SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 September 2021

Day 15
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Afternoon Session

CONTENTS

14:05

THE CHAIR: Good afternoon, Professor Cuddihy. I think we're ready to resume. Mr Duncan.

Professor John Cuddihy
Examined by Mr Duncan (Cont'd)

MR DUNCAN: Thank you, my Lord. Good afternoon, Professor Cuddihy. We concluded this morning with my asking you about whether you had received a response to the letter that you wrote to Dr Calderwood. I think you indicated that you had. From whom did that response come?

A Initially from Dr Calderwood herself, acknowledging everything that I'd said and offering to make contact directly with the Greater Glasgow and Clyde Medical Director and that she would facilitate an introduction, which she did.

Q Yes. And did you then get a letter from the Medical Director?

A I did.

Q And who was that?

A It was Jennifer Armstrong.

Q Yes. And would that be around about the 23rd of July 2018?

A Yes.

Q And can you recall what, broadly, she said to you about the concerns that you had raised?

A So, it was quite an interesting letter in many ways, and again, it's about knowing your patient and knowing the extended family. So, bearing in mind this was the 23rd of July, I had penned the original letter in June. At that point, Molly was 15. So, when the response came back, it was very much about, "Very sorry to hear about the diagnosis for Molly," and, as I say, they showed empathy, but immediately then went to, "Of course, now that Molly is an adult, I can't go into any of the clinical details in relation to Molly. It would be wrong to do so," as it would be. Absolutely.

But it was an interesting point for me in relation to it, because it was immediately pointing out that she's now 16. As a consequence, if we have to have any discussion around her clinical care, it would have to be Molly's consent. But obviously, within a matter of days, Molly had only turned 16. So, I was acutely aware of Molly's clinical care at that point, and the letter was around broader issues.

And Dr Armstrong sought to reassure me in relation to the structure and format of the IMT, and as I have mentioned earlier about all of the individuals who were there, and that collectively they would seek to get to

the root cause of what was ongoing in relation to bacterial infections. And within that, she had said that everything that they had done they had done in accordance with NHS GGC guidance and broader Scottish health guidance.

So, all of their responses were within protocols that were identified. And she had stated at that point that all of their efforts had led to the ward now returning almost to normality with no new reported cases. And that sorry for how I felt in relation to how information was communicated, but there was a mechanism behind us and please accept their apology in relation to it, but to give me an assurance that the ward was safe, water was safe, and everything that was done was done in accordance with guidelines and protocols.

Q Are you indicating that effectively she said that the issues with the water had been successfully addressed?

A Mm-hmm.

Q What about the issues with the drains? Did she say whether they had been successfully addressed?

A Yes. Well, made specific reference in relation to that because within the letter I had drawn reference

– the original letter to Catherine Calderwood – to two specific points, that being the water issues in March of 2018, but then again, the drains in 2018, but May of 2018. And so, that distinction was recognised, and she said, “You are quite right. The May incident relates to the drainage.” But the letter was intended to leave me with the belief that all of the issues had been sorted.

Q And did she, in effect, say that the ward was now functioning normally?

A Yes.

Q Was that what you saw when you were in and about the Schiehallion Unit?

A Again, this is back to what I'm hearing and what I'm seeing is entirely two different things. Absolutely not.

Q I mean, this was the 23rd of July 2018. What happened almost exactly two months later?

A Closed the wards.

Q By this stage of things, by the stage that Schiehallion Unit was closed on Ward 2A and 2B, were you aware of the extent of recorded bloodstream infections within the Schiehallion Unit?

A Again, because of the inquiries that I was carrying out, there

was different sources that I considered. Primary source of documented information was by way of NHS Board papers. Bimonthly, they have a report, an infection control report, and within that, they were detailing those infections within Ward 2A, contained within a broader report from Jennifer Armstrong, who is the author of that report. And so, within it and leading up through that period of time, it was identified that there was some 23 Gram-negative infections. This was my first point of concern.

A board are there to scrutinise, to hold to account. But the Board were only being provided with half the story because, of course, my inquiries identified that mycobacterium chelonae is not a Gram-negative bacteria, it's a Gram-positive bacteria. And so, when I would review these documents, I was doing so through the lens of Molly Cuddihy. What is being reported about this rare pathogen, having not been seen in 10 years, save for four cases? So, that was one of the sources.

The other source was other patients and families which I knew had other types of bacterial infections, but also from nursing staff and others, and the figures didn't stack up to me. None of the figures stacked up to me, and so

I started to ask direct questions in relation to those figures. How confident could the Board be in the figures that were being supplied? How confident could Scottish Government be in the figures it was being supplied? Because if they're only having half the information, how could they then scrutinise the level of effectiveness on the part of Greater Glasgow and Clyde?

Q When you say "only half the story" or half the infections, that's within the Schiehallion Unit that you're speaking about. What about the rest of the hospital campus? Do you know what, if any, reporting of, or investigation even, of bloodstream infections over that period was being recorded or reported?

A The detail in it's all right. I wouldn't be able to give an opinion, other than to say that those reports highlight emerging issues in relation to infection broadly across the Greater Glasgow state.

Q Now, as you've indicated, the Schiehallion Unit within the children's hospital closed September 2018. How did you discover that that was about to happen?

A I had, during this time, requested a number of meetings with management in relation to primarily

Molly and what had happened. And during one of those meetings, I understood that action would be taken in relation to the ward, which I welcomed. Even although there was a culture of denial, I welcomed the fact that they were closing the ward. Welcomed the fact some investigation must therefore be ongoing. The concerning for me was, "Well, where will Molly go?" This is the bespoke facility for child cancers in Scotland, heralded as the flagship.

Back to business continuity, what was the plan? Surely, they must have had a plan in relation to the hospital? If there was ever a power outage, if there was ever a flooding or a fire, where would we take our vulnerable children? Where would we go with them? So, I asked what will happen, and at the meeting was Mr Jamie Redfern, who was part of the management within the Royal Hospital for Children, Dr Teresa Inkster, a variety of other people at different meetings. Specifically, I asked, "What would this plan be?"

And I was told there was an options appraisal carried out. And that options appraisal would consist of, "Could these children be displaced to a safe environment within the Royal Hospital of Children?" If "Yes", great.

If not, you go elsewhere. If they were to go elsewhere, where would they go? One of the options was to be displaced to another haemato-oncology facility in Scotland. The challenge there is that you do not have the infrastructure that is contained within the RHC, both in terms of that physical infrastructure of Paediatric Intensive Care Unit in relation to all of the support because of the small margins. But also, you don't have access to that medical family, so as I understand, that was discounted.

They also considered a mobile facility, and this is in the broad sense that I was told this, that a mobile facility would come a self-contained unit onto the ground space, wherever – I have no idea. But it was considered, but not a feasible option. And the remaining one, if there was not a safe ward within the Royal Hospital of Children, would be a displacement to the adult ward, and that that adult ward would then cater for the needs of those children that would be displaced. Within that, there was nothing that I could see or hear that then related directly in terms of an impact assessment on the patients. So, this was to be a displacement of these vulnerable children, too.

An interesting thing for me is that

almost if they could not find somewhere that was safe for them in RHC, they would go into an adult, implies to me there's not somewhere safe within the RHC. And in going to, what assurance can you give me that this was a safe environment? What assurance could they give me in relation to my daughter that the infection that she contracted, that there would be no further impact on her in relation to the exposure to any other environmental organism?

