professor Cuddihy. We don't need it up on the screen, Ms Ward.

And what you say there is that the 2015 report highlighted a raft of very concerning issues with water

management and bacterial control, resulting in a number of high risks being identified, including no formal management structure, written scheme or communication protocols; and filters having been bypassed introducing debris into the system.

Does that capture the main points that you have taken from this report?

A It does, sir, yes.

Q Yes. Now, if we leave for later what you say about the report being lost; if we leave for later the question of what you subsequently discovered had been done in relation to this report.

I wonder if we can just maybe interrogate a little further the summary of the concerns that you set out in paragraph 99.

I mean, I'm assuming -- and in due course we will come to the work that you did with the oversight board; and are we right in understanding that you are quite familiar with the material that we are presently speaking about; is that right?

A Yes, sir.

Q Through your work with the oversight board, you have had an opportunity to interrogate this report and indeed other reports in relation to the water system; is that right?

A I have, yes.

Q Just thinking about the 2015 report. Do you recall whether DMA Canyon said that they had been made aware of, quotes, "out of specification" microbiological results in the water supply?

A Yes, sir.

Q And who was it had made them aware of that, as far as you can recall?

A Estates staff.

Q And can you recall whether those results had been shared with DMA Canyon?

A From the report, the results had not been shared with DMA Canyon.

Q Now, as far as risk is concerned, are we right in understanding, in relation to the risks that you have mentioned, that DMA Canyon graded the risks in their report?

A They did with the RAG status: so red, amber, green, yes.

Q Now, the question of the design and the operation of the water system, did they indicate that they had some concerns?

A A number of concerns, yes.

Q Yes. In relation, for example, to the question of management which you touch on, did

they say what level of risk attended in relation to that?

A There was a high level of risk.

Q Do you recall whether they said anything about communication issues and, in particular, the effectiveness of communication between the contractor and NHS Greater Glasgow and Clyde?

A They concluded that there was a lack of communication between all the parties involved.

Q Yes. And can you recall whether they indicated that there were potential consequences from that?

A Yes. Because there was a lack of communication and a lack of exchange of information, that in itself presented a vulnerability over the management of those risks.

Q Just thinking about what you have said in paragraph 99 and the filters being bypassed. Can you recall whether they indicated that that breakdown of communication, as they saw it, might have potential implications for the bypassing of filters?

A It had significant implications to bypass the filter system.

Q And as you say in paragraph 99, was the issue that they

identified, in relation to the bypassing of filters, that it might permit, as it is described in your statement, debris into the system?

A Yes, debris and contaminants.

Q And just when you mention contaminants. Although, as you have said, this firm were specialists in Legionella and I think the report seemed to be principally about Legionella, were they considering bacterial risk as a generality?

A Absolutely.

Q Okay. Let's move into 2016, and at this point I assume you still have no particular need to be interested in events in the hospital; would that be fair?

A That would be fair, yes.

Q From what you now know, do you know whether, by 2016, the report that you have just been telling us about had been acted upon by NHS GGC?

A Despite repeated requests by microbiologists for access to that report and to any of the findings, it's never been shared.

Q Do you know when those repeated requests date from, even just roughly?

A From 2015; June 2015.

Q I mean, do you recall,

where you have very succinctly summarised the 2015 report; there were quite a large number of concerns raised?

A Yes.

Q And are we understand from your evidence that, from your researches, none of those had been attended to by 2016?

A Absolutely none of them.

Q Yes. Let's move into 2017. Are we right in understanding from your evidence, Professor Cuddihy, that your later researches would disclose that there was a further DMA Canyon report in 2017; is that right?

A That's correct.

Q Yes. And again, was that provided to NHS Greater Glasgow and Clyde?

A Directly to Mr Tommy Romeo, who was also an estates personnel.

Q And if you still have that section of your statement in front of you, Professor Cuddihy; do we see you, in paragraph 100, set out again a very succinct summary of what was being reported in 2017; is that right?

A That's correct.

Q And DMA Canyon provided a further report in 2017, and expressed significant concern that all

recommendations, including those high-risk recommendations from 2015, had never been implemented. Then you go on:

> "They further detailed concerns with regard to the filtration systems, bypassed due to issues with pumps and filter sets, which would introduce contamination, debris and (potentially bacteria) into the system. As the tanks had not been cleaned, even since recommendations in 2015 to do so, any material or contamination then present, could potentially have been flushed into the system and have colonised parts of the system. The report also made reference to positive tests for bacteria in 2017 indicating potential bacterial control issues."

And then again, there is a reference to the report being lost, something I will ask you about later.

But just ignoring that aspect for a minute. Again, you essentially summarise the main features of the 2017 report, as you saw it?

A I have, sir, yes.

Q Staying in 2017, did there come a point, in terms of what you learned later through your work at the oversight board, would there come

a point where you started to become aware about internal communications in 2017 and perhaps earlier among staff and about concerns around the sort of issues that were being raised in the DMA Canyon report; is that fair?

A That's correct.

Q Yes. I mean, for example, did you become aware at some stage of a document known as an SBAR, S-B-A-R?

A Yes.

Q That was prepared in late 2017?

A That's correct.

Q Can you tell us a bit about that, please?

A So an SBAR, as I understand it, is "situation, background, assessment and recommendations" and it's a process adopted by NHS GGC and others to outline a particular problem profile; and in this instance, in 2017, it was a collective effort on the part of a number of microbiologists employed within GGC expressing considerable concerns in relation to the broader environment, specifically in relation to water, air conditioning and a variety of other risks that they had identified.

Q Yes. How far back do you understand the concerns of those individuals to go?

A 2015.

Q Now, we will return later to the question of what, if anything, was done in 2017, in relation to the DMA Canyon concerns. But what's the overall position, in relation to that, as regards 2017?

A Again, they've done nothing, and that was also in the face of direct emails identifying bacteria from ward 2A from a microbiological perspective and a request for water samples to be taken. Nothing happened.

Q We will go towards the end of 2017 and into January 2018; and we get to the real reason or the principal reason that you have come to be sitting here today, and that is as the father of Molly Cuddihy. Would it be fair to say, Professor, that, as of January 2018, you knew none of what you have just told us about?

A That's correct.

Q Would it be fair to say that your only connection to the hospital in January 2018 was as Molly Cuddihy's father?

A Yes.

Q As we have with every other witness, Professor Cuddihy, I'm going to ask you to give us a bit of background. Tell us a bit about being Molly Cuddihy's father, just before she

became ill.

A Extremely proud; I just love her to bits. She's remarkable, inspiring, just a beautiful person; but she's also vulnerable. And she is an individual who has a moral compass that I have never experienced before. She is the single most inspiring person that I've ever met.

Q Now, Molly told us yesterday what her plans were in late 2017 and about her studies, about her ambitions and about how, initially having disavowed that she did anything else with her life, it was about piano and about singing and the guitar; and she also told us about how all of that changed, and she has given us a detailed account of all of that; about getting her diagnosis and about being ill. I'm not going to take you through all of that, Professor Cuddihy.

But I would ask you, as Molly's father, what your perspective was when you got the news that you got in January 2018.

A As a father and as any parent, your first duty is the protection of your child, to protect them from any threats that they may face in life; and you will do everything within your power to protect them.

When you're told that your daughter has contracted cancer you

feel, and I felt, totally impotent in relation to this. I could do nothing about it. I couldn't protect her. I couldn't prevent what had happened. You feel guilt, shame; you feel anger. And you look to place the most precious thing that you have into the trust of strangers. That's an extremely difficult thing to do for any parent; who would leave their child with a stranger, as something you would do?

But you don't have the skills, you don't have the knowledge, you don't have the experience or expertise in relation to how to deal with cancer; particularly when the emotion of it is your own child. You have to trust someone. You have to imply trust in someone, even when you don't know them.

And so again, you feel a sense of guilt that you are devolving the responsibility of the most precious thing to someone you don't know, and placing their life in the hands of people you have never met before. You are entrusting them to make the decisions, all to protect that most precious of things.

And it's your own vulnerabilities that are exposed. How do you manage this? And whilst you are dealing with it all, as a subject; and whilst Molly is a clever individual, astute, thinks and

reads a lot, if she has a discussion with you in relation to her illness, the type of illness it is, what do you say? How can you reassure, when you don't know the extent of the threat? The word "cancer" itself conjures up so many emotive things in your head, and even from my own experience of it, nothing, nothing prepares you if it's your son or daughter; nothing.

Q You have mentioned a few times in that answer, this question of putting your trust, as a parent, or trusting in strangers with your daughter.

Yesterday, Molly gave us a vivid picture of what the Schiehallion unit looked like and I'm not going to ask you to repeat the virtual tour, as it were.

One of the things she did was told us a bit about the people as well and that's what you've just touched on, and I think I want to maybe ask you a wee bit about that. When you are talking about this question of placing trust in strangers, just think about, first of all, the clinical staff then; and maybe describe to us your first impressions of the clinical staff on the ward?

A I remember at the outset, someone said to me, "John, when you embark on this journey, strangers will become friends and friends will

become strangers"; and those within the Schiehallion family became our critical friends. That's not because any of your friends leave you; it's simply because you do not wish to burden them with the trauma that you are -- because they don't deserve that.

The Schiehallion family, and whilst they are all human beings, every one of them a mother or a father, a brother, a sister, an aunt or an uncle, they have sufficient emotional empathy, skill and experience like no other. It's never a family that you want to be part of; I would never wish it on anybody. But when you become part of that family, they cover you with a love and kindness and support that, if it was a pill, you would have the ready-made cure to cancer. The strength of character that they show is remarkable.

This was a group of individuals who, at the very first point, communicated in a language that you recognised within ...

Simply, and the name of Schiehallion, it's named after a mountain range, it's about walking with you. And when you climb that mountain, and you will, they are there to support you. When it flattens out at points, they will walk beside you. However close you need them to be,

they will be there; never intruding in your privacy; but they'll always be standing by you.

