SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 September 2021

Day 16
Wednesday 27 September
Morning Session

CONTENTS

10:00

THE CHAIR: Good morning. We are able to resume with Professor Cuddihy?

MR DUNCAN: I believe so, my Lord.

Professor John Cuddihy, Cont'd
Examined by Mr Duncan

THE CHAIR: Good morning, Professor Cuddihy.

A Good morning.

THE CHAIR: Mr Duncan.

MR DUNCAN: Thank you, my Lord. Good morning, Professor Cuddihy. I wonder if we might just start by picking up where we left off yesterday and the exchanges that you told us about yesterday with, first of all, Mr Redfern and Dr Inkster and then subsequently Jane Grant. I think it's clear from your statement that you met with Mr Redfern and Dr Inkster on 8 August 2019. It's paragraph 344 to 346 of your statement. And, as I say, just to sort of tie up one or two things from that evidence from yesterday, at that meeting with Mr Redfern and Teresa Inkster did you ask the question, "Who was it that told you not to tell John Cuddihy about the further MC infection?"?

A Yes.

Q And did you get an answer?

A (No audible reply)

Q And if we move then to the later – sorry, I apologise. You told us, of course, that you wrote to Jane Grant and set out a number of questions, including that question and including a question about who had updated the IMT by saying John Cuddihy had been informed, and I think you said yesterday that in her response none of those questions was answered. Is that right?

A That's correct.

Q And then I think you told us yesterday that you then had a meeting with Jane Grant and other senior management individuals. Is that right?

A That's correct.

Q And if we go, please, to paragraph 351 – and, Miss Callaghan, could we maybe just have this up on screen? Thank you very much. Again it's:

> "Further, on 12 November 2019, I attended a meeting with Professor John Brown …".

And a number of others. Is that the meeting that you're referring to?

A Yes, sir.

Q Yes. And you say at that meeting, as well as Professor Brown, there was also present Dr Armstrong, Medical Director, and Jane Grant, CEO, and you say:

> "During this meeting I expressed concerns around a number of matters including this event."

And is "this event" the discussion with Mr Redfern and Dr Inkster and the instruction not to say anything to you?

A Yes.

Q And:

> "Jane Grant assured me that she would look into what I had to say and apologised to me. I advised her that she had already 'looked into' this event and had sent me a letter regarding those findings!".

And just pausing there, tidying up one matter from yesterday, did Miss Grant, or indeed anybody else, ever clarify to you the question around who had given the instruction not to tell John Cuddihy about the MC infection?

A The name was never given.

Q And you go on to say this:

> "This had followed written communication from me posing a series of questions around the events alluded to earlier."

Which you've told us about. And then we go on to a slightly different matter, which you also touched on yesterday, and say that:

> "In addition, Dr Armstrong articulated the response to the identification of mycobacterium chelonae, and proceeded to outline the events of June 2019 on ward 6A and how water samples and bacterial samples were sent for advanced Gnome testing. I had to interject and advise that the event she was

describing was actually another patient and that such testing and comparison of water samples could not be made with regard to my daughter, as no samples were taken, certainly not to my knowledge."

I think you did touch on this yesterday but just to be sure we understand your position on this, are you indicating that Dr Armstrong thought you were the father of the person who had been infected in 2019?

A I don't know if she thought I was the father. I think she had simply misrepresented and provided information which related to another patient. She knew who I was and she knew my relationship with Molly but the subject that she discussed, and the Gnome testing in relation to samples that had been taken and samples from a patient, certainly not Molly, and it was the other patient she was talking about. Yes.

Q And you go on to say:

"It was embarrassing for Jane Grant and Jennifer Armstrong and it was uncomfortable for John Brown who agreed to take away the issues and report back formally. This meeting was a further example of a lack of corporate knowledge and corporate memory and a leadership in crisis, unaware of what was happening across their areas of responsibility."

And I think you said all of that yesterday. Is that right?

A That's correct and I followed that up, sir, with an email confirming all the points that were discussed and sent that email to them.

Q And the formal report that you understood you were to get, did that come to you eventually?

A (No audible reply)

Q Thank you, Miss Callaghan. We can move that to one side. Professor Cuddihy, can we move back to Molly's story? Now, we know that Molly relapsed in August 2019 and Molly has taken us through that, and I don't need to ask you about your perceptions in relation to that and how you came to learn of that. But we do know, I think, from your statement

that there was a meeting with Dr Sastry on, I think, the 9 or 10 August 2019 and a discussion of options. But also, in that context, a discussion about what effect the bacteria had had on options. What was your understanding of that issue at the time?

A Primarily, sir, it's a consequence of the antibiotics and Molly's kidney function at that time that had significantly reduced the options that were available to Molly and that Dr Sastry did come up with a plan, she did, but it was quite apparent that the development of the bacteria was having a detrimental impact on the treatment of Molly for cancer.

Q Yes. I think step one in the new plan, and of course this isn't the first change of plan, but in this new plan, was there would be an operation on 12 August. Is that right?

A Yes.

Q Now, you do deal with that in your statement, and just for people's references, it's paragraph 170 of Professor Cuddihy's statement. I think you say Molly was quite unwell after the operation. Is that right?

A Yes.

Q But she got to go home, I think, on 30 August. Would that be about right?

A Yes.

Q Yes. And I think by that stage she's now going on to the new plan and she's having chemotherapy by pill, I think. Is that right?

A Correct.

Q Now, I wonder if we could just have you have a wee look at that just to identify the relevant part of the statement? I think it's paragraph 172 we need to go to. I don't need it on screen, Miss Callaghan.

A Yes.

Q You've a recollection of that and, again, in terms of Molly being very ill again.

A Yes.

Q Is that right? And I think you go on to say, just a little bit further down the page, that by 15 September Molly is, in fact, needing blood transfusions. Is that right?

A Yes.

Q Yes. And she goes to 6A for that. And the way you put it is it was just horrible----

A Yes.

Q -- being in 6A again. Is that right?

A Totally.

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

A Molly was to be treated for cancer, which was her primary

illness, and now we're finding that that primary illness was in the treatment plan was being inhabited as a consequence of something that was contracted in the hospital, and I say this because of being told it was a hospital acquired infection, and so to go back in the very same environment which had had such a detrimental impact on Molly's health, which has taken her to the cliff edge so many times, you're not simply fearful of the consequences of cancer, you're fearful of the consequences of the environment and remembering that from the outset there will be bacteria that will be the greatest enemy to Molly. That will be the greatest threat, yet we had to go back into that environment to that greatest threat. Even more so, all the planning, all the preparation, to protect and all the clinicians and everyone tells you that this is what you need to do to protect Molly from bacteria. I would just want to shout at everybody, "Well, why don't you practice what you preach? Why don't you protect Molly? Why don't you ensure she will not be vulnerable to the environment?" She had to go back there. Where else would I take her to? Dr Sastry was there. I already ensured that Molly was with us. She came home. I was just terrified that

she may not come back. She was going away outside our control, back into the hands of people we have to trust but I couldn't trust that. Would she come back? Back to the start of the story, the most precious thing you're handing over. I'm handing her over in the knowledge that there's something wrong. If I was standing at the roadside and I saw the bus coming and hold Molly's hand, I wouldn't allow her to walk across the road. Of course, I wouldn't. I was supporting Molly to go back into an environment that was going to be an impactive on her, threaten her. We were reliving that because we had no other option, no other option.

Q Yes. I mean, let's not look at the story of the hospital. Let's just look at the story of 6A, 2019, the contingency, the escape from whatever risk there was, Ward 2A, and look at the story of the contingency 2019. You've already told us this, and as have others, ward 6A itself had required to be closed on occasion. Is that right?

A (No audible reply)

Q Once? More than once?

A Several occasions.

Q Yes. You were aware of issues on ward 6A. For example, you mentioned this issue to do with a

kitchen, something that was described as a leak but, in fact, as you described yesterday, the leak involved apparently the creation of mould or something of that nature in the environment of ward 6A. Is that right?

A (No audible reply)

Q So when we then jump back into Molly's story on ward 6A, 2019, and we go to the later part of the year, October 2019, we know that from what Molly said, she did indeed go on and contract another issue or another infection that Dr Sastry will tell her, apparently, is the result of being in the hospital without prophylactic medication. Is that right?

A (No audible reply)

Q Okay. Let's stay on Molly's story for a bit though. Before we get to that, we've got this from Molly on Monday. I mean, despite everything that was going on in 2019, especially late 2019 and everything additionally that she faced, Molly and decided that they would set up a charity. Is that right?

A (No audible reply)

Q Did the "Every thank you counts" charity exist before Molly and decided that they were going to do something about that?