I was told that this ward, if identified, would be deep cleaned. It would be considered in relation to the environment to make sure that it's fit for purpose. There would be point of use filters placed on the taps. During that, I then asked, I says, “Well, why are you placing point of use filters on the taps? This is going to the adult hospital.” And it was during this that I understood that it was a separate water supply into the adult hospital, which, of course, gives you a level of confidence at that point. But notwithstanding that, these point of use filters would be put in place, but that that facility was examined.

So, all of the learning that they had, and it would be fit for purpose to protect our children. Not just Molly Cuddihy, but all of the other children

currently and any of those, sadly, who would be diagnosed and coming into that environment. And so, back to the risk of doing against the risk of not doing, not only we’d still be near Dr Sastry, Molly would still have the rest of the facilities around her. But was I reassured in relation to that ward? No. But I thought it was a better option than the one we were in that they were having to close. They took the decision to close Ward 2A and 2B; that is not taken lightly. That is a major, major decision. That implies to me crisis. We are displacing our vulnerable children, immunocompromised children, to an adult hospital. What was the impact and implications? What impact assessment was done?

And it's something I’d inquired as to had they considered the child risk impact assessment and the framework that that brings? And this is a tool which is available to all public authorities, developed through the United Nations, in relation to the rights of the child. It's a framework that has been signed up to by the Scottish Government, and it's been in place since 2014. You follow a profile; you follow a protocol. No one had done anything like that. No one had considered the impact and implications

on these patients as we displace them. It was almost as though we were removing them from this 10-minute bubble, and who was actually considering the impact where we were putting them to? Who was doing that?

And again, the IMT, who would be considering the root cause of the infection are focused. This is where the broader hospital management have to take absolute responsibility. What was the business continuity plan? And I asked for it, and I have yet to see it. Perhaps there is one, but it suggested to me, sir, that there wasn't one.

Q Just to identify where all of that is in your statement, Mr Castell, I wonder if we might just have a look at paragraphs 94 to 96? (After a pause) As you've indicated to us, Professor Cuddihy, you sought meetings with Mr Redfern and others about these matters. And you say that, at the end of paragraph 94, something you just touched on a moment ago, you say you were advised that the ward had a different water supply.

A Yes.

Q Can you remember how you came about that understanding?

A It was during the discussion that information was imparted to me.

Q Yes. So, as far as you can recall, a meeting or something.

A It was in a meeting. It was in a formalised meeting, and I would expect there would be minutes of that meeting.

Q And then, at paragraph 95, you mention that you were told there had been an SBAR completed, and, of course, you told us earlier about an SBAR. And what did they mean? Or rather, where did you learn this? Again, was that in a meeting?

A Yes.

Q And what did you understand at this time completion of the SBAR to have involved?

A Again, it would be about the situation that they were facing, the background to it. An assessment in relation to the suitability and the applicability of this other ward and the recommendations that would fall in line with that options appraisal.

Q And Mr Castell, if you can just scroll a bit further, please. Sorry, can just go up a little bit further so we can just see the remainder of 95? Thank you. You make the point there that there was as you say, and as you said a moment ago, there was never an impact assessment. Sorry, Mr Castell, could we go back to where you were? Now, you say that that was

something that you'd raised again during the Oversight Board meetings, and we're going to come in due course to your involvement in the Oversight Board. But at this stage, and in these discussions with Mr Redfern and others, at that stage, were you asking about impact assessments?

Q I had asked about what was the impact on the patients, yes.

Q Yes. And you then go on to mention the Scottish Government Children Rights and Wellbeing impact assessments, and is that something that you were aware of at the time? Or is that something that you've subsequently become aware of?

A Again, it's a learning curve. So, I took it upon myself to go and have a meeting, request a meeting with the Children's Commissioner and to, as a statutory being, again in relation to advice, guidance, assistance, and indeed, suggested that this is something that Greater Glasgow and Clyde should do.

And I also, in relation to the Information Commissioner suggested the same, because within their dialogue, it seemed to me as they were confusing confidentiality and duty of candour. He says, "Please, go and see the Information Commissioner. Seek guidance of how you should communicate within the terms of all of these issues. They are there to help you. Please, reach out to them."

Q And I think we can see, as you said a moment ago, in paragraph 96, that based upon the discussions, you put it, "I formed the opinion that there was no business continuity plan." And you then say, "I asked if the prepared site, namely Ward 6A, was safe" and you were told it was. And where did that discussion take place?

A In that same meeting. And specifically, I had asked about we need to ensure that no other child contracts this horrible bacteria. Molly had it. I also didn't want her to get anything else. She had it. We had experienced. I sought assurance that that wouldn't be the case, and indeed, when I then reflect on Jennifer Armstrong that everything that we are doing to resolve this within guidelines, within protocols, is receiving letters from a variety of individuals all seeking to give assurance and to take a comfort: "This won't happen again.

This won't happen again." So, we were taking our children from 2A, trusting them with what? They knew at that time – that's hugely important. What they knew at that time, and they were telling us that this was a safe

environment.

Q Thank you, Mr Castell. We can put that to one side. Thank you. Just trying to maybe sum up what you were looking for at that time, not to be lost sight of, perhaps, is this: the first thing that you were looking for still was to understand what was actually going on in relation to the Schiehallion Unit itself, why it was being closed.

A Absolutely. But I could accept if they says, "We don't know, but we're closing this because we have your child, and all these other children, demonstrably at the centre of our decision making. We don't know."

Q And just on what might possibly be the second thing, this question of whether there was an impact assessment, can I just confirm, do you know whether there ever was an impact assessment?

A I have asked; I've never seen.

Q I mean, was there ever one provided to the Oversight Board, as far as you are aware?

A And indeed, one of the members of the Oversight Board said that. "That's a really interesting point that you raise, John. I was actually involved the crafting of that framework for Scottish Government." Nobody had seen any impact assessment, and indeed, it was considered that this could have been something that could be utilised.

Q And I think, in your statement, perhaps under the same heading, you say something about contingency arising from the issue of colocation of services on the site. It's at paragraph 256 in your statement. Interested by what you have in mind in relation to that. Do you want to explain a wee bit more about that?

A So this again is when you go back into your own experience, and when Police Scotland became an entity, I was tasked, in relation to the creation of the Organised Crime and Counterterrorism Unit, which would be housed within Gartcosh; that would be a colocation of specialist services. Colocation of particular assets that would be used within high-threat environments, because colocation leads to collaboration, and collaboration leads to communication. But of course, whilst we strive to fuse together, if we don't have coordination, fusion becomes confusion. And so, within this, we had to demonstrate within the colocation our business continuity plan.

So, if you brigade all of these assets, something goes wrong, where

will you displace to? Will that entity be fragmented? What is it that you will do? And you have to have plans in place. It will not be a like for like, but there will be a plan that will allow you to manage business as usual, should something go wrong. So, when I talk about colocation of assets in relation to the Royal Hospital of Children, a shiny, new, fantastic facility as it is, what if something goes wrong? What's the plan?