Then when you go through the harder times of carrying you, they will carry you to the top.

And that's the journey and how they experience it. Every episode is almost taking you to a cliff edge and you are held over it.

And so I talk about getting good-bad news. It's never good news when your child has got cancer. It's only good-bad news. And you are held over the cliff edge till that good-bad news and you are taken back from it till the next time. And the staff there, whether it's a cleaner or whether it's a consultant, they have a respect for one another, a mutual respect for one another; and they see beyond those roles and responsibilities, those individual responsibilities, morphs into a collective responsibility, caters for your needs, whatever they may be. Whatever your needs are, they are there.

At times, if it was someone thinking about picking up something at the shops for you, they'll go to the end for you, regardless of what is going on in their lives; remember, this is over a two-year cycle. Some of these Schiehallion family members are

experiencing cancer of their own, they are experiencing all of the vulnerabilities that we have, within your marriage, with your child, how they are growing up, their own illnesses. They came in there, because it was their vocation; their vocation was there to support us. And never once did they let you down.

Q Sitting here today, Professor Cuddihy, saying all of that, recognising that probably you will spend most of your evidence today and perhaps tomorrow saying things that are not so complimentary about the hospital, does it trouble you at all to think about the people you have just described?

A I wake up every morning, thankful that Molly is here. I go to bed every night, fearful of what might happen. And I associate that, when I wake up in the morning and I see Molly, I see the Schiehallion family; that's why Molly is here.

I go to bed at night, nightmares about those within the corporate entity of the hospital. That's why I don't sleep with it; because I am mindful as well that sadly there will be other children and other families who will embark on this journey. We have a world class clinical team in the Schiehallion, world class, who have

saved many lives and they have allowed our children a quality of life. You can't forget that.

But at the same time, there are those within the hospital who have exposed and exploited that vulnerability through their failure to engage in their statutory duty to protect, particularly when they have had information that would enable them to more effectively protect our vulnerable children, and prevent them from experiencing the additional trauma that they have experienced.

Q Now, we will come to that in due course. Let's go back to where we were, the Schiehallion family and the clinical staff, in particular; and visit something you have just said. It is maybe wrong to single out an individual from that team, but you can probably imagine who I'm going to single out. Tell me about meeting Dr Sastry.

A A wonderful man. Any doubts I had about placing my faith, trust and honesty, it shows you at times that you have to trust someone, and I can never repay him, ever.

Q Can you remember where you were and what was said when you first met Dr Sastry?

A I first met him, it was -- Molly was -- we were in ward 2B and

we were in one of the private rooms and he came in. There's nothing to him. He's that height and not ... There's just nothing to him.

But what stands out is that he has such a huge talent. He comes in and he's so unassuming and that's what makes him stand out. And that's why I was intrigued by him. A very humble man, a very patient man, a very empathetic man. Even in that room, very polite, and he made his introductions; he spoke to Molly. That impressed me straight away, was that he had the presence of mind to speak to Molly. Molly would need that. He may not have known that, but his experience and expertise.

And so that journey when you are seeking to develop a relationship which ultimately builds trust, starting at that point. So his actions, his deeds, his words, is taking me on that journey of the relationship.

And as he explained to us where we were, very much in a language which understood how traumatic it would be for us, I'm quite sure he'd said it many times to many parents, and that in itself is a measure of the man, because the emotional baggage that must come with that, how many times do you tell a family that their child has cancer? That in itself must

carry a terrible, terrible heartache. But he still came in and he managed to use that knowledge, experience and expertise.

He also then took time away from it to phone me and he would give an undertaking to phone me before we went back to the hospital. But he would confirm what he thought in relation to Ewing's sarcoma, and in order to give me thinking time, he phoned me at home to tell me the full diagnosis, and more importantly says "We are treating to cure"; treating to cure.

So to have the presence of mind to take time out and consider me, it's not about me, it's about Molly, it enabled me then to prepare myself and ███ to support Molly. And he took the time to do that. That's the measure of the man, and also a measure of the doctor.

Q I think you set that all out in your statement, at paragraphs 36 to 38, for those who wish the reference. I'm not going to take you to it just now, Professor.

I think you indicate really from the start, then, you trusted this man; is that right?

A Oh, I was developing a relationship with him. He still had to prove himself.

Q That is what I was going to ask you about. That is really why, in a sense, I am using Dr Sastry just as an example of something. What would you say the components of trust are?

A There's a number of components within this, for me.

First and foremost, humility; to have the humility to say when you don't know something. To have the leadership, experience and expertise to reach beyond their own knowledge and ingest that knowledge, in order to cater for the needs of your patient. Trust, and other components within it; it's not only humility and leadership, but honesty, transparency, integrity, all key tenets. That is not to say that I would always agree, but whenever Dr Sastry would speak to you, it was from an informed position and one that he could defend, his reasoned argument. And so for me, he represented the key components in relation to trust.

Q Yes. And presumably there are a number of strands to this. Presumably there is a kind of inbuilt inherent trust when you are in this impressive looking unit and you meet this humble but impressive person. Presumably there is that sort of inherent willingness to trust. Would that be fair?

A Absolutely. You would

like to think that he wouldn't be there if he wasn't good at what he did.

Q Yes. I mean, similarly to us getting on a plane; you would trust the pilot?

A Exactly, and dependent on the carrier, trust them even more, because you knew they would have a level of training and expertise to fly that plane.

Q And something that I think we have picked up on yesterday a fair bit and we will pick up possibly in your statement as well, is having protocols and plans, having rules; is that something that was important to you in cementing and building trust?

A Absolutely. But within those plans and those frameworks, sufficient flexibility that would enable you to respond to any emerging needs within that; so not to be so rigid, because the world of cancer in relation to children has many twists and turns. So whilst the policies, the protocols and procedures are there and should be there, they also have to have the flexibility within them to cater for those emerging needs.

Q Yes. I mean, I'm looking at what you say at paragraph 42 at this point, and you have captured a number of points there. You found the processes and protocols to be clear

and understandable, if not daunting. There was quite a big information dump at the start of all of this?

A Yes. Just, it's a tsunami of information; and because everyone is trying to do their best for you, and I liken it only to -- a number of years ago there used to be an advert on the television and it was someone with hypothermia wandering through. That is what it felt like. You are wandering through and people are talking to you. You know they are saying something; you have no idea what they are saying. You are listening but you are not hearing, seeing, or you are watching but you are not seeing. And that's what it's like. You have to then go back and gather your thoughts and read again, read again. But they were cognisant of that and they knew that they would provide you with information, but they would always seek the reassurance from you that you knew and understood what was expected of you.

Q It's pretty clear from what you're saying that communication was a vital, perhaps the most vital, aspect of cementing and building trust. And I guess you would probably accept that there are strands to that, too. When we think about communication, there's the question of what you needed to

know, the question of when you needed to know it, and there's the question of how it should be communicated. Do you agree with that as a general proposition?

A Absolutely.

Q Yes. As regards what you or Molly or ███, or indeed anybody on that ward, as regards what they needed to know at the start of the journey, what would that be?

A What we needed to do to help Molly. Even what shouldn't we do in relation to helping Molly. That's it. Everything was Molly.

Q And you speak, it's at paragraph 60 of your statement, Professor Cuddihy, you talk about really the process of preparing for treatment. I'm quite interested in what you say about that at paragraph 60. It's really towards the end. You say:

> "During these early days, everything appeared 'major', however staff and indeed other families [and I will come to the other families] enabled understanding of 'major' in the context of child cancer and as such I was better equipped to manage each developing episode."

It's a learning curve, self-evidently?

A Absolutely.

Q And I mean, I take it, at the start, everything just looks scary and horrible; but are you indicating there that actually as you go on and through communication, you begin to be able to distinguish between the "major" in the eyes of a concerned parent, and "major" in the eyes of a clinician?

A Absolutely.

Q And presumably that's of some assistance in proceeding with this journey?

A It gives you some perspective and your risk threshold changes throughout.

Q I mean, to take one aspect that would become a regular feature of Molly's treatment, and I think a regular feature of everybody who we have heard evidence about so far: temperature spikes. It's obvious from all of the evidence we have heard, including yesterday, those were concerning episodes; but again, there was a protocol and there was advice and you were told what you had to do. Did that help?

A Absolutely; and if you adhered to that protocol, you soon became socialised to wards, that protocol.

Q And then just moving on

to think about, not what is communicated, but how it's communicated. You have already dealt, Professor, with Dr Sastry. In terms of how the staff generally communicated with you as a person, a parent, how would you sum it up?

A Each of the staff members within that unit knew exactly what their role was. They took the time to know and understand, in general terms, what the prognosis was. They knew when to come in with a cup of tea, which in itself was communication, to say that they are thinking about you, caring about you. When the nurses came in, they knew and understood what the doctor had required and so that gave you a confidence that there was a continuity in a decision that was made; the actions were carried out.

But within that, everyone took time to let you know that there was a world outside and you would talk about the future, you would talk about everything and anything, and it enabled you to then start to accept a lot of the major issues or the major aspects of treatment; it's just another day. It's not to play it down, but you needed that for your own head, you needed that for the space that you were in, in order to function properly.

So each of those members of staff played their part in that, because they took the time to gather the information in relation to you and catered for your needs.

Q Yes. And as regards Molly, we heard a bit about this yesterday, but we obviously picked up really quickly on the fact that this is somebody who likes information, she likes to know?

A Yes.

Q And that connected to her ambition. And I suppose, I mean, you say this, it's at paragraph 55 of your statement, Professor Cuddihy; was there an element where you also welcomed information, because if you could better understand, you could better support?

A Absolutely. As I said at the start, when you asked me to describe Molly, Molly is still a vulnerable child and your duty is to be there to protect, and protect is also to have a calming word, to be able to communicate about that which is ongoing, because I know at times Molly will say differently but you like to think as a father that you know better, or at least you know something that can contribute to the discussion. And quite often, Molly would know if I didn't know and understand that which was

happening, so that helped us to get through it.