A (No audible reply)

Q And I think they arranged a ball. Was that on 5 October? Is that right?

A (No audible reply)

Q Yes. And who was at the ball?

A Everybody. 750 people were there. Each of them were there for Molly and [redacted]. However, they wanted to ensure that the Schiehallion family were there so they invited as honoured guests seventy of the Schiehallion family on (inaudible) to the consultant. They were there to benefit and recognise what we thought about them as a thank you, a small price to pay in relation to say thank you. It seems it's not befitting of whatever it is we have to say if something (break in recording).

Q And I think we see from your statement that that's the other reason the cleaners and the consultants were all sitting next to each other and the sense I had from your statement was this truly was a family affair in that sense.

A Even the lead-up to it and it was intentional. This was again driven by Molly and [redacted], was that everything that's ongoing was to be put aside. No one was to mention the environment in the hospital. This was good news. This was to be a

happy time and all the staff, and you could see them and talking about their dresses and where they were going, and make-up and their hair, and who would be staying and who would not be staying, and, as I understand it, it's the first time that such a gathering was made possible, even so much so that those who were not attending had covered shifts because they still had business as usual to take care of, still sick kids, still vulnerable and critically ill patients that had to be cared for, and many of them who were there were still on-call, responding to the needs of the hospital. And so it was the lead-up to was important as the event itself. The event went by in a heartbeat. That's a memory.

Q I think Molly and spoke at the event. Is that right?

A Yes.

Q You can have dresses, make-up and hair. I imagine you felt like a pretty proud father that night?

A Molly was there.

Q And did anybody know, beyond the immediate clinical staff, did anybody know that Molly had actually relapsed by this stage?

A (No audible reply)

Q On the negatives that weren't to be mentioned, along with water, ventilation and other problems,

nobody was told about that either? Is that right?

A Only [redacted] and had knowledge of it but it was nobody's business.

Q I think Molly in her statement explained that she'd actually gone onto the maintenance chemo to make sure that she was going to be able to do this, but we can see from your statement that, in fact, on that night, after the ball, she became unwell again. Is that right?

A Yes.

Q And I think that then leads eventually, we can see from your statement, that you have to take Molly to A&E one night. Is that right? Have I got that right, that that would be around about 23 October, just very roughly?

A Yes.

Q Now, how long did it take you to get from A&E onto the ward?

A Several hours. It was three hours, I think it was, yes, about three hours.

Q Now, in your statement, Professor Cuddihy, in that context you say something about patient pathways and that you asked questions around that issue too. Can you tell us a wee bit about that?

A Yes, certainly. So our experience in relation to a response and the protocols, one hour away in (inaudible), roughly about ten o'clock at night there is no doctor physically on the ward in Schiehallion. They were still accessible. They work very, very long hours there, until it was not unreasonable that ten o'clock is a cut-off time. Often they would be there beyond that but it's because they would be dealing with the needs of a patient. And so you would be required to go to Accident & Emergency and the reasoning there is that you can have a doctor to assess vitals and what have you before you go on to the ward. But when you enter an Accident & Emergency, any Accident & Emergency is a zoo. It's a zoo. It's a dreadful environment and you only feel for the people who have to deal with what they have to deal with. And whilst they will take the care as they can, taking in a vulnerable child into the environment for me was not acceptable. I'm not saying that those who are coming through Accident & Emergency aren't deserving of the proper – of course they are, regardless of whatever state they're in. Of course, they are. But even down to the infection aspect, going into that environment I didn't think was conducive to the protection of Molly or, indeed, any other child. So I brought it up in terms of the patient pathway, so if you're to ask for patients who are immunocompromised and who are vulnerable to enter that environment, surely we should be able to have a plan to text them and it doesn't take the three hours. And so I raised that as a particular point with Jane Grant and others at that meeting and again I followed that up in writing, that they would give due care and attention to that, and in the hope, with everything else that was ongoing, that that broader patient pathway would be tethered. But, as you see, there are sinks within that environment, but to ensure that there was filters on those sinks, that we would have within anywhere else, in 2A or 6A. Was the air conditioning suitable for them when they go into that environment? One would think, if you're within 2A and even the knowledge now that the air conditioning system wasn't fit for purpose, but it was to be designed so that it catered for the needs of immunocompromised children. One would then expect that that would be the same for ward 6A or, indeed, the broader patient pathway because if we're to protect our children within these closed environments, they

become vulnerable when they move out with it. So what was the plan? And it was simply to say to them, "Are we considering this? Can we consider it?" You also have to be realistic and I accept that, but within the planning regime, the development of this crisis, it would not be unrealistic to expect that if we are saying that we need to protect them from those environments that they're currently in, that we look to further protect them within the broader environment of a hospital. And that's all I ask for.

Q And just to be clear, the A&E that we're speaking about here, was that in the adult hospital?

A Where we come in there's an A&E aspect of it, yes, that's where it was. There is an aspect in a children's hospital where you bring in children there but it was through the adult section.

Q And I think we know from your statement that, despite everything you've just described, Molly meanwhile was doing an entrance examination to Cambridge. Is that right?

A (No audible reply)

Q But then jumping back into the reasons why you were in A&E on that evening, I think there were scans taken, is that right, around about this time and they showed something on Molly's lungs? Is that right?

A Yes.

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

A Scans had been taken. Her breathing was very, very laboured and obviously because of the tumours that had previously been in Molly's lungs, and the recurrence of tumours, everything else that was ongoing, your heart sinks and you think this will be it and she was very ill. So the scans had showed up significant abnormalities.

Q I think you describe them as "black dots"?

A Hovering over her lungs.

Q Yes, and I think you described that Dr Sastry was in discussion with you and Molly and your wife about that, and do he know what they were to begin with?

A He wasn't sure but he feared the worst.

Q But in the end are we in the way you described as "good/bad news" territory, that it wasn't tumours, it was, in fact, what Molly told us about, PCP pneumonia? Is that right?

A (No audible reply)

Q And what did you understand that to be?

A Life-threatening still. It's from what you're saying, tell us that

you're almost pleased it's not cancer, happy it's not cancer, but you're accepting that it's still another critical ill disease. It's the margins. She's got a better chance. Or has she? I don't know.

Q And it's a disease or an infection that you understood to arise from what?

A Fungus – fungal infection.

Q So at this stage, on hearing that, what were you thinking?

A The kitchen, the ward 6A. I accept that people say, "Well, you need an evidential link". In my head, my background is I need an evidential link. In the balance of probability, all I could see was this mould and I could see Molly and I could see everything else that had happened. That's what it was, again this environment had taken hold of Molly. You can't shift that and everything else I'd seen, I'd read, and this is also the whole impact of this, is that I'm reading things that I should never have been reading. I'm finding out things I should never have wanted to find out because you want to make an informed decision. There is nothing other than I had to still take Molly into this environment that wasn't safe, and here again she's contracted another and I failed to protect her.

Q Does this take us back to those parental instincts right at the very start of all of this, one of them you mention is guilt?

A It eats away at you with the cancer, inside out. Consumes you. And I understand, and people will listen, and emotion is a terrible thing. Emotion can eat you up. I still tried at times to be as realistic as I could, to consider and bring myself back from it. But the doctors are telling me Molly has a fungal infection, Molly has bacteria. They're telling me these things. I'm reading reports that's telling me that there is an increased risk as a consequence. There's a correlation here, an absolute correlation, demanding of answers, demanding of information. But the silence was deafening and all we had to face up to was the fact that this was another episode that we had to deal with and is Molly going to get through it?

Q I asked you a lot of questions yesterday about communication. At one stage you reminded us all this was not just about communication, it's about impact. Was there, quite apart from the impact of the fungal infection, was there also an

immediate impact on Molly as regards what they had to do as regards the fungal infection?

A Of course, there is. There was further treatment, more of the treatment that Dr Sastry said, "It would seem at times that we're being cruel". How more cruel can you be? What else are you going to do?

Q One bit of treatment or investigation that you describe in paragraph 192 is something called a BAL test – B-A-L test. Molly gave us a pretty vivid impression of what that involved for her. Something that would usually be done under general anaesthetic was done while she was awake. I won't ask you to relive that just now but I take it we can assume that was an horrific thing to have to observe? Would that be fair?

A It was that (inaudible). The doctors had said to me that anybody going through this should have anaesthetic. "We can't give her the anaesthetic and do that. The risks are too great". They put this in her throat, into her lungs, and put water in. Look at this. Molly's described it to me as though you're drowning. I don't know about that. I can only sense what they would be like. Horrifying. Again, she's living this, feeling this, and she's thinking, "This is treatment to help me". But it did and it's there to wash out and to flush out all of the horrible stuff that's there so that they can deal with it, and this is just constant, constant, one after the other that she's going through and Molly's wee body at the time was just – I pick up on it, I pick up on that. All this was constant and what's it doing not only physically to her? You're into her head. What's it doing to her in relation to what she's thinking and you're allowing this to happen. What kind of parent are you?