And when, in 2015, Robert Calderwood and others, who was the then Chief Executive heralded this beautiful plan, and they said that, "Demonstrably at the centre of our decision making is patient-centred care," that being the case for patient-centred care, what was the plan in 2015 should the lights go out? Where will they go? Shouldn't have come as a surprise to them. Yes, in relation to the significant challenges. Yes, in relation to the enormity of what happened. Not the fact that you would have to be displaced from an environment; it's not a new thing. What would the plan be?

Q Thank you. Now, thinking about the questions that you wanted answered at that stage of things, can you say whether you would have considered any externally provided advice to have been something that would have been an interest? For example, the DMA Canyon work, that kind of thing. Would that have helped in understanding what was going on?

A Absolutely.

Q Yes. If we just take two building systems in the hospital, let's take ventilation. Now, you deal with this in your statement at paragraph 98. What was it around this time that NHS GGC said they were going to be doing, if anything, in relation to ventilation during this period when the ward would be closed?

A NHS GGC made a number of statements – specifically, Mr Kevin Hill, then Director of the Royal Hospital for Children, and indeed, later by Jane Grant – that the closure of the Schiehallion Wards would afford them the opportunity to upgrade the ventilation system. Afford them the opportunity to upgrade the ventilation system, and that statement ends to suggest that they were thinking ahead, which one would welcome, want to be a progressive, always ensuring that we have the best standards possible. But to say we are taking advantage of the fact that the water has been closed implies that that's simply what they were doing,

and for me, that was disingenuous at best.

Q In paragraph 98, you mention another external company, INNOVATED Design Solutions, and you refer to a detailed examination provided by them October 2018. Was that something that was available to you in October 2018?

A Not long after it. I understood that a report was available. I understood certain findings, but for me I have to physically be able to read it. If it's not written down, it didn't happen. So, I have to read it to I understand myself. So, it was after the fact that I eventually get a copy of the report.

Q I think, as is obvious from paragraph 98, you have had an opportunity (inaudible) what it says, is that right?

A Yes?

Q And having done so, what reflections do you have on the use of the term “upgrade” in relation to what was going on with the ventilation system?

A Jane Grant and Kevin Hill and those within Greater Glasgow and Clyde knew the system of air conditioning installed in wards 2A and 2B had increased the risk of aerialisation[sic] immunocompromised children. It was a system that was installed not fit dealing with immunocompromised patients and, further, that the pressure within the rooms was not in accordance with that which should have been required until, simply, the balance of pressure – if you open a door in a room – should be positive pressure, so nothing should rush in; it was working the other way.

The air flows, but it should be six air flows over a period of time per-- It was three. Probably the most concerning fact is that this air conditioning system was extracting dirty air from toilets in the upper part of Ward 2A and the TCT. So, toilet plumage was taken up into the air conditioning system. Any water egress or flooding that could cause any mould – it was taking that up into the air conditioning system. One would think “great”, however, as it took the dirty air up, it deposited it into the clean rooms of the immunocompromised children. Dirty air in clean rooms – that's what was happening, that's what was on the INNOVATE Design Solutions report.

It's nothing to do with taking advantage of the ward being closed and upgrading a system, the system in

place had increased the risks to immunocompromised children and my daughter. They knew that. They knew it but they chose, and they continue to choose, to tell everyone that “we upgraded system”. Nothing of the kind.

Q Now, just thinking then about other rebuilding system that we've been speaking about a lot today, water, the water supply, thinking about the availability of external advice on safety or otherwise of the water system. Taking yourself November 2018 and the closure of the Schiehallion Unit, were you aware at that time of the DMA Canyon reports?

A I became aware of the details in the DMA Canyon report post June/July of 2018, but again, being advised of the detail but I hadn't yet touched the report, but I was advised of information which I later clarified once I accessed the report.

Q I mean, you say “the report”, but – in total, as far as you understand – how many reports were there from DMA Canyon?

A There are three separate and distinct reports from DMA Canyon There is a 2015 report commissioned by GNC in furtherance of the statutory requirement for Legionella risk; and sent through email communication and

verbal dissemination, Ian Powery of the Estates Department.

In 2017, following up continued statutory requirement, DMA Canyon delivered a similar report, this time to Mr Tommy Romeo, and that arrived circa June 2017.

Then, again, on the 30th of January 2018, there was a third report by DMA Canyon, and that report was a gap analysis, and a gap analysis in relation to the risk management of Legionella across the Greater Glasgow and Clyde estate. So, three separate and distinct reports from 2015 through to January 2018.

Q Are you indicating – just thinking in particular about what you just said about the third of those reports – that information within that report and the other ones would have been of interest not just in relation to the water system on Ward 2A but across the whole estate?

A Absolutely.

Q Yes. It dealt with the whole estate, is that right? And just on a point of detail, when you indicated previously that you had been led to believe there was a separate water supply, Ward 6A, what is the position as far as you understand it?

A The position as far as I understand it is that, technically

speaking, there is. But from the point of commission, one of the main valves enclosed so, in effect, it's one water inlet coming in bypassing the cold water tanks, bypassing the filtration system. So, we had contaminated water with debris entering the system in 2015 continuing for two years. A point in 2017, as such, debris and contaminants suggested in the reports – not from me, in the reports – was colonising in the water system.

Q And thinking then about the third report, the 2018 report, the gap analysis, can you say whether that continued to point to significant gaps in relation to Legionella and other bacteria management?

A Absolutely. Significant within this report is less about the technicalities, which were horrendous to know that this was ongoing. This was more about how they identify, manage, and mitigate Legionella – a statutory requirement. That report identified that the authorised person for water for Greater Glasgow and Clyde was never trained, had no operational or professional competence to discharge the duty of authorised person.

Q When you say "authorised person", is that a term of art of some kind?

A The authorised person is, I understand it, a designated role within the scheme framework of Legionella management. Such is the risks associated with Legionella and other bacteria, you want to know that the people engaged are trained and they know what they're doing – not just in relation to the patient population, but in fairness to the individual with the role, the Health Board should be ensuring that those engaged are suitably trained to do so.

You wouldn't allow Dr Sastry to work on Molly if he hadn't had his medical degree and understood it. Why would we allow someone engage in water, the very thing that we all need whether for hygiene or sustenance, someone who doesn't know what they're doing? And we can see from the reports that unfiltered water was entering the system at the point of source.

Q And can you recall what the assessment of risk was in 2018, from DMA Canyon, in relation to the management of Legionella and other bacteria risk?

A Not only was it high risk, it had a sentence within it – and that sentence said the response required is "immediate urgency". "Immediate

urgency" is written in that report. That's what it said. That tells you everything.

Q Can you recall whether the report, at any stage, described the water supply as being "wholesome"?

A There is a reference or two to the word "wholesome", it is in the 2017 report, page 12.

Q And can you recall whether that was a term that DMA Canyon themselves had applied to the water supply or whether it was something that had been said to them by somebody else?

A It was said to them by estates and actually within the report they draw reference to the fact that, whilst they were carrying out the review, this phrase that the water was "wholesome" did not quite match even their observation – notwithstanding what they were finding: contaminants, unfiltered water – but they were observing signage which says "do not drink the water" but they are being told it's wholesome.

This is experts, experts dealing with Legionella who are identifying contaminants in water. They have said that there is debris in the water in 2015; the same debris is in the water tanks two years later. Now, not only does that tell you that the contaminants are still prevalent, it tells you all you need to know about their maintenance. What's happened in two years?

And, again, they make reference within DMA Canyon that, every time they asked for the maintenance records, they were not available or documented in the report.