Q Yes. I mean, you say that at paragraph 56. You say:

"To reassure her that everything would be alright whilst in truth I had no idea. Molly knew this and actually protected me more than I her."

A Absolutely.

Q Now, it's wrong to single out individuals, but another individual that you single out among the staff is Angela, the day care manager?

A Yes.

Q Can you tell us a bit about her?

A Angela Howat. She is a band 7 nurse and, again, when you saw Angela coming towards you, you were just thankful. You could see it, that there was someone who knew intimately, intimately Molly's case, as she did with every child; absolutely. How she did it. It was -- I would operate with Molly with a risk radius, without amending it. I knew what I had to do with Molly.

That risk radius almost, you would change when you saw the likes of Angela coming into it, because you knew that she could influence, you knew that she had a level of knowledge, experience and calmness.

She's going to sort this. And the staff loved her; and that's about respect, that's about leadership, that's about her having all the values that they trusted her. Everything I have said with Dr Sastry, she possessed all of that, and some as well; but never once, never once let anybody down, would mentor people; had a real calm and influence, even in the most dreadful set of circumstances. She is just an amazing person.

Q I mean, this may be one final thought about the clinical staff, as you have identified yourself and as we all saw yesterday. Molly is a pretty unusual person, and not everybody on that ward would have arrived with the skills she's got. Are you able to say, from where you were, the extent to which the staff were able to calibrate their communication with people?

A 100%, as -- it would be wrong for me to single out, because whenever I talk about any one individual, please, that's times 75, every single one of them.

[redacted], who was one of the auxiliaries, was just an incredible character, incredible; and she would talk to Molly about these various, these programmes on, Love Island and, you name it, whatever. And they would communicate in a way that would take

-- she knew to take Molly's mind away from, because whilst Molly has a thirst for information, sometimes she needs a wee break from it. And ██ and others would all come in and they would be able to communicate with Molly in relation to anything and everything; again cater for Molly's needs. And they were just -- they were just marvellous.

And there was a time when -- I was born and bred in Pollok, when the ice cream vans used to come around, and ██ would talk about having the "oot to the van slippers. Molly had no idea what the "oot to the van" slippers were. So they would talk about these things, and it was just fantastic. It just allowed Molly to get involved in all aspects of knowing and understanding the people that she was interacting with; and it was a lovely thing to see.

And that is when I say to you about: strangers become friends. You talk about things that you wouldn't talk about ordinarily and they allow you into their household, if you like. They laugh with you. They enjoy a story with you; and they deserve to cry with you. But they are a group of people, they don't ask for your thanks, never want your thanks, but deserving of your thanks, absolutely.

Q And was it your

expectation, indeed was it your understanding, that that level of communication would be going on all across the ward, and even with people who did not have the ability that Molly had to understand all the medical terms, etc.?

A Everybody knew Molly. Everyone would come into the room and talk with her. It was great for her, fantastic for her.

Q Just thinking then about other people, non-clinical people on the ward, so patients and their family members. That became an important part of your experience as well; is that right?

A Yes, absolutely.

Q Molly told us a bit about the importance of the facilities in relation to that, and she obviously mentioned the Teenage Cancer Trust room in that context; and we don't need to go over it again. I'm guessing you would endorse everything she said about that room; is that right?

A Yes, absolutely.

Q I think in your statement, paragraph 52, if anyone does want the reference on this, I think you say that that room gave Molly two gifts. What were they?

A It gave her the table where she continued with her

education and it gave her ██; and, by extension, ██'s dad Ronnie, and her mum, and indeed her brother; as a family unit, it was remarkably similar to her own.

And when, I mean, Molly would talk about things with ██ that they didn't want to speak to their parents with. The same applied.

And so when we talk about communications, it's non-verbal communication, and I walked into the TCT room for the first time, Ronnie saw me and he knew immediately that I was new, this was a new parent, and he introduced himself, and he was going through a terrible time with ██ and through a traumatic time. He took the time to come and introduce himself. He put that metaphorical cover over you. And we developed a friendship which fostered into something very, very close. And the same applies with ██ and ██.

And it's something that others can talk about that they don't talk with their husband, and fathers can do likewise. So this room became far more than just about the Teenage Cancer Trust room. This was a room that supported the needs of the family unit. This was a room that enabled us to inform ourselves. Someone had been further in the journey and they

could tell about an MRI, they could tell you about a particular drug, they could tell you about the side effects. They could tell you about the trauma that's coming in. And you didn't feel that you were burdening one another, because we had experienced it. So that is why I say they became critical friends, because without them, I don't know how I would have got through that.

And when I look at what they were going through themselves, to take time for us, that's why you will find each of us parents will then do the same for someone else. It's not something you want to do; it's what you need to do, because you are there.

And so the room became a focal point individually and collectively where we would sit and we would talk about everything and anything, and the staff and everybody would interact and interface in a way that would allow you for a moment, just a moment, to forget.

Q Thank you. Let's move on with Molly's story. Go past her first cycle in January 2018 and let's think about February and March, the second and third cycles. I will focus for the minute just on Molly's story.

I mean, again, I will try to avoid going over evidence that we went over yesterday. I think Molly described to

us, and you do so too in your statement at paragraph 61, that this is where you start to become aware of this thing called mucositis.

And I think you then go on to tell us about another thing that you learned, and that was in relation to the admission to ward 3A; you discovered that these protocols that were so important on the Schiehallion unit, they wouldn't be going with you to 3A; would that be right?

A Yes.

Q And similarly, the kit that would be an aspect of those protocols, in particular, administering the -- the taking of temperatures, that wouldn't be there either?

A Yes.

Q Yes. So it illustrates really what you said a moment ago, that there's a learning curve here; is that right?

A Yes, absolutely.

Q And I think we can see from your statement that, in March, Molly goes back to ward 2A and then she goes to the cardiology on 1E, and I think the way you put it is that the protocols there are not so different; but there's obviously a different focus and a different training, but there is still that element of concern; is that right?

A Absolutely, yes.

Q And at paragraph 65, if we can look at that, I think it's paragraph 65, yes. Towards the end of paragraph 65, you say that, by this stage, you are starting to think about something called "business continuity". What do you mean by that?

A Business continuity, in relation to my previous background, was so important for us. Whenever a crisis developed and resource would move towards the crisis, I would be dealing with the business as usual. So we had to ensure that there were sufficient contingencies in place that would enable us to have that business continuity. If there was a power outage, where would you go? If there was a flood or a fire, what would happen? And so these plans had to be in place and they were owned by invariably the leader of the department and those action plans would be outlined. But if the need arose, we already had a plan in place that would allow us to then continue with business and that there would be a continuity within that business.

Q Yes. We will come on to look at that question a little further. Are we right in understanding, at this stage, you are starting to think about that question? You are seeing Molly being moved away from the business

that you would usually be subject to, and you are wondering: what is the contingency here for ensuring that all of that continues and goes with her; is that what it comes to?

A Absolutely. It was about capacity and so when there was no beds, what would happen? It couldn't be left to chance, particularly for critically ill children. You have to deal with it and risk manage it of course, but there has to be a plan in place that you know where these critically ill children will be displaced to.

Q Yes. I think we can see from your statement, Professor Cuddihy, it's paragraph 68, just to orientate you, that we are now in March 2018, as I said, and just summarizing: would it be fair to say that you are starting to see the impact of the treatment building up?

A Dr Sastry again, and one of the times that he spoke to us separately from Molly, had said that when you go through this journey and you'll see that Molly is here to be treated and to be cured; but the treatment plan, you will see having a detrimental impact on Molly. There will be visible signs that will shock you. There will be visible signs that you will wonder: how can this be a help? She walked into the hospital, and now she

is in a wheelchair. She had a full head of hair, she's bald. She didn't have all of these terrible burns from her mouth, all internally. This is treatment to help her. It's hard to reconcile that in your head.

But what was important was to have that information beforehand. I mean, many people, and everyone has been touched by cancer, everyone in this room will have been touched by it, but did they ever actually listen to it? Because again, as I have said, no one wants to tell you about the intimacy of it, because you don't want to burden someone.

But he actually started to take us through a journey and to really focus what this would do to the most precious of things. You saw in front of you, he deconstructed. Everything about her was just -- she was just losing so many things. But this was to help her.

If he hadn't warned us of that and told us "the plan is", and said to us before, tell it -- back on Schiehallion, we are going to take some dips before we go for the next hike up, the next 200 metres; "You need to know this, otherwise you will never make it up the next 200".

And so it was important to have that information as we went through

and that's where I started to see; and kids are cruel to one another. They perhaps don't mean it, some of them; they can be. And body image, boys and girls, but particularly girls, a dreadful thing.

And when you see that and those visible signs of your illness, the stigma which is associated with it, you wouldn't imagine it, but there is cruelty with it. And even if you don't see, if you see there is a world that -- people are staring and looking, inwardly I know how Molly would feel, because you automatically feel it yourself.

So when you see all of these things, you are wondering: what can we do? Molly can get a wig, put her make-up on, even the wheelchair. You are thinking about all these things that will mitigate against the impact. You are looking to have a plan in place that will, in some way, mitigate the harm to the most precious of things.

Q Thank you. Just thinking about the first part of what you said there, and I'm going to back to what Dr Sastry had warned you about. Essentially he was saying: expect to see something that looks like deterioration?

A (Nods).

Q I mean, just at a high level, and we will come to look at Molly's infection incidents later. If you are being warned that you should expect to see something that looks like deterioration and that's normal, does that make it more difficult to distinguish between the normal and the abnormal, when she has an incident that's not part of the plan?

A Absolutely, bearing ...

Things happen in life that are never part of your plan life. Molly getting cancer was not part of the plan.

But there has to be contingencies in place and, of course, that's why we have hospitals, because people become ill. And so our infrastructure is catered around those contingencies for what might happen.