Q You got through it and she was discharged 27 November 2019, and what did she do after that? (After a pause) I mean, I think we can see from your statement.

A Sorry.

Q Once again, lipstick and wig and----

A They got to Edinburgh. Molly had an interview at Edinburgh University and the difference in her when she walked and she bounded through the gates at Cambridge, as high as a kite. She was just so, "I'm going there, dad." And she couldn't walk up the stairs at Edinburgh but she had to, because that's – that would be the future. She just had to focus so she dragged herself up those stairs and we watched her, because she has

to have a future. Molly has to because she only (inaudible). Molly protects us better than maybe I protect Molly during anything she's done. She done her interview for Edinburgh University and then came away from it back to her bed.

Q And then you, I think, round about this time, as well as everything else with Molly and your job and wife and your son, you go back to engaging with the issues to do with the hospital again, I think. Is that right?

A Yes.

Q Let's switch then to the story of the hospital for a bit and just help us a bit of some of the timeline here. I think we can see from your statement that in about October 2019 Professor Craig White was appointed to act as a family liaison lead. Is that right?

A That's correct.

Q Now, who is he?

A He's an official of the Scottish Government and let's just say he was taking on that role on behalf of the Scottish Government and it was part of, as I understand it, the escalation to level 4, in which Greater Glasgow and Clyde was placed, because it was considered that they were not fit for purpose.

Q I'll come onto that in a minute. And what was his role, as you understood it?

A He would, well, first of all, establish exactly what the communication and engagement was with patients and the parents and the families and the hospital. He would seek to then be a conduit of information in the first instance between those families and the hospital and thereafter he would seek to develop and work with a number of internal and external stakeholders to develop a communication and engagement strategy that would enhance the relationships, would build trust and re-establish the faith in families, between them and the Health Board.

Q Did you, in your experience – in due course I'll come to your role on the Oversight Board – in your experience, did you find that role, and indeed the way in which he fulfilled that role, something that was effective?

A I did, yes, and the reason – and I'll qualify that by saying this was some months, I think some eighteen months, after, if you like, the height of the crisis, and a number of months after the cabinet secretary had announced various things, but it was

still welcome nonetheless and so filled the gap so the need was there. So I saw that as a positive step forward and I made it my own intention to go and speak to him directly, so that I could understand, "What is it that you're going to do here? Will you act on our behalf? Will you enhance existing communication and engagement?" And this could be somebody who could have a subjective view, to consider both sides, because I am sure on both sides there will be individuals who will consider that they were perhaps good or bad. The issue is was it effective, and that's why I welcomed it because if it allows then to consider from almost an impartial view what that current communication and engagement looked like, and if there was any improvements, what would those improvements look like? But also for me, which was usually important, was that he was willing, he was willing, to communicate and engage and to enable the co-production and co-delivery of that strategy. That for me is true engagement. He was inviting input from everyone and from that we would work out a way forward.

Q And I think around about this time as well, you yourself, as well as meeting with Professor White, I think you also had meetings, or a meeting, on 23 October, with Ms Freeman and Professor Fiona McQueen, who was at that time the Chief Nursing Officer for Scotland. Is that right?

A That's correct.

Q Can you maybe set out what that meeting was about and what happened at it?

A Well, that was the first of several meetings that I had with Jeane Freeman and primarily again it was a visible demonstration on the part of Scottish Government to communicate and engage, but it was an opportunity for us, myself, Molly and [redacted], to put forward what our concerns were in terms of parent communication and engagement, in terms of the environment, of the culture, of the organisational behaviour, and of aspects of trust and other different points that developed further. And specifically I asked her how confident was she in relation to the level of information that she had been provided that enabled her to make informed decisions?

Q And by "she" do you mean Ms Freeman?

A Ms Freeman.

Q Sorry. Please continue.

A Yes. And within the room there was Jeane Freeman, there was Fiona McQueen, but there was also one of the SPADs, the special advisors, who were there making notes. And specifically when I asked about the level of information that she was receiving, because I had significant concern that when it came to disclosure of information, GG&C were determining relevance. They were determining relevance and were disclosing that and, in my opinion, they should have been making full disclosure for others to determine relevance. An example I gave her was in relation to the reporting to the board and at that time the 23 gram negative infections of patients, a number of different episodes. And I gave as an example, I says, "Molly Cuddihy does not feature on that list, yet she has a rate pathogen and I've just explained to you the impact that it's had. And so even working within those small margins, gram positive had not been reported. Broader bloodstream infections are not being reported. So how confident are you, cabinet secretary, that the information that is being laid before you is representative of the sum of all its parts because I would suggest to you it's not. I would suggest to you, you look further." And

I also told her about my experiences in relation to wilful falsehood. I told her about my lack of confidence in the Chief Executive for the reasons that I have articulated and I identified to her that there was an absolute lack of confidence in the board to do its job because the reason they were not being provided with the information. So how can you scrutinise, how can you hold to account, if you only have half the story? And this is when I say about having a confidence the Greater Glasgow and Clyde were disclosing full disclosure of all of the information to allow you to make an informed decision? And, of course, even with the partial information, they thought it necessary to place Greater Glasgow and Clyde, escalate them to level 4, which in itself told me, she agrees with me. "They're not competent and they're not competent in the area of infection control", because that was one of the areas. And not competent in the area of communication and engagement, because that's another of the areas. So she listened, she noted and she said she would take forward her concerns.

Q Now, just to identify where we are in your statement, Professor Cuddihy, I wonder if we might have a look at paras.267 and

268? Miss Callaghan, would we be able to have those up on screen? (After a pause): Thank you very much. Can we jump back to 267 and 268, I think, please? On mine it's jumped ahead. I don't know how it is for everybody else. (After a pause): It may just be me. Thank you. It probably was just me. So this is the meeting that you've been speaking about, is that right, Professor Cuddihy?

A Yes.

Q So it was at JB Russell House. You meet Professor White and then you provide him with the update of concerns around communication and you welcome his appointment, albeit, as you said a moment ago, eighteen months following the height of the first outbreak in May 2018, and nearly eight months since the cabinet secretary announced in Parliament that she would look to address concerns. You outlined the experience to Professor White. And then you say that later that day, you, Molly and your wife, attend Atlantic Quay and meet with the cabinet secretary and Professor McQueen, and you say:

> "I expressed my concern of the lack of open, honest and transparent communication and engagement between NHS GGC and myself. I updated that I was concerned as to the level of … reporting with regards to the bacterial and fungal outbreaks ...".

And just pausing there, was it your understanding that as well as not capturing the gram positive infections, reporting on gram negative didn't capture fungal outbreaks as well? Is that right?

A Certainly not within high-level report to the board, no.

Q Yes. And you provided examples. You invited the cabinet secretary to consider whether she had a confidence in the figures and the types of bacterial outbreak being reported to Government.

> "I provided a number of examples of poor communication and engagement and of a culture concerned more with reputation within the media and criticism from political figures

than one concerned for the safety and well-being of a vulnerable patient group."

Can you remember what the reaction was to that being said?

A She listened. She was empathetic. I didn't expect to come away with an immediate response to that which I had to say, expecting her more to reflect on it and to go and exercise her own further due diligence in relation to this and, indeed, Professor Fiona McQueen to do likewise in her capacity as the Chief Nursing Officer. But certainly, from the engagement, she seemed determined to take forward our concerns and to look to have answers to those questions that were being posed, individually or more broadly, in terms of her response to what was ongoing.

Q Thank you. Now, something that you've mentioned a couple of times in this context was the escalation of NHS GGC stage 4, and I think we know that that happened on about 22 November 2019, and I think we know that that was a decision taken by the Director General of Health and Social Care in the Scottish Government, and the Chief Executive to NHS Scotland, and the decision was to escalate GGC to what I think you describe as "stag 4 of the NHS performance escalation. Is that right?

A That's correct.

Q And I think at or about the same time, do we understand from your statement that an Oversight Board was created to oversee that process essentially? Is that right?

A Under the chair of Fiona McQueen who had been at that meeting.

Q And do we understand that the Oversight Board comprised essentially a group of experts and representatives drawn from Health Boards, Scottish Government and affected families? Is that right?

A That's right.

Q You say the chair was Professor McQueen and do we understand that there were sub-groups, an infection control sub-group, a control and governance sub-group and a technical issues sub-group? Is that right?

A That's right.