Q Did you become aware of another source of expert advice in relation to an aspect of systems within the hospital, a company called Intertek?

A Correct.

Q Tell us a bit about that.

A We found out that this company, Intertek, again experts in their field, commissioned by the hospital-- And they were commissioned to consider a number of points, primarily they were invited to consider flow straighteners, a kind of tap within the hospital.

And the significance about these flow straighteners – and, within further inquiries, microbiologists and others raised significant concern about the use of flow straighteners when the hospital was commissioned, and the reason for that was, sadly, there was an outbreak of bacteria in Belfast at the neonates hospital where wee souls died as a consequence of bacterial infection. And sourced in relation to

that was flow straighteners. And so, whilst within the planning, you could have the best plans, but we now learn from experience, and the request was-- replace them; but, of course, they weren't replaced.

So, these flow straighteners were considered by Intertek in 2018. My understanding from reading the report is that they had access to that type of tap that unused, almost as control samples, and those that had been used within Ward 2A.

Controlled samples were examined, found to be free-- without bacteria. 17 flow straighteners that were examined were all positive for bacteria; 12 of the 17 were heavily contaminated with bacteria.

Now, the second aspect: we're asked to consider two sponges, household sponge that had been recovered from old water tank. They estimated that those sponges had been in the tank for over two years. And how they make the estimation is by considering 2015 DMA Canyon report which highlighted-- and then again in 2017 (inaudible) DMA Canyon report. Some of the trap sets themself are so heavily contaminated that they wouldn't examine them in the laboratory for fear of contaminating the laboratory of various objects in the trap set.

However, I understand they did examine a sealed trap set, and examining the seals found they were contaminated with biofilm bacteria.

And the fourth aspect that they were invited to consider was in relation to water samples. Water samples, as I understand, that were taken from every floor within the hospital, so from 1 to 11, and there was a quantity of samples in relation to each – but also extended to the ground floor, to the basement, to lower ground, if my memory serves me.

Every one of those samples were examined and, within those samples, not all of them but a percentage of them, various ranges, identified biofilm bacteria. And they were looking specifically, if my memory serves me, for cupravirus(?) bacteria. I can offer you nothing about it. I don't know anything other than it's a bacteria. And because of everything that they were doing, they considered to look at the system itself and, as I understand, examine the system, examine the expansion vessels, again found the presence of that bacteria.

So, in all the circumstances of contaminated sponges, contaminated taps, contaminated water supplies, in

all the circumstances, they concluded that, at the point of entry, the system was contaminated and colonised. And that was in June 2018. They had that information. They had that information even before they closed the ward. It tells you why they closed the ward because they had the information; they chose to tell us: “replacing the air conditioning because it's advantageous to do so”; “the water is wholesome”; “the water is safe”. Of course, we know – because this is experts, not John Cuddihy, this is not other patients, this is not individuals emotionally charged. This is experts who they commissioned write this, and if there is a contra-view, a contra-report, I have yet to see it, but it tells me why they closed the wards. It tells me exactly why they closed the wards.

And so any communication narrative that follows from that, at best is disingenuous, and at worst it’s corrupt.

Q Now, after what has been a long discussion about the story of the hospital, I'm going to take you back to what would’ve been your principal focus at the time: the story of Molly, October 2018. Just to help everybody with references, we’re at paragraph 107 of Professor Cuddihy’s statement. Again, Professor Cuddihy, we’ve had quite a bit of this from Molly, so I won't go over things again unless there's anything in particular that you want to add.

We know from yesterday that Molly was admitted for her delayed surgery on the 18th of October 2018, and I think Molly agreed with my description of that event as a “near miss”. And am I right in understanding that she told us yesterday – it’s something you say as well in your statement – that the antibiotics that she ended up on this occasion were designed for leprosy, is that right?

A Yes.

Q I mean, just thinking back to how things were at that point following the cancellation of the operation, following the information that the mycobacterium chelonae was back, following the information that there was another change in plan, following the information that there's more weird and wonderful antibiotics coming. What was the effect of all of that on Molly at the time?

A As I say, we were taken to the edge of a cliff so many times. There’s only so many times you can be pulled back from it.

Q Yes. I mean, is it what you said a number of times this

morning and helped us visualise that it's the margins?

A Just continued to shorten.

Q And we know that Molly was admitted to Ward 6A for periods in late 2018, and she's walked us through the treatment plan and her treatment, and she's also given us her description of that ward. But I would be interested in your description, just your overall description of how Molly's situation appeared to you on Ward 6A.

A Molly's very inspirational. She's very determined, very considerate. She's always very, very positive because she believed in the mindset. Dr Sastry instilled this in Molly: "Molly, you're not a statistic." If we were to go with statistics, Molly wouldn't be here. "This is about you, Molly. You will get through this."

I could see Molly starting to think she was a statistic; and that, not only was she a statistic, the deck was getting stacked against her.

So, it was simply skill of the surgeon, skill of the haemato-oncology team, Molly would have a chance. She was being presented by and made challenges, it was further impacting on her already. Quality of life was reducing and reducing. She became a shadow of herself, and very difficult

because she never had [redacted] to help her, she never had her other friends around about her. Confined to barracks. They did not have that focus going to a table to allow youto be that distance away from the feeding tube, the lying in your bed looking at your four walls. Only your companion is your pump for the chemo or the antibiotics, and she had nothing there to help her.

This is where we should come in, and this is where Schiehallion family-- Even the Schiehallion family were beat. And anyone knows, in any family, there's only so much you can take. They rallied the best they could. The resilience of the people in there was remarkable. But even the narrative of "we will be here two weeks, two months, we're now going to give you a parents' kitchen." You're here longer. "We're now going to start to create a playroom". You're here longer.

I imagine Jane Grant and others said: "God bless COVID". God bless COVID 'cause it gave them a barrier. See COVID is a threat on our children, COVID is just but another. Yes, it affects the wider capability and capacity, the resource allocation. That's no excuse – no excuse at all.

We were in an environment that was not fit for purpose. We were in an environment lacks support, despite the best efforts of the very good people that were there. Dr Sastry, all of those other individuals who are now fighting, not one arm tied behind their back, two arms, what was coming next because they didn't believe the narrative. We're trying to encourage Molly and bring her back. Thankfully, this is more about Molly than it is about any of us.

Molly bounced back from it, started to see a pathway through it. Wanted to then embark on “What’s the solutions to this?” And that’s what dragged her through it. And we probably got through by default at times – not by design, by default. It was a dreadful experience no one would ever want to go through. No one. It was lonely. We were isolated. We lost hope. It's a terrible thing, losing hope. We lost hope, but thankfully better than that (inaudible).

Q And in fact, I know Molly was discharged from the 21st of December----

A Yes.

Q -- and the plan to have her back in for surgery on the 16th of January the following year. Is that right? Molly’s 17 now, is that right, at this stage? And as we've come to

expect in the short time we've known Molly, she was still getting on with her studies and planning to do her Highers the following year, is that right?

A Mm-hmm.

Q So, let's go into January 2019. And I think Molly’s admitted again to Ward 3B, and is it the same surgical team as was going to be involved in the October surgery, is that right?

A Yes.

Q Yes. How did you feel about that?