And even though it was the most terrible of news, as I said to you, it would be either bad-bad news or good-bad news, it enabled you to play your part; it gave you information that allowed you to make an informed decision about the most precious of things. That's what's important. Even if you couldn't do anything, you would need to know that.

Q Now, just one final aspect of planning at this stage, which Molly mentioned yesterday and you mention in your statement, and it would prove to be a godsend, was the harvesting of stem cells. That takes

place, I think, in March as well; is that right?

A Yes.

Q Okay. Let's pause the story of Molly at this point and go back to the story of the hospital. That's now a part of your story as well, of course.

Can you recall, just at a general level, Professor Cuddihy, can you recall what awareness you had by March as regards issues to do with the hospital environment, or would your knowledge come a little later, once you actually saw the impact upon Molly, or was it somewhere between those two?

A That would be somewhere between both, in that there was an awareness that there was issues in relation to the water ongoing in March. That depth of knowledge didn't come until shortly afterward.

Q That is helpful. Would you therefore tell us whether, as at March 2018, that awareness was only an awareness or whether it was something that had become a concern for you, I mean?

A It became a concern more generally when it reached Parliament and there was discussions within Scottish Parliament around the concerns about the hospital and, in particular, the water. So this risk radius that I talk about, this was now

more specifically involving Molly. And up until then, I'm so focused on what's happening with Molly and becoming socialised with what's ongoing, and you are seeking to manage and to protect everything, this was something else. So what did this mean for Molly? Molly is in this hospital that is being discussed in Scottish Parliament. What did this mean for my daughter?

Q Yes. So you mention the discussions in Parliament. I think we know they were on 20 March 2018. You mention them at a couple of points in your statement; for example at paragraph 253, if anybody wishes the reference. We don't need to go it just now, I don't think.

And I think you tell us that the then Cabinet Secretary for Health and Sport, who was Shona Robison at the time, was required to answer some questions about the hospital in Parliament. I think this was to do with an incident, as I think she described it, in which bacteria had been discovered in the water; is that right?

A That's right.

Q Can you recall what she said, just roughly?

A It was specifically in relation to -- I would take this as "the water incident" and the increase in bacterial infections on ward 2A. And

the questions that were posed, or there was a number of questions posed from a variety of opposition MSPs; but principally it was around the safety of the environment in which critically ill children were, and could the then Health Secretary give an assurance that the environment was safe; and more importantly, was the water safe? And she stated at the time, she had been given assurances by GGC that, yes, the water was safe and indeed the water would be switched back on within 48 hours.

Q I think she said: no patient was giving any cause for concern as a result of bacterial infections associated with this incident. Is that your recollection?

A That's correct.

Q I mean, just pausing there. Did you then have any concerns about the assurance that was given by the Cabinet Secretary?

A I took it at face value at the time, because again, it's balanced on the information that she would have that would allow her to make an informed decision; and I wouldn't expect that she's going to misinform Parliament in relation to her knowledge at that time.

Q And as regards the position of GGC, if you go to

paragraph 323 of your statement, page 88 if you have the same copy that I have, there's the comment that you made about the reference to everything going back to normal within 48 hours. Is that the reference there?

A Yes.

Q And was that something that appeared in the media, as you indicate there?

A That's correct, yes.

Q Yes. And was it sorted out within 48 hours?

A No.

Q Molly has described to us that there was bottled water being used, I think, in February. Did that go away within 48 hours?

A No.

Q Did the filters come off?

A No.

Q And I think you indicate in your statement, Professor Cuddihy, and it's paragraph 237 for anybody who wishes the reference, and by all means have a look yourself, but you indicate, I think, at this point; is that when you start to see what you describe as really a divergence between the messaging and what you were actually seeing?

A What I was hearing did not correlate with what I was seeing, definitely not.

Q And going back to my initial question about this matter when I was asking you about: are we at awareness here or are we at full-on concern here? You mentioned risk radius. Would it be fair to say that this is now something that is a concern; it is potentially in the risk radius for you now, is it?

A Absolutely.

Q Can I just ask you something I forgot to ask you about a little while ago about risk radius, going all the way back to the protocols that you were given at the outset; and one of those, I think, was about the importance of infection control. Paragraph 43 of Professor Cuddihy's statement, for anybody who wishes that reference.

And the reason I ask, you mentioned a risk radius, and it reminds me of it. What lengths did you and your family go to, to ensure that Molly was protected from the environment around her?

A I am sure my wife won't mind me saying this, but my wife is a clean freak. Bleach is her friend. That's how you know when you're approaching her. So cleanliness is something that's there.

This was taking us into a whole new environment, and I think this is

important to say: that within one of the more lucid moments, I remember sitting down with the outreach nurse, it wasn't to be our dedicated outreach nurse, it was someone else who was filling in, due to capacity issues. She gave us a booklet. And when we were talking about infection, she left us in no doubt, no doubt that infection was a significant threat; that within this treatment plan and as Dr Sastry had said we would see certain physical changes, there would be other things that we wouldn't see threaten Molly: bacteria, you see it readily.

And so they encourage you to ensure that the environment that you're in, and we all hear about Covid and about FACT and all of the "creating a bubble". We were doing all of that and more then.

Two wee dogs. Our wee dog would get HEPA scrubbed every weekend; yes, to clean this dog and girl.

And everything about our house was geared around Molly. This risk radius; this is where Molly would be. And we would ensure that everything, everything would be in place for Molly. We were very fortunate enough that Molly had her own toilet, her own bathroom. No one else would go anywhere near that. Anyone coming

to our house, if indeed we allowed them in; because that's the thing, the terrible thing. You keep people away. Allowing them in, you came under the condition: Molly requires this, that. If anybody has even the slightest cold, if there's anything wrong with you, please do not come near. We understand your kindness and your support, stay away.

And at the times, even if we would go anywhere, ██ would have cutlery in a bag that Molly could use, because we knew how they were cleaned. We knew all of these things. In our home, it was all of the -- our towels, we used all the hand towels. They were all replaced, everywhere you go; and all of the bottles in place.

Visible demonstration; that will be the compass of our home. It was as sterile as we could have it. And indeed anywhere you would go in the car, or anything with Molly, that would be the risk radius, the bubble that she was in. Because why would you risk anything with the most precious thing to you? You wouldn't do it, absolutely.

And someone is warning you, someone is providing you with information that enables you to play your part to protect, and that is what we did. We did everything in our power to protect Molly, based on the

information that was provided. That's how we functioned, how we would live our life. And there was no price to pay, no price to pay, because Molly is there. It's no price at all. If I don't see another person till the day I die, it is the price to pay, because I will see Molly. That's it.

Q Let's go back into Molly's story, then. Let's go back to the story of her treatment and we are into the fourth cycle in April 2018; and it was obvious yesterday from Molly's evidence that the treatment really was beginning to take its toll now. Would that be fair?

A (Nods).

Q I mean, the music had stopped. She wasn't doing the piano and guitar anymore. I mean, it must have been pretty tough on you and your wife?

A It wasn't nice but, as I say, that's the price you have to pay; and if the price is that Molly stops playing the piano or doesn't play the guitar, it's a challenge, it's difficult, but she can always play a record. She can listen to them. We have got enough tapes and memories in relation to that. It's difficult, it's challenging.

As I say, this is when your risk threshold, when your appetite for such things changes. You will accept

certain things, because you know the price you have to pay. But it's a traumatic thing to see.

But it pales into -- because it's not about me or my wife or my son. Whilst it impacts on all of us, and particularly my son who, it's been extremely difficult for him; it is about Molly, it is not about us. Everything in this has to be about the patient, has to be about these children and that's the focus of this. All of this is about people, vulnerable, critically ill children who need our support, who need our protection. They can't do it themselves. That's why we are here. Our legacy is our children. That's what it's about and that should be our focus.

Q One thing that very clearly wasn't diminished in April was Molly's determination and, as we heard yesterday, she continued with her studies and her exams, her Nat 5 Spanish on 30 April, the day before she went back into 2A. How did you feel about the fight your daughter was showing?

A It's something that I have -- and anybody listening may think: what a terrible parent; how could you stand by and see your daughter put herself through exams while she's so ill? That's something that both ███ and I have challenged ourselves on.

But this is needed. Molly needed the focus. Molly needed a future. If we were not to support her, we would be saying: there is no future. Molly is going to become a doctor; Molly will become a doctor. And so her gateway there was her exams.

And her school, I have to say, her school was fantastic, absolutely incredible; people from the day whenever I went to speak to them, they could not do enough; because again, they put Molly demonstrably at the centre of the decisions, as they would do with all of the pupils. That's why it's such a fantastic school, █████ , fantastic school. They are a beacon for any other schoolchildren, particularly children who have been in hospital. And they catered for Molly's needs in a way that I very rarely can speak, or her English is more able to say than me. They can support her in French and Spanish and all of her sciences. I don't have anything like that. I have a level woodwork. And so they were there to support her and with all her needs.

And whilst we watched her at times and we could see it, you think: is this cruel? And at times, yeah, you are watching it, and there was that.

But even more cruel is a father who doesn't support her future, her

ambition, her desire. You cannot take that away at all and, as Molly will always say, the illness will not define her; in a way -- and you have seen her, you have heard her. She is a determined young lady. And she needed to get those grades in her head, because that would be the normal, that was her plan. They would give her the vision, they would take her through her illness, and it would allow her to be the person that she wants to be.

Q Thank you. Let's move on a bit with the story, then. We are back into the Schiehallion unit at the beginning of May, as we know. More treatment, more impact. We can see from your statement that her mobility is pretty badly affected by now; is that right?

A (Nods).

Q More exams?

A (Nods).

Q And then discharged home. And then she's back on 9 May with a temperature; is that right?

A (Nods).

Q A prolonged temperature that the team is unable to identify the cause of; is that right?

A Yes.

Q By "prolonged", that would mean more than 48 hours,

presumably?

A Yes.