Q And did there come a point where you were asked to serve on the control and governance sub-group and on the communication and engagement sub-group of that in particular?

A Yes, the communication and engagement sub-group was chaired by Professor White in the (inaudible).

Q Now, just so that I understand all of this, did you eventually become appointed to the Oversight Board itself?

A Yes.

Q I am grateful for that. I wonder if you could just have a look at your statement again? We don't need it on screen, Miss Callaghan. It's just to clarify, for me at least, the timeline on that. Paragraph 270, Professor Cuddihy. I think you say that following – you having taken confidence from Professor White's involvement, you agree to become part of the communication and engagement sub-group and that is about 5 December 2019. Is that right?

A Yes.

Q And if we just again, and it's just really just so we can identify this in the statement, do we see that, if you go down from there really to 272, I think you're speaking about a meeting with that group on 5 December where you provide an update to them about the situation. Is that right?

A That's correct.

Q And broadly what was it that you were saying to that group?

A The message consistently that I had no issues and, indeed, it appeared the broader families had no issue with communication and engagement between ourselves and clinicians, those are the point of care. No issues at all. It was a good news story and almost a framework then that would allow people to work from. But I separated that from corporate entity of GG&C which I considered were of poor office in relation to communication and engagement. So I laid out where I was coming from, from my observations to them.

Q Yes. If we just read a little further on in your statement just to complete the timeline of your engagement, if you go to paragraph 274, we see that on 15 December you met with Professor McQueen and Professor White again, and, in fact, did you at that stage agree to become part of the Oversight Board itself? Is that right?

A That's correct.

Q I am going to come back to the Oversight Board later. Just stepping back and giving us a sort of broad overview, did you find your involvement with the Oversight Board to be a positive process or otherwise?

A I mentioned earlier that within any conflict it requires both sides to come together and so for me, regardless of the intentions that people may perceive on the part of those that have created it, I considered it to be a visible demonstration of an intent to more effectively communicate and engage by having a families' representative on those groups. And what it would enable me to do is to put forward from my perspective my observations, my considerations, my understanding, whilst at the same time, if there was any contra-view to that, I would be able to better understand that contra-view. If there was any misunderstandings, we'd be able to better engage and if there was a blockage between the strategic communication and the operational service delivery, we could identify where those blockages were. So I saw it as a positive step forward but also, from an individual and a selfish perspective, I was in the tent. I know that many of those around that table did not like it one bit that I was round that table. There were those who would not wish to see John Cuddihy sitting across the table from them because I would pose a threat, because I would ask questions that were maybe uncomfortable. And at

times I could see that and about people, in the aspect of confidentiality and the release of information, I could see there could be conflict and I actually said at the time, "Please, I will not be embarrassed if I have to leave in order for certain discussions to take place. I don't want to know about any other patient. I don't want to know someone's private business. I know and understand how to sensitively deal with information and intelligence. It's been my world for thirty-five years. I understand it." But this presented an opportunity. I didn't see it as a challenge. I saw it as an opportunity to engage and to see if we could work together. And if there was mixed messages, we could then clarify what that message was and if I was to be a conduit then I would do so. So I saw it as a positive step forward.

Q Thank you. And just to complete this little section of the story of the hospital, I think another thing that you did around about this time was you engaged with the independent review which had been announced some months earlier. Is that right? And I think you provided them with a witness statement. Is that right?

A On two occasions I met with the independent review. A total

of, as I understand, five hours of tape-recorded evidence was provided to them.

Q Yes. Let's go back to Molly's story, towards the end of 2019. An ambition was released through the Make a Wish charity to get to sing with Paolo Nutini and, indeed, play with him and I think write a song together. Is that right?

A (No audible reply)

Q Were you there for that event?

A Yes.

Q And there is footage of that available on Facebook, is it?

A It's another indication of the kindness of people, the humanity of people. What a lovely guy, what a lovely man. He took so much time with Molly and it was just like sitting, forgive me, in your granny's front room, a guitar, and he actually wrote a song called "Mad for Molly". I cry at an egg boiling just now. You can imagine what I was like at the time. He wrote a song called "Mad for Molly", and he didn't know how she would react to that. And then he had her playing the backing music which he wouldn't know the significance in this. I could see Molly saying, "I have to play the piano in front of Paolo Nutini. I'm not going to be able to get to the keys because the neuropathy in her hands", and I could see what she was thinking. But she was brilliant and she did it. And then she started to sing various songs and it was just a gig. They sang the songs between one another and what we were seeing was that Molly, with all the problems that she's had with her breathing and everything, I could see how she was going to go, "Can I sing this song?" She was going to sing that song with Paolo Nutini. She was going to play that piano. What other chance would you get? And he never, at any time, saw Molly, or indeed us, as a sick child. He just felt humbled that she wanted to see him, and he went out his way and he could be sitting there into the small hours had we not had to leave. He just made so much time for her. And the videos that were made were made by other people who were there. I had no idea they were making the video. And, indeed, they had to get permission to – I had no idea that this was ongoing, in case it was wrong, because we have to respect this guy. A musician, he's got a career. He's got all of these things and he's opening up himself to – It's a private thing, him and Molly. "What else do you want to do, Molly?" And, do you know what, because it was coming through, poet, and he said – I

hope nobody minds me – he was always like considering whether we could continue in music. Molly was just, "Why would you not want to continue music?" And the importance of that was that saying these things says, "But we get through where we are just now and let you come back and if one of your friends is a drummer we can finish doing it", and one of her friends is a very accomplished drummer in the Royal Conservatoire for Drumming. "Come back and we'll do this." The thing for me was this was a future for Molly. Molly was coming back again. Molly was standing her height again. Molly was back in the fight again. Molly knew where she was going. "I can sing again. I'm singing with Paolo Nutini, dad." He presented her with a guitar as well and it was just the most marvellous thing, and those videos would then help Molly through later on and, indeed, we left, Molly was sat thinking about it and she sent him a letter afterwards, sent him this wee note, and "I can't believe that you would want to give up music because it's your words and your music that has such a profound effect on people like me. It helps me through. Why would you want to – why wouldn't you want to continue with that?" And, again,

that's just about Molly and the inspiration that she is regardless of all of this. But the value in these things is huge. The value that that young man brought to that table was incredible. So much so that he continued to phone Molly. Not because he was Paolo Nutini, a musician, but because he had a relationship with her. I don't know if he knows it but that's had such a profound positive impact on Molly and us because again it reinforces your faith in humanity and there are more good people than bad. There are more people who are prepared to do the right thing and nice things. And it was a hugely, hugely powerful event that helped us through.

Q Thank you. Staying with Molly's story, go back to somebody else that you've described, as she has, as somebody who's, from what we've heard, always prepared to do the right thing, and that's Dr Sastry, and by that I mean we can see from your statement that shortly after being with Paolo Nutini Molly had to go for another scan. Was that on Christmas Eve, in fact?

A Yes.

Q And you had a discussion with Dr Sastry around that time and what was his advice at that point?

A All the way through this you're in a bubble. You're limited in where you can go and what you can do and he advised us to go on a family holiday.

Q And you went to Dubai, I think we heard, and it sounded like you had a pretty good time. Is that right?

A Yes, it was bitter/sweet. That's just the thing about it, life's for living. I think you forget that. Life's for living. And whilst we understood what he was doing was allowing us to make memories, once you make that decision again you're thinking what can come of it? Anyway, we took it on, the family. We took it this was going to be positive and we were going to go and we were going to enjoy ourselves, and we were going to be thankful for every minute of every day that we were together. That was it. That we're with her.

Q And what was your attitude? What were you thinking when you came back then?

A Well, we had a couple of discussions when we were away and we'd say, "Look, we're waiting till we hear, live our lives. Be normal. We'll do what we do. We've demonstrated through the different things that let's just – we can't change, can't change the fact that Molly's got cancer. We can't change the fact that she has this bacteria. We can't change the fact that she's all these things. We can start to exercise as much control as we can, directed by Molly, everything around Molly, and we would be as normal as we could be. We'd be a family and we'd enjoy each other because there are lot of people going through terrible things. Things can happen instantaneously and someone can be cruelly taken away from you. We'll live our lives, live our lives."

Q I think the way you put it in your statement, at paragraph 206, is, "We'll live our lives and we'll chap their door when we need to." Is that right? And, in fact, Molly did chap the door soon after that and that was to have stem cell transplant in----

A Yes.

Q -- January/February 2020. Is that right? And I think, just continuing with that then, I think we can see that she starts off in 6A and then, I think, she's in ward 4B for a bit, and I think you describe Dr Sastry, this maybe helps us on the communication side of things again, Dr Sastry walks you through – and Molly – the plan and the sense I get from the way you describe it is that everything was worked out to the nth degree. Would that be right?