A Fantastic. I had absolute faith, trust, and honesty in both the consultants and the anaesthetists. They had planned for this. They’d put so much into it. They knew Molly intimately. They knew it-- the margins that they were dealing with. So, to change it and it gave us a confidence that they continued and that they wanted to do it.

Q You mentioned trust there, and the sense I get from your statement and from Molly's is that, again, there was a lot of explanation and communication about what was going to happen. Was that important to you?

A Hugely. I mean, they were very blunt at times, but they had to be because they told us it was going

to be 12 hours that Molly was going to be under the knife, and they described it to us as that the trauma that Molly would experience in the operation would be akin to being struck head-on by a double decker bus. That's what Molly was going to go through.

Q Are we right in understanding that Molly was simultaneously having the surgery to remove the affected sites, and also having the reconstructive surgery----

A Yes.

Q -- in one go? Now, Molly has given us evidence yesterday about the immediate aftermath of that surgery, and you deal with it too in your statement, paragraphs 122, 124. And I think Molly had the period of there being no pain relief at two days. I think you've got it at three days, is that right? Give or take. How was it? I mean, do you recall how it was it was discovered the epidural hadn't worked?

A Yes. So, again, Molly's going through all of this, and she was just in excruciating pain. You could see it, but they believed Molly had had the epidural and, because of all of the other things that were ongoing with Molly, overburdening her, there would be more risk.

It was after, as you say, the

second or the third day, it was assisting Molly to change your bed - happened regularly - and this bed was wet, and her back. It was then they realised that the point of entry for the epidural-- See, Molly still has a tumour on her tenth vertebra. The epidural was above it. Whilst at this point, the tumour itself, which can't be operated on. They thought they'd dealt with the tumour with the radiotherapy, but it's still there. It was still a physical entity. So, the epidural wasn't getting to Molly. It's seeping out her back.

Q Yes. I think, did there come a point after that when there was a discussion about going back to Ward 6A. And did anyone express any concerns about that at the time? Do you want tell us a bit about that?

A So, everything was ongoing, Molly wanted-- Again, this is about the risks. She's in a place that she wasn't able to get pain medication and again, because of the protocols, at that point, Molly is unable to get her required concoction of oxycodone and ketamine because the protocols don't allow it. With all of this and whilst we managed to overcome it - I'm sorry, Dr Murphy, in his own inimitable style - managed to overcome it.

Molly still wanted to go to those individuals that she could go to and

comfort from and could care for her and help her, and despite all of the other this was (inaudible) within it that Molly needed, because she needed help. She needed their experience, their expertise to help her. And she knew that.

However, staff were saying to us that, “Don't want to go 6A. 6A is not a good place to go to. 6A has bacteria in it. We're seeing patients with other episodes. Don’t go near it.” This, again, is when people will say - and staff cannot be faulted - staff and doctors have a Hippocratic Oath, which says in it that there’s anything that they see as detrimental to their patients, should step in. They’re the patient’s advocate, and that’s what they did. And they told us, “If you’re going anywhere, go home. Go home.” That's what we did.

Q I think, just for people's notes, that’s paragraph 129 of your statement, Professor Cuddihy, you deal with that. And just linked to that, if the staff were saying, “If you're going to go anywhere, go home”, was there any suggestion that you’d actually be safer at home?

A As long as Molly’s pain medication is under control, as long as Molly's surgery and the aftercare did not preclude her from being in that

environment, she was safer at home than being exposed to the environment in Ward 6A. Clearly, that was said to us.

Q Yes. And just again, for people's notes and notice, paragraph 131 of your statement, you refer to that.

My Lord, I'm not sure whether your Lordship was intending to have an afternoon break at any point. I’m probably past the point where we would normally take the break, but----

THE CHAIR: (Inaudible) in your hands as to how we best use time. We could take a break and even sit beyond four, if that makes sense to you.

MR DUNCAN: I'm in in your Lordship's hands on that, I suspect.

THE CHAIR: Right. Okay. Somebody's got to make a decision.

MR DUNCAN: I can say this. There is no prospect of finishing Professor Cuddihy today, with or without a break. So, I have no strong view on the matter. Perhaps, Professor Cuddihy has a----

THE CHAIR: As you can see, there's a decision to be made. Somebody's got to make it. Are you quite content to sit on?

A Absolutely.

THE CHAIR: Yes. Well, unless

I'm getting a steer from anybody else, carry on.

MR DUNCAN: Thank you, my Lord.

So, on Ward 6A at that time, in early 2019, to your knowledge, what was the situation in the ward in terms of any concerns that there might have been?

A There was significant concern: staff, families, patients. And indeed, there was closures of the ward in order for further examination.

And as I understand later on, in the months that followed, there was a specific SBAR, further SBAR submitted in relation to that ward by microbiologist clinicians, with 13 separate recommendations, which ultimately concluded the environment of Ward 6A is increasing the risk to immunocompromised patients, and there has to be an urgent review. The options are present.

Q Was that information that was shared with patients and families to your knowledge?

A (No audible reply)

Q Do you know whether at this time there was or there wasn't any a sign of an increase in infections among children on the ward?

A Yes. That was clearly evident from speaking with families,

but also specifically in relation to mycobacterium chelonae. There was another patient who had contracted that.

Q I'll come to that later, Professor Cuddihy, but if we look at paragraph 338 of your statement, and as I say, if we put to one side a further instance of the MC infection, are you indicating there that, at least as far as you understood it, there was evidence of an increase in infections among patients at that time?

A Yes.

Q Now, at a number of points in your statement you mentioned that on Ward 6A, there was an issue to do with the kitchen.

A Yes.

Q Now, I'm not clear in my own mind when that arose or indeed how many times it arose. Can you help us a bit with that?

A When Molly was in 6A-- The kitchen I'm talking about is the staff kitchen, if you like. The kitchen that was there to support the ward, separate and distinct from any patients' or parents' kitchen.

At that point, and you can see - and it's back to communications observation - and you could see a lot of different individuals coming to this room. And communication narrative

that was coming from the hospital is, “We’re sorry, there's a leak in the room. That's why it's closed off.” And when I was watching management go in, see microbiologists, see further infection control: “It’s just a leak.”

And bearing in mind, this is a ward that had been deep cleaned, had been prepared for immunocompromised patients. So, I was wondering what's ongoing in the kitchen. And, as you do, you talk to people who had been in and out the kitchen, and there was a significant leak that had been found in the kitchen. I've seen the photographs of it.

Q What sort of leak?

A It was from a water-- It was from a pipe, back of one of the utilities within kitchen, and it quite clearly had been there for some time.

Q Yes. When you say you've seen photographs, photographs of what?

A Of the damage caused by the leak.

Q And what was the damage?

A You could see mould behind the facilities.

Q And so, even just roughly, when did this issue become apparent?

A To me, it would be early on within the 2019 when Molly was there, because that's how I’d seen the individuals going in. It became apparent, about the full extent of it once I was shown the photographs, because again, people's perceptions of what it is that they’re seeing as a leak, and because of everything that is ongoing, sometimes things could grow arms and legs.

So, I wanted to speak to some informed people who had been in the room, (inaudible) me, and there was significant mould as a consequence of that leak. And I've seen the photographs of the leak, and it was clearly apparent to all.

Q Okay. Going back to the beginning, then, of 2019, we know that, following those discussions about whether Molly would be better at home or not, that is, in fact, where she went. And how did everybody feel about that?