Q Any alarm bells ringing for you at that point?

A From everything that we had been told, the temperature is an indicator of effect. One of those indicators of effect is that something is now wrong, her body is reacting to something, whatever it is, but something was wrong. And not only did we know that, because of the education that we'd been given within the hospital, the staff knew that. And whilst they couldn't see exactly what it is, they knew and understood enough that there was something going on and we have to find out more and respond to it.

Q Yes, yes. I think we can see from your statement that despite the unresolved question about the cause of the temperature, on 22 May, Molly started, I think it was cycle 6; and it was completed without incident. She goes home on 26 May.

Now, Professor Cuddihy, at paragraph 78 of your statement, you then set out what happened on 31 May; and I wonder if you just want to tell us a bit about that.

A So it was a time when Molly's temperature was high and, as the protocol dictates, everything was in

place and we'd gone to ward 2B. And you go in as normal and they would take you into the room and they knew Molly was coming, so there is no surprise for them; they are ready. And my son was with us. He had just come home from France at that time.

And obviously -- so they charged the line. When I say "charged the line", it means charging the line to administer. And there was an immediate reaction to it; and again, as I understand it, this tells them that the infection could be within the line and what have you.

And Molly just was uncontrollably rigoring. It was a dreadful thing to see. And again, when you go through this, and as I said previously about how you then start to socialise yourself with levels of rigoring; and this was off the charts, this was just -- she was just uncontrollable. Her face, her body was just ... but you have no idea what's happening. You just don't. And again, this is -- they are here to help her, but whatever they are doing, it's -- and everyone was trying to get fluids into Molly, and they were unable to, because they can't use the line. They've got to use cannulas. Her wee body is already shot to bits. So it's a challenge for them.

This isn't -- as I said, my son was there and he's assisting. We are all helping, we are opening up syringes, syringe after syringe with fluid, which they can send into Molly. ███ is doing it, as though: "I just need to help my sister".

And you just think that: we're going to lose her. That's the margins, that's the margins of infection. As quick as that. That's why the protocols of the hour, and the timing that you get in, and they have this because they have learned from experience and they know when you are in that environment, what they need to do. So many fluids went into Molly. Thankfully, thank God that they managed to stabilise her.

But when you go through it and all you are doing again is you -- you can't -- this duty of a parent to protect her, what can you do? Your life, Molly's life is in their hands, the most precious of things is in their hands; and you are watching this most precious of things just slip away. But those remarkable people in the Schiehallion unit had our back, they saved her life.

Q Yes. I mean, going back to something I didn't ask you about at the very start, of your experience of meeting those people. You talk about the way they carry themselves, their

confidence. On that occasion, what was the body language and the mood music in the room?

A They were concerned. Whilst they knew and they had been through this and they could see each other, they all knew what they were doing, even the nurse who was very close to Molly, she was supposed to go off her shift, and you think that she's there and she's trying to do what she can do for Molly and they are all there.

Still, in amongst the madness, there were those who were there, who were within Angela Howat's team and the control, they knew what they were doing. But you knew within that, this was -- they were at the threshold of their abilities, and I mean that in no way to be critical, because they just didn't know. They just didn't know.

But I could see from their demeanour and how they are -- and that is when I say that communication is not just about the written or the spoken word. When you watch what's happening and you see the reactions of people, you can gauge from those reactions how they are feeling; and they were in a fight. They were in a fight. Thankfully they won it.

Q I just want to ask you a couple of questions about a few

aspects of what you describe in that paragraph. Molly yesterday told us a bit more about rigoring, but it's something we have heard a lot about; and she described at yesterday as being like, I think she said it was like a conscious fit. I mean, I take it, that's something that you would agree with, in terms of a description of what you saw?

A Yes. It's -- she is totally aware of what she's going through, and that's the -- you see her looking at you. She's wondering what's happening. Everything I'm seeing, Molly is seeing. And she can't control. This is an important thing, this is about exercising control. Not only could Molly not control her own body, she can't control the abilities of those people around her, as much as at times she would love to; she can't. So you trust their ability to deal with it. And she's watching all of this playing out and that's why I say you're taken to the edge of a cliff. She must be thinking: I'm not coming back from this.

And that in itself, that trauma, how many times can you go through that, that you think: my luck is going to be up. How many times can they bring me back?

But also you then say: why am I being put in this position? And at that

point, we had no idea what was happening to Molly; no one did. And everyone dealt with Molly in relation to their protocols, their training, their experience; and even if you don't know the cause, you still know and understand what you have to do to mitigate the immediacy of what's happening; and that's what they did.

Q Yes, and they got her stabilised?

A Yes.

MR DUNCAN: Yes. Well, I wonder if we should maybe just pause there and, maybe after the break, my Lord, we can talk about the cause of what happened on this occasion?

THE CHAIR: Right. As I said, we usually take a coffee break at about this time. I make it just before 25 to 12, so can you be back at five to 12? We will rise until five to 12.

11:35

(A short break)

11:58

THE CHAIR: Mr Duncan?

MR DUNCAN: Professor Cuddihy, if I can take you back to where we were. You've described the events at the end of May, and at the beginning of June.

And moving on slightly from

there, we were just about to look at the question of what it was that had caused this incident and I think, as Molly told us yesterday, you came to learn that she had an infection, a line infection from an organism I think known as mycobacterium chelonae; is that right?

A That's correct, sir.

Q Now, just for everybody, just to orientate us. I think we are round about paragraph 79 of your statement, Professor Cuddihy. And really what I was just wanting to get from you was sort of, the: who, when, what questions. Who told you, when was it and what did they say?

A The first communication in relation to the bacteria was Dr Sastry; and he said that it was a consequence of the cultures; having been further examined, that the bacteria, which is mycobacterium chelonae, was identified.

And he said, straight off, that he knew very little about this bacteria, because it was a rare pathogen. In his experience, he had not come across it; and that he has been involved in this type of work for some 20 years. He was honest enough to say that, as far as he was aware, that it was -- it could be contracted as a consequence of the environment. But again, his

knowledge was such that he couldn't give us anything further.

As you would imagine, your first -- certainly my first thought is that: okay, this is what we have to deal with. What does it mean for Molly? What does it mean, in relation to her treatment? First and foremost, because the whole thing is about the cancer, so what does it mean for cancer? What does it mean for her treatment plan?

And then what is mycobacterium chelonae; what is it? What does it mean? So there was two parts to that.

And he gave us as much information as he could, which was very little, to be perfectly honest.

And so I had asked if I could speak to one of the microbiologists and Dr Teresa Inkster met with us, met with myself and ███, and to again try and understand what this is, how did it happen, and any information at all that could be provided to us. And she met us, along with the ward sister for 2A at that time.

And so we went into the discussion. Simply again, it was reinforced that this was a rare bacteria; and their knowledge set in relation to it, there was not much known about it. I think it was at that point, actually, that reference was made to Edinburgh and

I believe Professor Lawrence is the gentleman that has the greatest level of knowledge in relation to mycobacterium chelonae. And as a consequence, that they would have to then go and speak and take guidance.

And generally, we asked about: how has Molly contracted this? And it was really unknown at that time that it was an environmental-type bacteria. And it was suspected that it was related to the water or it could be air.

And I remember it was -- when water was mentioned, ███'s immediate thing, that took her back to her influence, sphere of influence, was our home. Should we have Scottish Water attend our home and have it -- and we were told: no, there was no need for that.

And so the discussion side developed, but it was really just trying to find out where we are, what this was, what was the -- what would be the impact and implications for Molly. We really didn't know, other than that it would deviate away from that plan for her treatment in relation to the cancer.

We asked and reflected on the environment that we were in, and the reporting that was ongoing.

The cleaning regime that was developing at that time, because at that time the HPV, hydrogen peroxide

vapour cleaning process was in play, and I questioned: why was that not in play in March? My thinking is: if we knew in March that there was a problem with the water, and this was seen to be a solution here in June, well, why didn't we do it in March? And as I understand it, it was a consequence, it was not a recognised process, it was a consequence of research conducted by Dr Inkster in relation to this, that brought this process to the table. So it was going outwith the normal guidance and protocol, back to this piece about flexibility.

And as a consequence, HPV was then -- then I challenged it at the time, it was emotional. And some of the language and some of the answers that I was given, it was that it was a costly process and my answer at that time was: how much do you place on the life of a child?

And it was quite an emotive exchange and, on reflection, and I have come to have many interactions with Dr Inkster, it was a comment that was made at the time and I don't think that there was anything in it, other than that it was just that exchange.

But we were provided with information that was known at the time, which was very, very little. This

was a rare pathogen that was associated with the environment.

Q So I think I will take, really, two strands from your discussions at that time. Strand number 1 and your primary concern: what does this mean for Molly, going forward? And am I right in understanding, from what Molly said yesterday and from your statement, effectively, even on that, Dr Sastry says: "I don't know, but immediately we will be stopping treatment and the line will have to come out and we will come up with a plan". Was that the kind of position at the beginning of it?

A Yes, sir, exactly.

Q And Molly should have been having her operation by this stage?

A Yes.

Q Yes. And something that came over very strongly yesterday, and you have indicated today, Dr Sastry, straight out of the blocks, says he doesn't know much about this organism and this infection; is that right?

A Absolutely; and there was a further really important point about this, and individuals at that time were fixated on numbers: the quantitative aspect of bacteria. But what Dr Sastry, and indeed Dr Inkster

were saying to me: this was about the qualitative aspect. Forgive me, but this was about the nature of the bacteria, it's very rare. So it's not just about numbers of bacteria; why were we having these rare types of bacteria not seen before within this environment?

Q And just on that point. I think we can see from your statement that what was indicated to you at that stage, at least, was: we have only seen this on four occasions across the whole of GGC; is that right?

A Absolutely, and that is something that was a repeat narrative throughout all of my dealings; that Greater Glasgow and Clyde, in the last ten years, had only experienced four cases of mycobacterium chelonae, none of which were within paediatrics, and all were confined to the adult population. And I know specifically in relation to that, because I posed written questions asking: can you tell me if any of them related to this hospital and what did you do about it?