A I've mentioned a number of times about the small margins. Dr Sastry knew there's no room for error and so he spent some two weeks putting this plan together. He'd only ever engaged in this aspect of this once in his career, putting all this together and all the complexities with Molly, he wanted to be sure about what he was doing. He knew the risks. The team that he had, pharmacists, all of the people that would be involved, identified the types of drugs that would have to be utilised, and he'd said to us that, "This will take Molly to Ground Zero. This will have a significant effect on Molly but it's what we need to do", and within that report, which we had to sign the report, and within it it identified the particular drugs that would be utilised and one particular called etoposide phosphate. Etoposide phosphate is a derivative of etoposide from the manufacture of etopophos and that's imported, because within that, in those very small margins, chemo drugs, which I didn't know, are also influenced by your height and weight and in relation to that, as a lead-up to it, it was 60kg on Molly and it would be 60mg per kilo of etoposide phosphate. So 3,660mg of etoposide phosphate were to be administered during the cycle of this plan together with other drugs. This was all detailed by Dr Sastry.

Q Okay. We'll move to the stem cell treatment in a minute but the hospital story hadn't gone away, I think we can see from your statement. Were you aware at this stage of issues to do with ventilation at the hospital?

A I was, sir, yes.

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

A I've already alluded to the Innovated Design Solutions Report in relation to the air conditioning within ward 2A and that it had increased the risk to immunocompromised patients. But, further, within that report there was a recommendation that all other areas in the hospital, where such patients would be, should be reviewed. All those other areas, whether it was 6A, 4B or the patient pathway, should be reviewed and, of course, through our time and through the observations we saw the HEPA filtration systems arriving on 6A telling us then the air here is not clean enough for immunocompromised children. I was also aware, sir, of a number of SBARs again in relation to air conditioning and those SBARs have gone all the way back to 2015, where concern was raised in relation to the air conditioning of 2A and other words, including 4E

and others. I was always aware that in November 2019 there was an SBAR was authored by an individual called Ian Powrie sent to Tom Steele, the director of estates, in relation to Innovate Design Solutions Report, in that they would have to go forward with the work in 2A. So all of this gave me significant concern, not only about the water but the air conditioning, and I knew that Molly would have to go into a sterile environment because of the stem cell. She would be taken to a place where she would have less protection than a new-born baby. She would have no protection whatsoever so there would be no margin for error. Within ward 4B there was four identified units, if you like, or rooms, but I understood that there was an air conditioning system that would satisfy the needs of Molly. I was determined that Molly was going in there. I was determined that Molly would need to be in to give her all of these chances. She couldn't go anywhere else. We would still cocoon her from all of the other things within her wee space, her wee bubble. We could do our damnedest to protect our daughter. I was going to do it and that's why Molly was moved to 4B, came to the stem cell.

Q Yes. And just so that we can pick up the references in your statement, Professor Cuddihy, if you have a look at paragraph 213 of your statement, as I say, it's just to help us when we come to the other evidence. You say:

> "At the time I had been reading documents about the transplant ward, particularly 4B."

Do you see that? Is that what you've just been telling us about?

A Yes.

Q Thanks. So we know from what Molly has told us and what's in your statement, that Molly proceeded with her stem cell transplant treatment. As you've described it, step one, take the immunity right now to, as you put it, like a new-born, perhaps even before that. Yes. Ground Zero as you say. And you would need a clean and sterile environment for all of that to happen. Is that right?

A Yes.

Q And did you have confidence that that would be the sort of environment that Molly would be in?

A I had hoped that we had made significant contingencies of our own that if Molly was going into any room, regardless of who had cleaned it, we were going to clean it.

Q Yes. I think we can see from your statement that, quite apart from some other matters that we'll come to in a minute, that Molly was very ill with mucositis. Is that right?

A Yes.

Q But now we come to something that you touched on a moment ago, despite the careful planning in relation to the etoposide phosphate, what happened?

A Molly was having 4,120mg of etoposide phosphate, 14 per cent of an overdose was given to her. Despite all of the careful planning, despite all of the efforts, the meticulous preparatory work, the nurses who came in and would check every label and check with Molly's CHI number, through the CHI number they'd administer the chemotherapy, all of the labels identified accumulation to 3,660 so those nurses were giving Molly what they firmly believed was 3,660mg over a period of time but actually they were giving her 14 per cent more of the drug. Gave her 14 per cent more of a drug. If Dr Sastry had intended it to be plus or minus 14 per cent surely he would have detailed that. Dr Sastry hadn't written 3,660mg, didn't mean 4,120. He did it through careful planning because he knew the effect that such a drug would have. He knew how these drugs burn the body, how they impact a body, how they attack the body. When you're given a prescription and it says on the bottle you're having 5mg of morphine or you're having 2mg, you expect to get that, especially when it says it on the label. Those labels did not say 4,120. It said 3,660 and they gave that to Molly. They gave Molly an overdose, an overdose of chemotherapy. It defies – how do you – how – how? The reason why Dr Sastry takes the care and attention is because they know the risk. The reason why we have two nurses with gauntlets, wearing aprons and gloves, because they know if it spills what it does to the floor, if it goes on the floor, or on their hands, how corrosive it is. And how they detail every single injection and every dose is there, carefully – carefully detail, and they gave her 14 per cent more in her wee body. Sorry, I get so angry. I get so angry. It's not right, not right at all. And with everything else, she doesn't deserve that. No way.

Q And we can see there for ourselves what you say in your statement about the impact of that on Molly and Molly herself has told us a bit about that. I would like to ask you about something slightly different. What's the reaction – sorry, what was the reaction of Dr Sastry at this event?

A The measure of the man, the measure of the man, when he was contacted he came in that morning and he was so upset, apologetic to Molly. What could he do? He said that, "You're my patient, Molly. It's happened. I don't know how this has happened. I don't know how it's possible it could happen but it's happened. I'm so sorry, so sorry, Molly." When you see, receiving the word – when I say about "thank you" is not enough, what's "sorry"? Sorry. When it's said – it doesn't describe – and in the end Dr Sastry, whilst he apologised and everybody through the duty of candour and harm was caused, and he was more than sorry. He was frightened, as we all were. He was frightened.

Q Just thinking about what you've just said there, you mentioned duty of candour, and we'll come onto that later, and the word "sorry", when this event, or when any of the other events where things did not go according to the Dr Sastry plan, did you ever see him at any point try and explain things away or cover things up or anything short of putting his hand up, in other words?

A Totally. He had absolute respect for Molly. Why would you not tell the truth? Why would you not let her know what's happening? He had trust to maintain between Molly. He was Molly's consultant and if he would start to tell an untruth to Molly, or if she'd a hint of an untruth, he knew that Dr Sastry was everything to Molly. He was the person that she hung onto, not only in terms of his clinical ability but as an individual who she absolutely respected. Why then would you wish to fracture that trust and tell an untruth or relieve yourself of the responsibility? He could have stayed in a house, stayed in a house and left someone to go, "You go and tell them". He came in, came on, and not only did he do that, because I was on my way to the hospital and when I got to the hospital and Molly couldn't really – we have to – I don't know what's happened but Molly couldn't say anything. was so upset. And I asked to see him again and he made time for me and he took me through what he understood had happened. As I say, it's about trust. It's about values. It's about how

you communicate and you engage. And I had even more, and I have even more respect for him for being the person to come and tell me. It would be easy not to tell you, easy not to tell you. And, indeed, on the bags it says 3,660. Had it not been for the honesty of a certain individual, you could be none the wiser just thinking this is another thing. But they told us and that allowed us to manage the bad news, allow us to deal with it, so that we could understand what was ongoing with Molly. We could understand the effect on her. This was just one other things. And perversely it was a form of comfort in Dr Sastry being the person to tell us, just – and he further explained it to us and he went through the detail with me straight afterwards.

Q I presume it wasn't Dr Sastry himself that discovered the error, and so when you say the honesty of somebody, presumably you're indicating that it must have been somebody else within the clinical team who discovered what had happened and whose reaction was that this had to be disclosed? Is that right?