A Molly came home. It was everything. She came home. She’d survived a double decker bus hitting her. She, whilst her drip (?) has been removed and reconstruction surgery and everything from her diaphragm and part of a lung, and all of this has been removed, and we knew the impact it would have, we had Molly.

That's why I say she came home; that's what's important.

Q Yes. Now, you would require to go to day care, though, is that right? And was that still in 6A?

A (Inaudible). Further to that, and because of all the issues happening in 6A, and the closure of 6A day care, we were decanted from there to an area on the ground floor of the Royal Hospital. We went from 2A, the risks exposed to our children, an environment in 6A, and now, we were within the Royal Hospital of Children again. Go back to the options appraisal. If it's safe to do so, we'll use a ward Royal Hospital for Children. We're back in the place that they said is not safe.

But you know you need to go there. The condition on Molly coming home was that every second day we went and so you would negotiate your way through all the different challenges of trying to get in, and then when you get in, you knew that you were in the same place that this water, air conditioning, and it was just that we'd get Molly in, get the treatment, get her out, get her home.

Q I think you deal with this at paragraph 135 of your statement, and you tell us that Ward 6A, as others have told us had been displaced to the

CDU, which I think is a Clinical Decision Unit, is that right?

A Yes.

Q On the ground floor of the Children's Hospital. And you describe it as another contingency. And going back to what you just said there about the options appraisal, where they had four possible contingencies, the first being somewhere else in the Children's Hospital, is that right? And the fourth being the adult hospital, is that right? And was it your understanding that they got to that fourth one as a process of exclusion (inaudible) the others?

A Yes. Well, I mean, it's just from the narrative. Whether it was a hierarchal option, but it was for me was important that we would go to a room in the Royal Hospital for Children if it was safe to do so. It wasn't safe, so they went in the adult hospital.

Q Once the contingency was no longer available, go back to the Children's Hospital, is that right?

A (No audible reply)

Q And what information were you getting at that time from the hospital in relation to this?

A Shocking. Absolutely shocking. The communication from senior management was dreadful.

Dreadful. And again, in speaking with them and trying to engage with them, and I know that they will say to you that they don't like being in front of the cameras or they're not this type of person. My goodness, they should have a media department. You should be able to find someone here that can go in front of a camera and articulate what's ongoing. Reassure us. You have a statutory duty to tell us, and even within the broader duty of candour, it's about harm. Harm is caused psychologically when people don't tell you what you know is ongoing.

And for me, I was in possession of certain information, which I was still waiting to confirm. I knew they were telling lies. I knew that they were engaged in wilful falsehoods by peddling a narrative that everything was "wholesome", everything was "safe". And it wasn't. And even if you strip back everything, close the ward, something's wrong. Close the second ward, something's wrong. Tells you that. Tells you. And they made those decisions based on the information that they were considering. Yet, they chose not to share that with us.

Shame on them. Exposed us pain to heartache, and they knew exactly what was going on. Exposed

the staff who looked inwardly, punished themselves about their processes and procedures. They knew that it was the water. It was the air conditioning. It was as a consequence of the debris which had entered the system for years. Statutory requirements by people who are untrained. They knew it and they tell us the reports are lost. Shameful. Utterly shameful.

Q I'm going to ask you in a little while, possibly today, possibly tomorrow, about what you've just said about reports being lost, because I think we know that that was something that was discussed by the Oversight Board, is that right?

But just on what you've just said about going back to the age of going to day care, CDU and the level of communication around that. Can I take you to have a wee look at paragraph 137 of your statement? We don't need it up on the screen. Just a bit interested in your reflections on the impact on the clinicians and the nursing staff and others at that time.

A So, it's always important, if you wish to land bad news, you may utilise a trusted conduit of information. Someone you trust is then used deliver certain bad news.

And I am in no doubt the same

way they devolved, abdicated their responsibility to the INT, they did the exact same. And by “they”, Jane Grant and her management team did the exact same to the medical staff. They were to be the conduit of information to us. But of course, they could only give you a narrative that had been given to them, and they didn't believe it.

What you actually were achieving there was to start to destabilise the trust with the only people that were there to protect it, so you expose them, you expose their professionalism, you expose their integrity. Why would you do that? Why? I don't understand it. This is world-class clinicians, world-class staff.

We require and we employ clever people for a reason. Why would we devolve the responsibility for such matters to these good people? It doesn't make sense other than further abdicate your vicarious responsibility for what has happened.

Q And just picking up on something that you just touched on there, and I think you mention this at 141, is this where you talk about the destabilisation of that critical trust relationship with the clinical staff and the nursing staff? Is that what you are referring to when, in paragraph 141, you speak about these individuals now starting to look like they’re the ones who are accountable?

A Yes. They're accountable for enough. We've already described in Molly's story, and so many of the children and their families will recount how staff have interacted their loved one, their wee souls, how seriously they take it.

If I could tell you, sir, when you walked onto 2A, or onto 6A (break in audio) period of time 84 cases reviewed by the Case Note Review Team. 21 of their wee souls have passed away. Lost (break in audio) journey. And even those recent times, they have experienced this, maybe not directly, but it was the consequence of a bacterial infection.

They've been deprived of support from the Schiehallion and their families have been deprived of that. Every time a wee soul loses the fight, staff feel it. Staff take that emotional baggage. Many of the staff have experienced intimately these wee lives of the 21 kids, carry that in them. And they learn and they review. When one of those wee souls loses their fight, you're on the ward, you feel it.

And as much as we want all of those others, and to all the kids and stay positive and what have you, that

emotional baggage is hard to carry around. They don't deserve anything, any other responsibility. They carry their responsibility. They have a vocation; they carry in their heart. And for somebody to devolve responsibility to them, put them at the forefront again is shameful.

In the period of time I have been there, it's tragic enough. Molly's experienced seven funerals. Kids. These families and what they get through, go through enough. The heartache of that, they go through enough. And how Molly sees that, and she sees those kids intimately, sitting across from them, then has to go to the funeral, or can't go because of her illness.

Can I tell you staff turn up to every one of those funerals? The staff turn up. Can you imagine that? They've got their own children. They go through all of this. And then they have been blamed for things not their doing. Shame on them. They do enough, and they take enough heartache, and they take that heartache home with them, and they come back again the next day and go through it all again. That's about impact, sir.

This isn't just about the environment in the building and the

water and air conditioning. This is the impact on the quality of life of our children. The quality of life of the medical people, the quality of life of the nurses, of the cleaners; all of those who engage with these children. Yes, we're only a small number. Yes, we're only a small number. Thank God we're only a small number, but they're deserving of far, far better.

Q If we move on a little from there. I want to take us back the story of the hospital. I understand entirely what you've just said. It's something we've been saying at the start of all the evidence here. It's the story of people. We'll come back to that.

Let's just remember a bit about the story of the hospital as well. February 2019, I think the Cabinet Secretary for Health, Ms Freeman, announces that there's to be an independent review led by two senior clinicians, is that right?

A Yes.

Q Let's jump back into Molly's story then, and just we'll come back to the independent review later. Pinpointed the date when that starts, February to June 2019, Molly rings the bell. Tell us about that.

A It was beautiful. Remarkable.

Q Yes. And I think we can see from your statement that over that period, well, it's obvious that Molly was, over that period, plans really are up and running again, and she goes to Cambridge for a course. I think it was a joint course between Cambridge and Oxford.