Q We will come back to that.

A Okay.

Q And that's really taken us into that second strand then, which is the: what is this, how did it happen? All of those kinds of questions. And I think you described your meeting with Dr Inkster at that time. I think it's at paragraph 334 of your statement. Maybe you could just confirm that for us, if you could just have a quick look at it, and just to give everybody the references.

A Yes.

Q Yes. And I mean, really just to paraphrase what you say. Were your concerns allayed by what Dr Inkster told you at this stage?

A Not at all. Not at all.

Q Yes.

A I was even more concerned. The reason why I was even more concerned was primarily the focus on Molly, because if no one knew what this was, how we were going to treat it. How were we going to protect Molly?

So everything around this was, for me, to learn as much as I could about this rare pathogen, back to this understanding of the threat, and that would then perhaps enable us to manage and mitigate that threat far more effectively if we could understand it better. That was my concern.

Q If we go back to what you were said earlier about what you knew in January, which was about the hospital, which was essentially nothing. In March, and into May,

where it's somewhere between awareness and concern, would it be fair to say that surely the hospital has now collided with the story of Molly?

A It is within Molly's risk radius. It's right at the centre.

Q And really, this is the point where you are taking on the active investigation of these issues; is that right?

A Correct.

Q I mean, if we just have you reflect on what you saw, in terms of what's happening on the ward and how GGC were responding. It's round about the time of early June; do you know what -- how would you sum it up?

A From my observations, there was a clear lack of leadership. There was a lack of communication. There was a lack of grip in relation to that which was ongoing.

There was quite clearly organisational chaos unfolding on the ward between the movement of patients, Molly being one, from room to room, to enable HPV cleaning, conducted by one individual who was exhausted. Talk about resilience. This individual was going from room to room to sterilise each room, which in itself had a huge impact.

And to give you some sense of what it required to do, was to remove every movable item from the room. And when it comes to, not only the patient rooms, but to those rooms for the preparation of chemotherapy and where they store critical drugs needed for the patient group, those shelves were cleared, absolutely right and proper to clear them, in order to facilitate the HPV cleaning. But communication should have been at the forefront, to say: well, what is the contingency here? If these drugs have been removed from this environment, what will this mean, in relation to access? And what I actually meant is that the nurses were horrified. "Where are the drugs?"

And whilst each of the patients' rooms will have a locked cupboard which deals with -- such as the volume of drugs, very significant drugs that are given to our children, at times they are required to go into the main store which is there, for all manner of significant medication; that wasn't there. Where was it?

If you think about that when you are dealing with small margins and someone has to have access to life-saving drugs, and they have decided to clean the cupboards, but not thought about the impact and the implications of doing so. By all means

manage the risk and clean the room, but consider the other risks associated. This is what I mean about business continuity and having the foresight, having that consideration for: what does this mean?

I also saw, in relation to -- when water would be turned off without any communication; what that would mean on the ward. And what that tells you is that no one is in control. You are leaving things to chance.

I mean, here there were planning meetings and this is when the strategic does not relate to the operational service delivery. Someone comes up with a plan, but what's actually happening in practice? And what was happening in practice was chaos. And that destabilises the faith, trust and honesty that staff have in one another; the visible demonstration, when you see staff quite clearly perturbed by what's ongoing, but concerned; that then impacts on the patients. It impacts on the families.

So as you are watching this, for me, it was about a lack of control, visible control, and it gave me no confidence and it further fractured my trust in this organisation.

Q Yes. And if we just look at your statement, paragraph 336. Ms Ward, I wonder if we are able to get that up on the screen. Just to maybe capture and sum up what you are saying about this stage. 336 and 337.

At 336 you say:

> "During this time, I continued to observe a ward that was in chaos due to a cleaning regime requiring of the decant from rooms and clearing of cupboards, including medicines that were required in the treatment of those patients, causing significant distress for staff. I observed and listened to medical teams not advised as to when water was being closed off to effect maintenance and cleaning, resulting in impact on basic hygiene with doctors unable to wash hands, and in one instance following their use of toilet facilities."

And that was the incident Molly told us about yesterday; is that right?

A Correct.

Q "I experienced us moving from room to room to effect the cleaning regime, but due to lack of coordination with those removing and replacing component parts for sinks, there was requirement to move again to facilitate additional cleaning."

It wasn't just the HPV cleaning that was going on at this point; is that

right?

A Yes.

Q There was kit actually being replaced as well?

A Yes.

Q "I listened to families terrified of what was ongoing and how this would impact on the lives of the children."

Tell us a bit more about that?

A Yes. So there was a couple of aspects to that. Media reporting was in play. Scottish Parliament was in session. Politicians were discussing it. And all of this was filtering.

But now what we were seeing was this, that was playing out of the bubble, was the inner bubble. And perception is truth, and the perception was that there is something wrong here, there is something fundamentally wrong that we are cleaning every single room to this extent, because it was not normal. It was abnormal within the framework. To have sink traps replaced in the room that you are in is not a normal thing to happen.

But also the coordination of that. A room would be cleaned and then someone would say: but we now have to have -- the sink trap, replace it. There was no coordination of activity, no prioritisation. And so again, the

impact and implications for the patients were not being considered.

And when you are within that bubble and you are watching it, and when you could go and you could speak to other parents, everyone was concerned, because there was no single version of the truth that would cater for our needs, and our needs are knowledge, information. What's happening here? Tell us.

And I actually questioned in relation to the sink traps at the time and said: "You are replacing the sink traps here at the washbasin and also in the toilet. What about the sink traps in the shower?" It was actually Dr Sastry who said: "That's a good point, I have got no idea, but I'll go and find out".

And the next two individuals from estates came in, and had a look at the water going round and round the plughole and said: "it's draining away okay". I said: "That's not the issue. The issue is the sink trap. If you are telling me that the trap here and the trap there has to be replaced, what about the sink trap in the shower?"

Q Yes. Now, just on that point. We have heard quite a bit of evidence about there being an issue with the showers flooding. That's a different issue, I think, I take you to be

saying, from the concern that there appeared to be in relation to the sink traps?

A Yes.

Q And was it your impression that the people from estates who were looking at these showers were maybe more focused on the flooding issue, then?

A Absolutely.

Q And so just looking again at what you say at paragraph 336. I mean, the families were terrified. That's the level it had got to by then?

A Totally. What does this mean for my child? And there is talking. Has your child contracted bacteria? Yes. What about your child? Yes. When is my child ...? That was the fear, because you knew the impact and implications that it had on that other child's treatment, and you didn't want that for your child.

Q A number of parents have told us that one of the first things they were told, particularly by Professor Gibson, so those in relation to blood cancers, was: it will be the infection that's the issue here.

A Yes.

Q And you also say at paragraph 336:

> "I also listened to the distress experienced by nursing staff, perceived by some not to be following rigid hygiene standards."

Now, let's just take that in stages. What distress was being experienced by nursing staff?

A The Schiehallion unit is known within the hospital as the "Schie-Hilton", because the standards are seen as being far better than anywhere else.

And these staff members are consummate professionals, administering chemotherapy and the processes they go through, how they glove up, the gauntlets, the aprons. When they wear a particular coloured apron, you know not to go near them. And the reason for that is a visible demonstration and a visible communication: I am involved in making up the chemo, so no one goes near them. And they would come into the room and they would go through these; and even, although they know your child intimately, they ask for the CHI number, their identifier; and everything is checked off.

Q The CHI number?

A The CHI number. Their unique identifier which would follow you through your chemotherapy and all of your other medication. They left nothing to chance.

And if you actually reflect on the episode that I described earlier and the nurse who thought she may have done something wrong with Molly, it was █ who is just so ... that is the level that they were at: what could I have done that may have caused it? So they were regimental in their checks and balances.

But all of those checks and balances were being considered, and they were being reviewed. I don't think anyone has any issue with the fact that we continually review a process and procedure to learn from the experience, absolutely. That's what maintains your effectiveness. That's what maintains your sharp edge and learn. And we move from a Schiehallion unit, from when it was opened, in prolonging the lives of two out of every ten, to prolonging the life of eight out of ten; remarkable. Their standards have enabled that. Their research has enabled that. Their professionalism has enabled that.

So they were all conditioned, their organisational behaviour, their culture was focused on patient safety.

But they were being reviewed against the media frenzy for what's ongoing, Parliamentary questions. No one knew it was happening, so they were looking for that area of

vulnerability and they took it; but they started to consider: what is it that we're doing that we shouldn't be doing, or what is it that we're not doing that we should be doing?

If they then maybe think that they may be responsible for something that's happening to these patients or something that's ongoing, I can only imagine the burden of that.

Q And so when you refer to "perceived by some not to be following the rigid hygiene standards", are you referring to, what, discussion in the media or something else?

A Absolutely. But even within the hospital and discussions: what is ongoing in the Schiehallion unit? Something must be ongoing. Something is making these kids unwell. What is it? And so you look at the point of least resistance.

Q Yes.

A And they were vulnerable.

Q And then you go on at 337 and you say:

"I observed a process entrenched in dealing with the bacterial outbreaks that prevented them from seeing the wider crisis that was unfolding."

And which part of GGC do you direct that observation at?

A Absolutely, unequivocally

at the Chief Executive and the management structure responsible for crisis management.

Q And you go on to say:

"A process demanding of open and transparent communication that would reassure during a distressing and frightening period."

You then say:

"The IMT was not the place for crisis management. However, from my perspective GGC senior management had devolved responsibility and accountability to the IMT, who whilst equipped to manage an outbreak, were not so when it came to the management of a crisis."

Now, we have not really had much, if any, evidence about the IMT yet. Can you tell us a bit about that?

A Well, my understanding that I have gathered from speaking to individuals concerning the documentation that's in place, the information management team is set up or convened in order to respond to an outbreak of bacterial or fungal infection; and to manage that outbreak, and to get to the root cause of that which is ongoing.