A Absolutely undoubtedly and I would say essentially what happened, sir, and this is by chance,

this was not even by design, this was by chance, the pharmacists on ward 2A and 2B, part of that Schiehallion family, and they know their patients. They know everything about them, their medication, the rhythm of each dose, and as I understand such a pharmacist, when reviewing another patient, spotted something wasn't quite right in terms of how a drug was being made up and when the drug had appeared it showed a quantity of the drug. This again is about experience and expertise and having trust in those individuals. A pharmacist noticed there's something not right about this, looked into and said, "How this has been made up is conversionary", and it was the same type of drug, etoposide phosphate, "conversionary that you've used here is wrong", and highlighted that to the unit that makes up the drug and, of course, that unit didn't consider that they'd done anything wrong. She stood her ground. She stood her height and she says, "No, those drugs are not going to this patient". She stopped it. She stopped it and prevented, prevented early intervention and the basis of knowledge. She prevented harm to another patient. Good on her. Then she says, "We have wee Molly's down at 4D". She said, "Etoposide. I'm

going to look at this." She looked at it. The conversion was wrong. She contacted them. It was too late. Molly had been given all her dose, full 4,120mg. She immediately alerted – Dr Sastry became aware. That's how we found out.

Q Now, I think we know that Molly was admitted to PICU in February 2019 and she was suffering an episode of rigor at that time. Is that right?

A Yes.

Q And you were there. Is that right?

A During that episode.

Q Yes. And we can see from your statement, you were worried at this point that the mycobacterium chelonae is on its way back. Is that right?

A Molly's in PICU, in the intensive care unit. She's being treated for everything and she was just in a poor state. So many people – and her temperatures during all of this were just around 40, 39-40, all the time. And getting back to your knowledge about indicators, is this – and they're doing everything round about her and they're looking, is there a bacterial infection ongoing or coming in, and examining her organs and her kidneys, her liver, her heart, even as she's lying there, an eye specialist came in to look behind her eyes to see if the bacteria is there. And as you go through it, you're pleased it's not there. You're thankful it's not in her vital organs. It's still there, there's something still not right, and you just – my head was, "This is mycobacterium. This is just where we are. This is mycobacteria." I've nothing to go through and you say you're pleased it's not there. It's almost as though it was working up her wee body. Molly's gift is her intellect. Molly's gift is her brain. If Molly was in a wheelchair it would be difficult, but we'd get by. If Molly cannot play the piano because of it we'd get by, but somebody came in and says, "The only place we haven't looked is her brain." The only place they haven't looked is her brain. Now, that was giving Molly a future, it was going to take her to university and let her be like Dr Sastry. She's rigoring and then she was just deteriorating and that's all I had in my head, was that it's in her brain, and I had to go to the front of the bed, where her head was. I'm holding her head, I just hold her. Everybody's round about.

She was – I mean, this guy, a Godsend, come into the room, Mark, an interventionist he's known as, an interventionist. My goodness, I hope

estates are listening to that word. Interventionist, an ability to intervene, and he came in and he was a most remarkable man and he just, he took over. "I'm giving 5mg of, I'm giving 2mg of, I'm now injecting", a commentary, a commentary to tell everybody what he was doing and why he was doing it. Molly's looking at me. The eyes are just – I cursed them, I cursed them, and Molly came back round, she came back round. Mark, the interventionist says, "Hey, Molly, I'll speak to you soon", and he left the room. He just left the room as though it was an everyday occurrence.

He saved my wee girl's life, my wee girl's life. She started to come back to us. I met him after. I had to go for a wander and seen this guy, seen him in Marks and Spencer's, all to – and he was getting a sandwich and a packet of crisps. And I hugged him. I didn't know what to do, I just wanted to hug the guy. He just saved a wee girl's life and he was away to get a packet of crisps and sandwich at Marks and Spencer's. There we are. Sorry.

Q Sorry is the last thing you should say there, sir. Molly completed her transplant and she's taken us through the rest. I will ask you some more about Molly's story obviously but we're going to go back to the story of the hospital. As we are changing tack, my Lord, I wonder if that might be an appropriate moment to have the morning break?

THE CHAIR: Twenty minutes for a coffee break. I will sit again at five to twelve. Thank you.

11:35

(Short break)

11:55

THE CHAIR: Mr Duncan.

MR DUNCAN: Thank you, my Lord. As indicated twenty minutes ago, Professor Cuddihy, I'm now going to go back to the story of the hospital. We're in 2020 obviously, looking at June 2020, and there's two things I want to have you think about, two significant developments at that time. The first is the independent review issued its report, I think, on 15 June. Would that be about right?

A Yes.

Q Just broadly, Professor Cuddihy, what is your overall view of that report?

A It lacked scope, it lacked depth and its conclusions were ill-founded.

Q It made a number of recommendations. Is that right? I think I have them making sixty-three

recommendations. Would that be about right? And about the same time, I think, the BBC broadcast a programme, a disclosure programme, about the hospital. Is that right?

A (No audible reply)

Q And, for those who wish for references, we're round about paragraph 250 of Professor Cuddihy's statement. I'm just going to ask you this, Professor Cuddihy. Is it your understanding that prior to the programme being broadcast, NHS GGC issues some sort of communication to their staff?

A Yes, sir.

Q Tell us a wee bit more about that.

A I understand that one of the directors, namely Mr Jonathan Best, sent an internal email to his staff alerting them to the fact that Disclosure Scotland would show a programme the following day and that certain things would be shown in the programme. The hospital had provided commentary in relation to it but just advising the staff in relation to impact.

Q And can you tell us now about what communication they sent to patients and families in advance of the programme being broadcast?

A Nothing.

Q Can you say whether that programme, to any extent, proved a catalyst for further disclosure to you by patients and families?

A Absolutely. In line with the independent review, the Disclosure Scotland programme resulted in roughly seventy-five/seventy-eight questions that had been raised by elected families to be submitted through the communication and engagement sub-group and the Oversight Board, and, of course, those questions to be answered by the independent review, Greater Glasgow and Clyde and the Scottish Government, either individually or collectively, with regards to either directly in response to the question or indirectly, if it related to one of the other entities.

Q Now, did you have any concerns when you watched the programme?

A It's a powerful programme. It shows you the power of the media but, of course, it is the media and what struck me again was in relation to what I say about the depth and scope of the independent review, because the Disclosure Scotland programme highlighted the concerns of a number of microbiologists who had intimate

knowledge of the goings at the hospital as they were inextricably linked to those issues, either as Chair of the IMT or microbiologists who had been engaged directly over the period of time between 2015, and their views were not considered within an independent review. And so we were left to consider the views of doctors. They'd interviewed less than forty people over a period less than 100 hours of tape-recorded interview.

Q And the doctors you're referring to are the doctors who undertook the independent review? Is that right?

A Exactly, yes.

Q Sorry, please continue.

A And so you compare and contrast, well, why would they not go and speak to the very people who had been raising concerns, even – even if they said to them, "You're wrong in this. You owe it to the families to stop telling these stories, stop highlighting that there are issues with the hospital, if indeed there are no issues." Went to further independent experts who proffered opinions in relation to that which had been put forward. As I'm watching it, I'm saying, "Well, what's the bother? Independent experts have provided information to the hospital and they haven't listened to them, so is there something in this?" And it took us through a terrible emotional journey. They left us with even more questions, exposed a vulnerability within that hospital. The two points, significant points, I referred to relate to those recommendations in the independent review, the first being that the general patient population can take a confidence in relation to the environment of the hospital. Fabulous. What about the immunocompromised patients? That's what the focus was.

And the second point they said was in relation to the safety measures on ward 2A. Ward 2A was closed, is still closed, so how can you make a recommendation about something that's actually still ongoing? It defied logic. So for me the integrity of the report was flawed. If you do not ingest into all of the points raised by these microbiologists and other clinicians and other experts, if you're not prepared to engage with the families and, as it turned out, I was the only family member who spoke to the independent review, as far as I'm aware. And, indeed, this was one of the questions that had been put to them.

And so Disclosure Scotland simply opened up all of the challenges, all of the issues, and what they also

did is reflected on a pre-prepared statement by GGC, a pre-prepared statement by GG&C. So they took their time to respond to the media ahead of the programme so they knew it was coming, in the knowledge when you deal with the media there are a few added attractions but, by and large, they knew it was coming so they had an opportunity to respond to this. But they chose not to communicate and engage the families or the patients, even to say, "Turn it off. There's misinformation in here", to protect us, but nothing. Nothing at all in relation to it.

And so what the Disclosure Scotland programme did, it opened up a further festering wound, opened it up and left us considering if you, Disclosure Scotland, and the journalists can access these individuals, who are engaged daily with us in our treatment and they're expressing significant concern about the environment, why would the independent review not speak to them? Why would the independent review not reflect on that commentary, even to say that there is a contra-view? Because they owe it to us if there's disinformation. Tell us, tell us. Do what Dr Sastry and others do, inform us, allow us to make an

informed opinion. This was over national television. This was following various reviews, an independent review, journalistic scrutiny. This tells you that there is some ongoing in that hospital and, as I say, they had over a week, Greater Glasgow and Clyde, and I know they had over a week to prepare the statement and they gave that statement.