And in the meantime, you have your own plans. As well, as being Molly's father, as well as being a husband and a father to your son as well, as well as running your business, you're continuing with your investigations and your work, and your engagement with the Health Board and the Government over this period, is that right? Why were you doing that? Quite apart from Molly, why were you doing that?

A It was on me, I thought. It's some skills that I've accrued over the years and might be useful to get source of what's ongoing. I could access documentation, I could be within, whilst trying to work with people to deliver solutions. I could perhaps get closer source of the bacteria and various other things that were ongoing. I could do something good.

Up until this point, staff and everybody else were just doing wonderful things and I was just a pavement bystander. This was my

way of contributing.

Q Yeah. If you look at paragraph 148 of your statement, you say:

> "I knew that I then had to take the baton and support the next family whose children required treatment at the hospital, or the next person with Ewing's Sarcoma. I knew that if the next family asked me about the journey and all of the issues at the hospital, that I would be honest with them. In that situation, you are honest with people who are on the journey because what it allows them to do is to raise the risk threshold."

What do you mean by that?

A You're in possession of the information, sir, so it allows you to consider that information and make informed decisions that will reflect the needs of your child because I didn't trust the hospital management to provide them with a level of information that would enable them to adequately manage the risks.

Q If we go back to the learning curve at the very start for you, the very beginning, 2018. And you describe something similar there in what Dr Sastry and the others were telling you about having to prepare for

things appearing to get worse and learning to distinguish between what is major and what is really major.

Are you indicating here that, by this stage, you were recognising that there were other variables to do with the hospital that weren't part of what you were told at the start, but they needed to be factored in for other patients and other families? Is that what you're getting at? Yeah. And why do you think it fell to you to do that?

A I'm not some brave guy, yeah, thinking that I'm taking the moral high ground. Just thought was the right thing to do. If I've got information that's supported by these documents, if someone asked me, how can I not tell them? How could I run the risk of their child? And this, I wasn't putting this out there. I would only act as a conduit should someone ask because, equally, people have got different thresholds and I would need to be respectful of that and to be considerate of that. But if someone would ask me, come to me, of course I would tell them.

Q But do we also see that, if you look at paragraph 155, you talk about the spring of 2019, you say that you are still trying to work with the board and get them to communicate

more effectively, is that right?

A (No audible reply)

Q Now, if we move on a little from the spring and into the summer of 2019, and I think there was a concert at the Albert Hall, is that right?

A I didn't go to it. Molly was there, I was----

Q Who appeared at it?

A It was Roger Daltrey from The Who. He is a patron of Teenage Cancer Trust.

Q And was Molly involved at all in it?

A Yes, yes.

Q What was Molly's role?

A Molly and [redacted] were to go down and enjoy the concert and to see people. Molly ended up on stage and took the opportunity to say to the audience in the Royal Albert Hall about the wonderful things that TCT did in Scotland. It's a fundraiser. She's never one to miss an opportunity.

Q What did she make of meeting Roger Daltrey?

A Again, very interesting. Molly loves her music and loves individuals, and I think it was lost on her and was asking exactly who this guy is, as you can see. Again, the kindness shown by strangers is-- Thankfully, we have more good people

than bad. More good people than bad. A remarkable guy who was so warm and so kind, so supportive-- [redacted], Molly and all the kids that'd gone down there, and that was for them.

Q And you are returning to your normal life, if you can describe working in Afghanistan as normal life. And Molly, as you say in your statement, is off to Cambridge to do that to do her course. Now, I think I just about dragged it out of her yesterday, but how did how did she get on there?

A Fantastic.

Q Yeah?

A Just fantastic. They just loved her to bits. Yeah, and she excelled.

Q I think, in your statement, you said you say that she was the dux of the course.

A Aye. Yeah. Molly didn't want me to say that, but she was.

Q No, I mean, I looked at her statement very closely and I didn't see a mention of it.

A Aye.

Q And when she returned, how was she?

A Oh, she was going to be the next Dr Sastry. That's it. "On my way, Dad."

Q Now, move into another matter around about this time, and it's maybe the last thing we'll deal with today.

There was a meeting, I think, between Molly and your wife and Dr Sastry in June 2019, and I think you deal with it at paragraphs 340 to 351; I expect people will want to have that in front of them as we go through this, and I dare say you might as well, Professor Cuddihy.

(After a pause) Now, just to sort of take a step back in relation to this conversation, prior to this point, had you had any discussions with any members of GGC about being apprised of any further instances of MC infection?

A Yes.

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

A So, through discussions that I had, either in writing or physical meetings, it was agreed that there would be a single point of contact for myself and, specifically because of my challenges in and around investigations about Mycobacterium Chelonae, having been told the rare pathogen, but this was only one incident, that any information that had an impact, a direct impact, on Molly and would be communicated to me. And it was known freely that I had

been engaging in the this.

I had engaged with people over in the States. I had identified various specialists in water, an individual who had studied water contaminants in Colombia, specifically in relation to Mycobacterium Chelonae. I tried to go everywhere and there was a dearth of information. And, indeed, the likes of Dr Inkster and various others were broadening their net to see what they could find out in relation to all of these matters that were ongoing.

And what was hugely important for us is that it was not breaching confidentiality, that any information that would have a direct impact on Molly would be shared. And this was agreed and was known, and that that conduit of information would be between myself and Jamie Redfern. That was the gateway to receipt of information to me, but also I had to access into other individuals – that would be the conduit.

Q So, if we then go to paragraph 340, you're overseas on business and you get a call from your wife. And you want to just walk us through what your understanding of what had happened was?

A So, Molly and [redacted] go to the hospital. It's a routine go to day care. And again, it's all about casual

communication as well. Molly and [redacted] had been asked to go into a side room. On reflection it is normally bad news is coming, and I can only imagine how they were thinking and you're not there to support them.

They go into the room. Dr Sastry, as I understand, cAme into the room. And so, the reason why I can speak to this: [redacted] phoned me and relayed it. Hearsay it is, but it will put into context what happened.

So, [redacted] phoned me to say that "We've just had a meeting with Dr Sastry and he has advised us another patient has contracted Mycobacterium Chelonae on Ward 6A." My heart sank. We could have prevented this, or at least we could have done our very best to prevent this. We could have done better to prevent this.

And your mind goes to "Who is it? What family is it?" because you'll know them. And [redacted] had advised me that Dr Sastry had to say it seemed to have consequences for-- Someone had had either phoned them when he was speaking to [redacted] and Molly or there was a call which meant he needed to leave the room.

And Molly was really upset about it as to who it could be, and, whilst yeah, that was also in my head as well. So, upset about it but also,

"What does this then mean for Molly as well?" It's terribly selfish, I know. I'm ashamed of myself for even thinking about it. You then think as well, "What does this mean? Does it give us an opportunity to source this? Does it give us an opportunity, now?" The impact on Molly as well.

So, you're balancing trauma of what's happened to another family, and they're going what we have just come through. There's a wee kid going through what Molly has gone through. Seeing the vulnerability of it, you've seen the trauma, you're seeing an opportunity-- Just all wrong, just all wrong.