And the chair of the IMT will operate in a way that they apply a RAG status to the impact and the implications of the bacterial outbreak. And so that will effectively be driven by: is it a single patient? Is it multiple patients? Has it resulted in room closures or a ward closure?

And so within that RAG status, if it goes to red, you can consider that there has been significant clinical intervention as a consequence of, but has also escalated into, an impact on the ward itself.

And that structured the demands within it. A communication network where information that flows from it, and out from it, is directed by the chair.

However, that narrative is only made public, once that communication has been considered by three separate and distinct entities: the management, GGC, the Scottish government and Health Protection Scotland. If you like, that's the top cover.

So the IMT are there to manage the incident.

My observation was that, not only could they not focus on the incident itself, they were being drawn into the wider impact from media scrutiny, from political scrutiny, from the desire of information from a whole host of individuals. And so essentially they were operating in a ten-minute bubble.

They were not allowed to deal with the terms of reference of their group and enabled to escalate matters to the management who are there to ensure crisis management: do you have sufficient resources? Can we deal with the communication strategy? Who are we communicating with? There are different audiences here. What is the impact assessment? The impact on this patient group. The impact on the wider community. The impact on politicians or on the media.

So who is actually dealing with it? That's not for the chair of the IMT; because if they are doing all of that, who is focusing on the outbreak?

Q And these reflections on the incident management team, are these things that you have come to discover later, or were you aware of all of that at the time?

A At the time, I was starting to develop a relationship and trust, and I could -- I started to feel the anxiety, the frustration from individuals who were members of that IMT.

Q Yes. And are the individuals on the incident management team, are they clinicians and microbiologists and people like that?

A They represent all of those bodies and others.

Q Yes.

A They represent Health Protection Scotland, the estates; anyone who can contribute to the problem is at that table.

Q Right. But your feeling overall was that they were being asked to do, or were doing more than they should have to do in managing the overall crisis, as you see it; is that right?

A Yes.

Q Now, just looking at your statement again, Professor Cuddihy; if you just -- we don't need it up on the screen. If you look at paragraph 330. Have you got that? It's page 89 on my version, but it may be different on yours.

Does that really capture how you were feeling at the time?

A Absolutely.

Q It was clearly -- you say:

> "There was something clearly wrong with the environment that was requiring of detailed investigation but regardless as to whether the cause was known, the impact was being felt and harm was being done, emotionally, psychologically, socially and physically. There was a clear lack of information from GGC corporate services and

it was having a detrimental impact on relationships between staff and patients. Staff were being held accountable for that which they were not responsible; the water and drainage and was fracturing trust."

That sums it up at the time for you?

A Yes.

Q And was it about this stage that you wrote to the then Chief Medical Officer for Scotland, Dr Catherine Calderwood?

A I did, sir, yes.

Q And did you report all of what you described to her?

A Yes.

Q We will maybe come back to that. Let's go back to Molly's story.

So after confirmation of her infection, so we are still in June 2018, I think we heard yesterday, and we can see from your statement -- and just to give people references, we are now at paragraph 85 -- we can see that Dr Sastry does come up with a new plan, and that's pushing back the operation, altering the chemo regime and there's to be parallel radiotherapy; is that right?

A Yes.

Q And I think, if you just

have a look at paragraph 86, Professor Cuddihy, Molly described this yesterday, so we don't need to go into it in too much detail perhaps; but did you see, as you describe it there, on 16 June, it almost had an immediate impact on Molly of this new plan, at least in relation to the treatment of the infection?

A Yes. So the decision was that Molly would embark on a treatment plan that would involve a trio of antibiotics; and again, all we really knew was about what the impact of those antibiotics would be primarily on the bacteria.

But they had an impact on Molly, and you could see it. Her stability had gone, collapsing. And as a consequence of that, Molly was further examined and, again, this is about the risk of doing against the risk of not doing. Molly was being treated for cancer. The plan was in relation to cancer. She is now being treated for a bacterial infection. So you have to balance the risk. Do we stop chemotherapy and allow the cancer to take hold, or do we focus on the bacteria in the hope that it doesn't exploit the vulnerability, in Molly's immuno-compromised state?

Then we have a third element; which is: now that we have risk

managed this and we are going to give you this trio of antibiotics, we are now seeing the impact on you as an individual and, as we'd found out, it's having a detrimental impact on her heart.

So even though I would reflect on what Dr Sastry would say, that the treatment would deconstruct Molly and you would see a visible change, Molly was now being treated for other things that were not in the plan and that treatment was now having an impact on the very organs that were needed to keep her alive, to challenge cancer and the bacteria.

And she was confined to bed. She had lost her ability to stand. She thought: what's happening to me? And it was because of the blood and the movement of blood in her heart. Her dignity was further eroded. Molly's quality of life has already been eroded. Even that quality of life, as small as it would be there, had been further impacted on, as a consequence of the bacteria and now even the treatment of that bacteria is further reducing those small margins. That was -- that left us: what do we do here? How do we manage this? Where do we go? What do we do? And in truth, we didn't really know what we were going to do; but that was the impact on

Molly.

Q Now, eventually I think she got home on about 20 June. She is wheelchair-bound now and, as you say, this was a terrible time for Molly; would that be fair to say?

A Mm-hm.

Q Yes. But the plan is underway and she's backwards and forwards to the Beatson for radiotherapy; and I think you describe in paragraph 88, you describe some more positive experiences that you recall in relation to that. Do you want to tell us about that?

A Yes. So as Molly was going through all of this, every day, I would take Molly to the Beatson.

And the Schiehallion ward is, however traumatic this is coming across, a happy place. As remarkable as that sounds, but that tells you about the resilience of the children and also about the staff that can make it like that.

And then you would go over to the Beatson; and the Beatson, if you'll forgive me, we as adults, we respond differently to bad news and Molly will tell you as well, even if I have a cold, I'm the worst patient in the world. And adult patients in the Beatson are no different. They have a right to complain, they have a right: well, you

know you are in a sick place, you know you are in ...

And so the staff recognised, and actually there's a -- to give you the kind of perspective on it. There was an elderly lady that had actually asked Molly a question, why Molly was there, and Molly had said: "I'm a patient". She said: "I didn't know children -- what cancer?" So that's the kind of environment you get into; it's a world apart.

And so to protect Molly from that, and there was no malice in that, it was just information, someone didn't know, but that's what you're dealing with; it is so unusual to see a young person going in. But the staff recognised it, and they would make sure that Molly was the first patient every morning, and Molly is not a morning person; so it was great in one sense, but it was a trauma in another.

But we would go along and they were there; and it was three days before Molly's 16th birthday. And again, the staff got Molly a birthday cake, a birthday card. They didn't know Molly. But again, it's about people taking the time to get to know. This is people taking their lead from the organisational behaviour clinically and a culture: know your patient, understand your patient.

And at that point, Molly was also, because she's 16, one of the perks of being ill was that, as a 16-year-old, you can go and get your provisional licence. I didn't know that at all. But they understood, even after the first day, and spoke to Molly. And within the whole piece, they'd remembered that. So not only did they get Molly the birthday card and the birthday cake and make everything, they would look to remember when Molly was going and they had a wee present for her, for the first time she would go and drive her car.

It just makes you feel important; it gives you an identity. You are not a sick kid. You have got an ambition, you have got a vision. I'm going to drive my car and I'm going to become a doctor.

And that was hugely important for Molly, in what was a very, very traumatic period of all of this that was ongoing and having the radiotherapy as well. They made it so much easier for Molly; so much easier.

And again, it's just this whole piece about the Schiehallion impact and it went -- because even before Molly going there, one of those nurses actually had come over to the Schiehallion unit to find out more. They exercised their due diligence with

Molly. So as they were in there, and Molly's line, they knew about it, and they could talk to Molly and talk about different things. That is the mark of the people and that sets them apart in relation to it, because Molly could then be better protected. I knew, when Molly was going into the room, that she had that, just -- she had support round about her, because people cared about her. Demonstrably at the centre of their thought was Molly Cuddihy, Molly Cuddihy, and that was hugely important.

Q So when we go back to think about your business continuity questions and the risk radius. You are describing that in your head through all of this, you could see that risk radius, that burden moving with Molly into the Beatson, back to the hospital; and that would be reassuring?

A Yes.

Q Except that on 27 July, something nearly collided with that risk radius; is that right? Do you want to tell us a bit about that?

A Every day, I would take Molly back and forward to the Beatson; we would drive there and drive back, going from home. But at this time, Molly was actually having her chemotherapy and she's effectively wired to these pumps, 24 hours over

three or four days, constant chemotherapy going through. And so Molly was an inpatient. Because of that, in the early morning, then I wouldn't be at the hospital. ██ would stay with Molly, quite rightly, because she wouldn't want her dad to have to help her with the toilet and different things. So because of this, the hospital arranged a taxi to take them both, so they would finish off the chemo and Molly would go in a taxi.

And so on this day, Molly had come back and she got out of the taxi, there was the taxi driver, and I know more about this because actually I enquired into this specifically; and Molly had to be chaperoned around a glass panel that had worked its way from its fixings and shattered on the ground at the entrance to the hospital. Molly, through the help of others, navigated her way through and got into the hospital.

And so amongst various questions that I had asked directly of the Chief Executive, Jane Grant, directly to Jane Grant, I asked about the risks and identified a number of risks, but in relation to the window; and I had asked: could she advise me in relation to the safety and security of my daughter as she would enter and egress the hospital, as I understood

that this was one of a number of windows that had worked their way free and fallen to the ground below; one of a number of windows. And at that point, I understood it to be five. I have no knowledge of the other ones, but this one specifically as it related to my daughter.

And I received a response in relation to this question, and the response -- and this is important in relation to communication, and they said to me: to their knowledge, no window has ever fallen out of the building. No window has ever fallen out. However, the event you may refer to, it's not a window; it's a decorative glass panel. But you also may wish to be reassured that it is designed in such a way that at the point of impact, it shatters into small pieces.