Again they reflected only on the positive aspects that they considered was in the independent review so they would be selective in what they would wish to take and would talk to staff, quite rightly – absolutely, I have no issue at all, it was the right thing to do – but what that tells you is they knew and understood and when they tell you that the patients are demonstrably at the centre of their decision-making, patient care is fundamental, well, I'm sorry, in Greater Glasgow and Clyde for the immune suppressed patient care is but a concept, not the reality.

Q Thank you. Just again to locate the relevant section of your statement, Professor Cuddihy. If I take you to paragraph 286, I think it will be. I think, in fact, we can see that the section on the BBC programme begins at paragraph 285. Paragraph 286 states:

"This was a deeply distressing programme which reflected on the Independent Review, hearing from 'whistle blowers' and 'experts' who all had comments that reflected an unsafe environment in which to treat vulnerable patients, including my daughter."

Just pausing there, quite apart from the question of whistle-blowers and their contribution to the independent review, never mind the independent review, to what extent were the concerns disclosed in that programme about the environment, to what extent had those been disclosed to patients and families prior to this time, publicly I mean?

A Most of it would have been new for people. Individuals would have concerns, they would have heard stories, but again perception is truth and you see it together in that narrative. It's very strong and it's powerful. It's compelling. And it takes you to a place and it reinforces the fear that you have for the environment in which a son or daughter is being treated.

Q To what extent had those terms and the views of these clinicians about the environment, to what extent had there been communication prior to this programme in any official way by GG&C about those sorts of concerns about the environment?

A The communication was to tell us the water was wholesome, the environment was safe. Reviews found there was no causal link. It was always a very positive narrative to try to articulate and to give a version of the truth, as they saw it, but in no way did they reassure because all of the other elements that you would consider were polar opposite from what was coming from GG&C.

Q Yes. And so still at 286 you say:

"I was extremely concerned as to the findings within the report and moreover, why GGC had not been proactive in their communication and engagement ahead of the program."

And you then say:

> "All of the gains made in the last few months and more importantly, the recommendations and findings presented to the Oversight Board, quite clearly had not resonated with GGC."

What do you mean by that?

A So during the time with the communications and engagement sub-group, the collective sub-group which had represented us, senior represented us, including those from the corporate communications, would be present on that group and together were deflected on a communications strategy through recommendations that were made to the Oversight Board. And within that was to be more proactive or transparent and more engaging to the patient population and their families. Something that was agreed urgently, not only at the sub-group and put forward, but then at the Oversight Board, and reflected within the Oversight Board report of March 2021 but preceded by an interim report in December 2020, agreed protocols were in place. And so all of this that had been developing, and I have to say there were certain aspects where I could say a positive narrative of

information, particularly around Covid and what the impact and implications of Covid would be on this vulnerable patient group, and so there was positive interaction and there was a good news story within that, and you said, "Okay, they can do it. They have a mechanism that can do it. They have agreed and now developing fantastic stats to build confidence", and there was good news in that. Although it was Covid, there was positive aspects coming out. It was a good story to tell and primarily the medium for that was through a closed Facebook group, and it should be highlighted because that was a good point and those involved in those, and those who had engaged in that, made every effort to inform us, allowing us to make those informed decisions over the broader Covid.

And, of course, Covid itself, we were used to the world of Covid, because of all of the preventative measures you would take, we were doing that and some, but it was still reassuring to know someone contracts Covid, what does it mean for the wider population? There was an answer. What does it mean in terms of the patient pathway and a lift, to give a dedicated lift? Fantastic. All of these things demonstrated that they can do it

when they want to, when they want to and there's a good news story. Fantastic. And this is something that you should welcome and engage it and it says, "Great, I'm listening." Not only are they're listening, they're hearing what it is that we have to say and they're responding and be proactive in that response. So that was a benchmark.

And then when you see the real impact of Disclosure Scotland and everything that had happened, and the bacterial outbreaks through the water, the drainage, the air conditioning, all of these things far more impactive on our wee children than Covid will ever be, and in many ways because of all the drugs they're on they're protected more in relation to Covid. When it really mattered they're posted missing. Nothing, nothing did they provide to us in relation to this. Now you think about the impact that that would have on a mum or dad who's watching that and their wee son and daughter has passed away, thinking, "Is this me?" When their son or daughter is going through a treatment. Or the patients themselves who's watching this. What does this mean? "The microbiologists that I know in the hospital are saying these things. What does this mean for me?" So not just the physical impact

on your treatment. Psychologically, what does that do for you? What support do we have? Who would you go to at the hospital? The very people that knew that this was happening have it within their gift, a menu of options to support you, and they chose not to do it. They chose not to have those interventions in place. It just defies logic. Any thinking defies logic and this is not singularly about the corporate communications people. This is about crisis management again. This is about the board. This is about the managers who have the foresight to tell the staff, who have the foresight to put in place their own protection measures and their narrative to the Disclosure Scotland, but the children and the families, "See you later. You're on your own but I know it will be coming. We're sorry, we're sorry. We should have done better." I can explain that further if you want me to but it was appalling.

Q Thank you, Professor Cuddihy. One thing that emerged in what you just said, perhaps a useful reminder about what the Oversight Board is, and I think it's implicit in what you said that we should not see that as being simply to do with the production of a report in 2021 and a static assessment of how things stood at that

point, or even in November 2020. It's implicit in what you've just said, I think, it was of itself a process to try and see if things could be improved. Is that right?

A Absolutely and you're measured by tangible evidence, tangible change. You can all say, "We have redrafted our processes, we have redrafted our policies and our procedures", but the impact or the indicators of effect is when you operationalise that new plan, when you actually demonstrate tangible change and this was an opportunity, a further opportunity, to demonstrate tangible change.

Q In due course, in your evidence, we'll come to find out what the assessment, as you see it, on that question was when the Oversight Board finally published its final report. But in the paragraph that we're just looking at, if we were to try and think about the story so far on how they were progressing, how GG&C were progressing, is it rather captured in that, as you see it, in the final sentence of paragraph 286 where you say:

> "This was further evidence of a Public Body that considered itself above any form of scrutiny and public duty to reassure those patients who were being put at risk."

Is that it?

A Yes.

Q Now, moving on from there, still with just the story of the hospital, now, of course, it's important to recall that the Oversight Board does not only focus narrowly on that individual hospital, it's focused on the board as a whole. Is that right?

A Yes.

Q Let's move to another aspect of review and oversight. I think we know from your evidence that on 28 January 2020, early that year, Ms Freeman had announced that there would be an independent case note review undertaken in relation to the question of infection of patients in the hospital. Is that right?

A (No audible reply)

Q Now, are we to understand from your evidence that there had also been, prior to that, a discussion within NHS GGC about whether they would do their own review on that matter? Is that right?

A Yes.

Q Can you tell us a little bit about that?

A So following my meeting with the independent review, I had attended a pre-arranged meeting with senior leaders from Greater Glasgow and Clyde, and that was following invitation by Jeane Freeman – sorry, Jane Grant, but through discussions and primarily through discussions where I had identified individuals who may offer some assistance, could we reach out to those individuals in estates or elsewhere, was there opportunities for us to work more collaboratively even as a peer review to what was ongoing? And it was very much about delivering of solutions and Jane Grant, in fairness to her, arranged for me to go and speak with three individuals and those three individuals she says were closer to the coalface than she was, closer to the activity than she was, so, of course, you're saying, "Okay".

My experience of Jane Grant is an individual who was not particularly informed as to what was happening. She didn't seem to me to be particularly an individual that had a grip of anything that was ongoing. Perhaps those who were operating below her had a better grip, so I welcomed us to go and see them, to speak with them. But as I do, I went earlier to the meeting, and the meeting

was cross from the main hospital within an area which was for teaching, the university aspect, so it's an open planned foyer. You can grab a coffee. I went earlier so I could have a coffee and sit and watch who was coming in. I done a bit of due diligence in relation to who these three individuals are. One was Jonathan Best, who's a Chief Operating Officer. The other was Professor Alistair Leonard, who was the lead microbiologist. Fantastic. And the third individual was a Dr Scott Davidson, who's now the Deputy Medical Director. So, great, but what I wanted to see how these individuals, and I sat across from them as they gathered waiting to go in, and had a coffee, just to get a feel for them as you do. And then I approached all three as we went in and I could see them, they were quite a close group of individuals, and they went into the meeting.