It's just because of the impact of the communication and what was in place, and I'm away from home and I'm trying to reassure them, saying, "Look, I have a single point of contact, ." Jamie Redfern is a thoroughly decent man. Jamie Redfern has been punched from top and bottom, he has been a human punch bag. Coming from patients who see him as that conduit, but also from others. I had concerns for his own wellbeing during this. I believed that they would contact us. I believed in my heart, and I says, "They will. There is a reason why we're not being told. Just have to trust him. I've said that we'll trust him. Be patient. Go home."

I waited, one week, two weeks, and in the interim, I had found out from those on the IMT, Infection Management Team, with whom I had relationships, that indeed someone had contracted Mycobacterium Chelonae and nobody compromised the integrity of those patient detail, no one. Because of the closeness of the families though, you would find out.

And I knew that a specific action had been taken at that IMT that I should be informed. I should be informed someone else had contracted Mycobacterium Chelonae, and further, that action had been given to two named individuals to speak to me. I waited two weeks, became three weeks. Couldn't wait any longer.

I sent an email to Jamie Redfern, and I didn't miss him and hit the wall. I was angry, disappointed, and I asked for a meeting. And we had the meeting, and it was scheduled, and I went along to the meeting. I flew back the night prior to the meeting, meeting the very first thing the next morning, the Royal Hospital of Children. And I went in and Jamie was there along with Teresa Inkster.

And I was in the meeting, and I made it clear why I was there, that I understood that there was information

that a patient had contracted Mycobacterium Chelonae that had a material bearing on Molly, but also that an undertaking had been taken:

> "You, Jamie, would be speaking to me in relation to this. You agreed to be the conduit of information."

And so, he gave me an explanation. First of all, that he was on holiday and apologised. And this brings me back to the whole resilience piece. You may be on holiday, but surely - this is a big beast of an organisation - someone else can speak to me, and I knew two individuals had been given the action. I knew the two individuals weren't on holiday. I had to have confirmation of what I was being told.

I was then told that they believed Professor John Brown, the chair of the board, would speak to me directly because they believed that, as I had already engaged in a number of discussions with him, specifically around Molly and all of the other challenges. Bearing in mind a bunch of information here, there is no John Brown, it's you, and the action is not to John Brown, the action is to you. I wasn't buying that. And we were on another offering, at which point Dr Inkster says: "Tell Professor Cuddihy the truth, Jamie. Tell Professor Cuddihy the truth, Jamie."

I sat back because, when someone says that, someone who's a senior clinician, the chair of the IMT-- "Tell him the truth" implies someone has told me an untruth. What else are they telling untruths about? So, what happened? What happened at this? Because I also knew that, following IMT, the action had been updated that I had indeed been informed so the action was closed off.

And what I learned at the meeting was that two individuals left the IMT following the action and went to a room to phone me to tell me whatever it was, they had to tell me. And as they entered the room, went to phone, they received a call: "Tell him nothing. Focus him on his own environment." What do you say?

And that call that was taken was from a senior manager, someone above the chain of Jamie Redfern, someone above the chain of Teresa Inkster, "Don't tell him." So, there was an instruction at that point, "Don't tell him", then someone goes to the IMT following it and updates the action, "He's been told."

And so my immediate response to both - and it was an extremely uncomfortable meeting, and I applaud

the honesty. I applaud the honesty of Dr Inkster, and I also understand that Jamie Redfern was trying to defend the indefensible; he had been instructed to do something. And so I left the meeting and said to them that "Neither of you have it within your gift to sort this" 'cause it's who sits in senior management who's given this instruction.

I made direct contact with Jane Grant, and I asked six questions. I put them in writing: "Who was it? What member of staff was it who gave the instruction to Dr Teresa Inkster and Mr Jamie Redfern not to speak to me?"

The second question: "What's the basis for that decision making?" Because, even then, I was still prepared, even then there was a good reason not to tell me. There was a good reason not to tell me. I'd yet to hear it.

And the third question, then, was: "Do you, Jane Grant, agree with this approach?"

And the fourth question was then: "Who took the decision to update the IMT that I had been told? What was the basis for that decision, and do you, Jane Grant, agree with that?"

I eventually received a letter, which was not worth the paper it was written on. It was dreadful. It never

dealt with any of the questions. It never dealt with the serious nature of what happened here, 'cause as I left that room, Dr Inkster – who was extremely upset, as was Jamie Redfern, emotionally upset. She had to seek recourse with the General Medical Council because she had been encouraged to tell a lie to the father of a patient; that's a breach of the statutory requirements. She went to the General Medical Council. That's the pressure that these members of staff are under. It demonstrates a culture and an organisational behaviour.

Your leadership demonstrate the styles, the values, the behaviour of your organisation, and when those behaviours are toxic, it permeates the very pores of an organisation. And those two individuals, I believe in my heart of hearts, are good people – they were given an instruction.

Notwithstanding that, it had consequences, significant consequences. They confirmed that I had been told a wilful falsehood. A wilful falsehood. Encouraged to tell lies to a patient's father.

And following the written response from Jane Grant, I had a follow-up meeting with her and Professor John Brown and Dr Jennifer

Armstrong, and at that meeting I brought this up – brought a number of things up, specifically in relation to this - and invited to articulate my high level concerns. I was extremely disappointed and angry, and Jane Grant said to me, no further than this, and looked at me: "I can assure you, will look into this for you. I will look into this."

I said, "Well, you know, Jane Grant, you've already looked into it for me. You sent me a letter." That's the Chief Executive of GGC, that's the Chief Executive. Mortified.

(After a pause) And I said to her, and I put it in writing, that she had neither the operational or professional competence to discharge her duties as a chief executive. An allegation has been made the chair of the IMT convened to get to the root cause of these infections had been encouraged to tell a lie. A senior manager had been encouraged to tell a lie.

And Jane Grant's response – incredible, absolutely incredible. And that followed up the great and the good who were there: the Chair of the Board, the Chief Executive, and the Medical Director. And the Medical Director, in the discussion, she wished to tell me what they were doing in relation to Molly, and in all her wisdom

and experience and expertise.

And remember, I go back to the point, even those in radiotherapy, the cleaner, auxiliary, made it their business to know you, made it their business to understand you and son or daughter – made it there business. And here we had the higher echelons of Greater Glasgow and Clyde, convened a meeting, meet with me in relation to all of the concerns that I had raised.

Jennifer Armstrong, the medical director, who had already sent me a letter which I had no confidence in, started to articulate how the advances of science and genome testing be utilised to get to the bottom of Mycobacterium Chelonae, and this was ongoing. "Stop you. Molly wasn't in 6A." Talking about somebody else.

You asked me about having confidence in trusting people. They had no idea who they were speaking to, no idea about Molly Cuddihy, because when it came to it, when they had the opportunity to demonstrate their competence, when they had an opportunity to build bridges, when they had an opportunity to demonstrate trust, for me to have faith, trust and honesty in them, they fell miserably; and by their very actions support a culture that encourages senior medical

people to tell lies. Shameful.

So, what else are they telling lies about? Perception is truth.

Q Thank you, Professor. My Lord, that might be a convenient point at which to break. It's also four o'clock, I see.

THE CHAIR: Might be a convenient point. You can come back tomorrow, Mr Cuddihy. Well, we'll intend to begin at 10 o'clock again tomorrow, but until then, we're adjourned – but we'll give you the opportunity to leave.

THE WITNESS: Thank you.

16:06

(The witness withdrew)

(End of the Afternoon Session)