So forgive me for splitting hairs here, but it's not a window; but it's a glass panel that fell from the tenth floor of a hospital, which is some 2 metres by 3 metres size, hurtling from ten floors up. You will not be reassured that it shatters on impact as it hits you on the head, because it will kill you.

That was an example of the level of communication from Jane Grant to reassure me, in relation to the safety and security of my daughter, and indeed others. To say that it downplayed the impact of that incident is an understatement. And actually, it said to me that "following investigation they would let me", and it demonstrates the quality of the letter. They couldn't even insert the word "know" into it; that they would let me know. The quality of the letter was such that: who cares? A patient demonstrably at the centre of the decision-making? I think not. I think not. It was an appalling letter, absolutely appalling. And I have still received nothing further.

Q Now, you actually set out the content of that correspondence in your statement, and we will look at it in a minute. But before we do that, you mentioned that you thought there were five such panels or windows that had fallen?

A Mm-hm. Yes.

Q Was that something that you were aware of at the time, or is that something that you have become aware of?

A Since, following discussions, that is information that -- afterwards.

Q So your understanding presently is that there had been something in the nature of five panels that had fallen?

A Yes.

Q I wonder, Ms Ward, if we could have a look, please, at Professor Cuddihy's statement again; and it's paragraph 240 and paragraph 242 and I think you set out the correspondence that you have just referred to.

Is that the relevant section, Professor Cuddihy?

A (Nods).

Q Yes. So you said, you wrote to her. You contacted Jane Grant to express your concern and you asked:

> "Are the windows safe -- a number have fallen out -- what is being done in this regard?"

She said:

> "We are extremely sorry that you have experienced a panel falling from the building on entering with Molly. It may be helpful to clarify that no windows have fallen out of the Queen Elizabeth University Hospital building, nor the Royal Hospital for Children building; all double glazed units have remained intact without issue, the windows are safe. The glazing failure we believe you are referring to is decorative glazing paneling, and this remains under investigation. If a failure occurs, they are designed to shatter into tiny fragments which are much less likely to cause harm. We will let you the outcome of this investigation."

That's the correspondence that you are referring to?

A That's it, sir.

Q And you go on to say at paragraph 242 that, while you understood that clarity was required around exactly what had fallen, you were not reassured.

Okay. We can put that to one side. Thanks, Ms Ward.

Now, following this incident, Professor Cuddihy, was there a change in the access arrangements to the Royal Hospital for Children?

A There was no access allowed through the main entrance, so --

Q So from that point -- sorry, please continue.

A Sorry, yes. And there was scaffolding erected and I would say a maintenance programme was in place in relation to this, so no one was allowed to enter or exit at that point.

Q Yes. You were aware there was scaffolding going up in relation to the glass panel issue; is that right?

A Yes, mm-hm.

Q And so from that point,

access to the Royal Hospital for Children was via which entrance?

A It was through the side entrance.

Q Yes. Was there subsequently a change to that, too?

A Yes.

Q Do you want to tell us a bit about that?

A So wider environmental issues, the Grenfell fire investigation and, following that, a number of recommendations were made, is my understanding; and specifically about a certain type of cladding that was considered to be unsafe.

And as such, various public authorities from around the UK were making arrangements to review their building, which one would expect and one would welcome, but to see if that type of cladding was involved in the structure of the building and, if so, to then determine what action they would take.

And as a consequence of that, I understand that various reports had been sent to the board, the GGC board in relation to this.

Whilst this was ongoing and being considered, Molly and I attended at the hospital. Molly was an outpatient at the time. And we arrived and parked as we normally did, an

alcove(?) within the children's car park, which was the multi-storey car park which is directly adjacent to the side entrance to the hospital. And we parked the car as usual, and we entered the side entrance, as we knew and understood that we were required to do.

And we were aware of other activity ongoing in relation to the side entrance, but we were allowed free and unfettered access to the hospital and, as usual, we went into day care and we would be received as normal. Angela was there, Angela Howat and the staff. But actually when we were there, Angela handed me a piece of paper, and the piece of paper was a communication to advise us that, as a consequence of building works ongoing at the side entrance, the cladding would be replaced; and as the cladding would be replaced and building materials could pose a threat to our patients. Two things: one, there would be a recommendation of prophylaxis to protect our children against potential fungal infection; and, two, that we were not to use that entrance/exit, because of the risk.

Now, one of the issues that I had with the hospital, and communicated to them consistently, was their lack of proactive communication because, of

course, Molly, a vulnerable patient, was arriving, went through that door, was exposed to those fungal spores, but it's okay, there's a letter to tell you not to do it tomorrow. And probably by tomorrow, we could have had a prophylactic. The damage is already done.

Back to prevention and protection. They had the knowledge that this was ongoing. They had the recommendations from the Grenfell fire. They were concerned those recommendations at the board. The board passed a paper and the funding that would allow them to carry out this replacement work. Someone had the foresight to say that: we will need to tell the patients. And as I understand, those on the ward were all told previously, but of course they are not the ones at direct risk, because they are not exiting or entering the building. They are already within the protective bubble, as we believed. Molly and those others were the risk. They were entering and exiting. But they tell us after the fact.

And so I posed the question to those staff members: when did you know about this? We have only been given them, the handout, as those day care patients come in. Too late, too late. They had the opportunity. And

that probably demonstrates their organisational behaviour. They have no consideration for the impact and implications on those patients that are at greatest risk. They exposed my daughter to needless risk and then told me after the fact what they would do about it.

And actually, in relation to the prophylaxis, which is almost a moot point, Molly was already on fluconazole, which was to be the drug that would be administered, and Molly had been given that for other reasons. But that's not the point. The point is that not only was this a reactive communication, it was a delayed communication; when they already had the information in front of them, they had considered it at board level. This was a risk. I would expect to see it in the risk register; and within the risk register, who owned the risk? And within that ownership, what were they doing to mitigate the risk, and the risk to those vulnerable patients? Because this is the important bit within the language. This is not about the general patient population; this is about immuno-compromised patients, catering for their needs, and they did nothing of the sort. They exposed them to increased risk. And they had it within their gift to better protect.

Q Just a couple of points on that. Just to complete the consequences of that, in terms of access to the hospital. Where was the yet further access to the hospital?

A Well, we couldn't access the side entrance to get our critical care, because of the risk of the cladding and the fungal infection. We couldn't enter the front entrance, because of the risk of a decorative panel falling from the tenth storey floor.

So we were directed to the rear of the hospital, called the discharge lounge; and the discharge lounge has an important function, obviously because it enables the conveyance of patients leaving the hospital, either going home or to another establishment; but also it was the area where patients, staff, Uncle Tom Cobley and all would gather for a cigarette. It was horrendous, absolutely horrendous.

To give you a sense, it was like going back 20 years in Scotland in a pub or a restaurant where individuals were smoking. It was dreadful.

And I had a number of altercations with people who would smoke actually not even outside, actually within the hospital. If they could get away with it, they would have been smoking in their bed. But there

was no management of this. This was known all across the estate. Everyone knew about it. But if I had to get the critical care for my daughter, and risk-manage fungal infection, a glass panel falling on her head, I had to put her through this smoke. Shocking.

This is even before I enter the hospital. This is Scotland. This is a flagship hospital. This is not some third world country somewhere. This is our flagship hospital we showcased in 2015. The Queen opened it. We told the world, we said it was the best in Europe. And we can't even get in the door.

All of these things were preventable. I can't even get in the door with my daughter. Shameful, utterly shameful.

Q Just to get a timeline on that, Professor Cuddihy. I think we can see from paragraph 232 of your statement that the incident where you do go in the side entrance was round about 10 September. And maybe just to think about this, just before lunch, and think about what you were doing over this period, as well as looking out for Molly.

You told us earlier that at about the time Molly got her infection in May/June 2018, you described a scene of chaos and you described

that, as you put it in your statement and as you have confirmed this morning, that the patients were terrified, as you put it; is that right?

A Totally.

Q And here we are, some weeks and months later; and of course, Molly's story by this stage has taken a concerning turn; is that right?

A Yes.

Q And yet, are we to understand that, in all of that, you were continuing to engage with NHS GGC in order to, if nothing else, at least try and improve the level of communication?

A Absolutely. As mentioned, I have no knowledge, no experience, no expertise in cancer or anything medical. And this was my wee small way of trying to contribute, trying to offer solutions to the problems. And I would engage with people, and I did so with respect, with dignity, simply trying to highlight our experience and to learn from the experience. It is a two-way street; and to provide information of our experience and see if we cannot influence change, if we cannot influence a better environment for our children, for their families, for the staff.

Q If you look at paragraph 92 of your statement, I think you

include that, round about July 2018. Does that capture what you were trying to do over these weeks and months; trying to improve the situation?

A Yes. Well, the letter to Catherine Calderwood was an enabler for people to listen to me and it afforded me an opportunity to get into the room with certain individuals; because even within conflict, two groups need to come together. We need dialogue, we need to know and understand what's happening.

And again, in order for them to cater to my needs, they need to know what my needs were. And as ludicrous as this sounds, I simply wanted an environment that was safe to enter and safe to be in. That's it.

And so in order to lay that before them, even if there was a blind individual amongst them that had not seen or heard any of this, if they had been in some far-flung land and had no idea, I could communicate to them, and to see if we could co-produce or co-deliver a communication strategy.

Q Now, you have mentioned again the letter to Dr Calderwood; and am I right in understanding that you did get a response to that eventually?

A I did, yes.

MR DUNCAN: Yes. However, my Lord, I do see that we are now at 1 o'clock. I wonder if that might be a convenient moment to break.

THE CHAIR: Yes. Thank you, Professor Cuddihy; and if you could be back by 2 o'clock.

A Yes, sir.

13:04

(End of Morning Session)