The intention of the meeting was certainly to discuss how we could move forward with potential solutions. That was the intention of the meeting. Jonathan Best assumed the chair of the meeting and I sat to his left, directly opposite Scott Davidson, or to the left of Professor Leonard, and immediately at the outset Jonathan Best says, "I know and understand all

of your concerns. I know and understand all of the challenges that you've had and I'm going to take responsibility. I'm going to deal with this." I said, "Right." He was setting the agenda. He was going to deal with this. So let's see if he will. And he introduced himself and his role. He says, "I will deal with this. I know all of your concerns. I take responsibility to work through those." That's it. I said to him, "That's great. Please, I accept everything you're saying, but I still hold John Brown, Jane Grant, Jennifer Armstrong responsible, but I accept what you're saying."

He then introduced me. I said to him first, "Well, but what can you tell me about Molly?" He really didn't know much about Molly. Nothing, in fact, really that he could say. When I was the chair I respected that and I said, "Okay", and he said, "I'll pass you over to" – and his words were – "my bug specialist". Okay, bug specialist. Microbiologist, Professor Leonard, eminent individual, fantastic. Okay. "Can you tell me about Molly?" "What I can tell you about is a report has been done and it's a report in relation to the collective figures in relation to ward 6A", and this was a report that was carried out by Health Protection Scotland, to give a reassurance in

relation to the environment of 6A. This was a redacted report. I had challenged the fact that this was a redacted report previously and who had requested redaction and under what disclosure protocols were they using. So he then starts to recount this report to give me some confidence around Molly, and all he does is he starts to disclose the redacted elements which related to Aberdeen Hospital and it related to another hospital that they had compared and contrast the terms of the quantitative data. I said, "Thank you very much. That's all very, very interesting. You've actually disclosed to me the points that were redacted in the report and thank you for that. What's that got to do with Molly?" "Nothing." "Thank you."

"Mr Davidson, it's your chance." Says, "What's happening in relation?" He says, "Well, I can tell you, you're going to have an internal review of the cases". Fantastic. Fantastic. "It's going to be conducted by a really good guy, a really good guy." "Oh, great. I wouldn't think he would be anything other than a competent individual to do it". It was a really good guy. "I know him really well. He's just retired from the hospital." He said he's just retired from the hospital. "He's highly independent". Someone from the

hospital will be checking your own homework. I says, "That's unacceptable." I says, "Well, tell me", I says, "how will you prioritise and where will Molly be in this priority?" "Well, we will prioritise her". I said, "Well, how will you prioritise her?" He says, "Well, we'll prioritise it in line with that MSP opposition guy and his comments". I says, "Well, I'm sure Anas Sarwar will be delighted that you're taking his complaints seriously. What are you doing about the families and the patients?" And I looked at Jonathan Best – sorry, forgive me – Best is the best, what's the rest like? It was an appalling, an appalling meeting. They'd have done better if they'd come into the meeting wearing training shoes, white socks and chewing chewing gum. It was a dreadful meeting and it demonstrated a culture to me, a toxic culture. He had no knowledge. I accepted the agenda. Perhaps they changed the agenda. Best changed the agenda. An appalling meeting, an internal case note review by a "good guy who's just retired", prioritised by an MSP opposition. Fantastic. Responding more to the needs of the politicians. Responding more to the needs of the journalists and the BBC Disclosure Scotland programme. The patient

needs, the family needs, where are they? Where's my book? Meeting's over and I walked out. I was disgusted, disgusted.

I get home and I received an email from an individual called Elaine Van Hagen. Elaine Van Hagen is the head of corporate services, another of the big guns. Highlighted the meeting obviously hadn't gone to plan. Of course, the agenda that we had planned wasn't what was discussed about. Not the fact how her colleagues, senior management, had acted, a bug specialist, someone who would deal with an opposition MSP and a "good guy" who will do an internal review because, of course, Jonathan Best knew everything about me. He knew everything about Molly's case and I had to trust this individual. I had to trust him to take forward our concerns about the environment. I think not. An organisational behaviour that actually permeates the very pores of senior management. Apathy, arrogance and ignorance. Their ignorance was bettered only by their arrogance at that meeting and I was appalled at how they'd acted. Three senior directors of Greater Glasgow and Clyde. This is how they deal with this crisis. It reinforced my beliefs they had no one that could deal with the

crisis, no one that knew and understood the risks associated with this crisis. Their behaviour was a disgrace and shameful.

Q Thank you, Professor Cuddihy. And just to help us when we come to consider your evidence, can you just clarify – have a look at your statement – it's paragraph 293 that you set out the narrative of that meeting. All right. Okay, if we step past that then and we move forward to the independent case note review. And, again, just giving us a sort of broad overview of things, what's your overall view of the independent case note review, Professor Cuddihy?

A From day one, Professor Mike Stevens and his team were transparent in their dealings. They had taken care and attention, they considered the impact of terms of reference and from day demonstrated a process and procedure that they would adopt. They had integrity, they had intention and this would be a collaborative process that would involve patients, where appropriate, and their families. And he had a team of experts – Professor Mark Wilcox, in relation to microbiology, Mike Stevens himself, who's a consultant haemato-oncologist, and a variety of others. Within the team everyone knew and understood what their role was. The team was actually broad enough that there would also run alongside this, under the leadership of Professor Davey and Dr Patricia O'Connor, who would carry out innovative work around a paediatric treatment pool. So as a collective, this was a group that outlined what their intention would be but they had reached out to Professor Craig White and myself in relation to early learning and the findings from the communication and engagement sub-group. They were exercising their due diligence and what was good, what were the learning points and, in particular, they focused in. One of the tasks during the communication and engagement sub-group, when we knew that the independent case note review was on the horizon, was to consider templates for letters for families and myself, the Scottish Government, represented by Phil Raines, and Craig White in particular, he considered how he would send a letter to a mum or a dad over one of their kids who had sadly lost in their journey. They considered how we would send a letter to someone going through treatment, someone no longer going through treatment and getting on with their life. How could we communicate in a way that was

respectful, was informative but not intrusive but also afford them the opportunity of deciding whether they would wish further information or not? They could make an informed decision on whether. And he would focus on these things and so he, and his team, engaged using a closed Facebook site as a medium. They set up their own email account but also had the foresight to consider, like myself, when you're sitting at three o'clock in the morning and you're looking at the four walls, night becomes day and day becomes night, but if someone sends a message they're looking for an instantaneous response. The foresight to actually say, "Thank you for your email. We will respond within …". That's it. You're not going to get it immediately but you know. So they were considerate and then they had themselves demonstrably at the centre of everything and something that I said at the time, and I would communicate, and they put forward their biographies, put forward their terms of reference, they put forward what their plan would be and the timeline, manage expectations of a collective whilst at the same time respecting the needs of individuals. And they would cater for that and they did it repeatedly.

But also as I said, and I said to Mike Stevens himself and to others, "So long as we have a process that's transparent, that's open and is honest, and it has integrity. We might not agree with the outcome but we will have confidence in how you've achieved that outcome." And so myself, I had a lot of trust. I knew there would be individuals who would be extremely concerned this is another independent. People who had a view on the independent review that was developed through the Disclosure Scotland programme. There was limited communication and no communication from GG&C when they needed it most. So he would have a fight, and his team would have a fight, on his hands, I thought, in engaging and developing a relationship with families and develop the trust. But importantly, he made himself available, accessible. So did the team. And they included me within a sub-group, which was their communication and engagement as they would go along. So the professionals would consider all of the information to make their informed decisions whilst, at each juncture, they would reach in for any conduit of information – whether it was a direct one-to-one, whether it was through myself, through the Facebook,

through Professor Craig White – any and all, they would cater for the diverse needs of that patient group. Even to think about language and then interpretation of documents. They considered all of this, which gives you confidence even before they put pen to paper that they're going to think about this, they're going to be considerate, and they're going to assess all of that information. And so from the outset I had confidence and I had faith in where they were going with it and at various points along that journey he afforded further interaction and engagement with the families when they needed it.

Q You've described the process as "transparent, open, honest, as having integrity, as involving individuals who were accessible" and your assessment of the independent case note review process, was it along those lines at the end of the process too?

A It was not without its challenges, specifically in relation to data acquisition, the data analysis and to data management.

Q I'll come to that in a minute. I'm sorry, Professor, it was a fairly appalling question, I suspect. Just going back to your description of the independent case note review, as

far as the review itself, and those who undertook it, you describe it as those individuals undertaking their work in a transparent, open, honest way and with integrity and in a way that they were accessible. And were you satisfied by the end of that those individuals had continued to behave in that way?

A Absolutely.

Q The reason for asking that question is this, it was me, in my question, who described it as the independent case note review. Do you consider that that adjective, "independent" in the sense of being independent from any of the institutions who might have an interest in the events that gave rise to that review, whether it's GG&C, whether it's Scottish Government or some emanation thereof, do you consider that the process is worthy of the description "independent"?

A Absolutely.

Q Now, we'll come in a minute to what, in relation to Molly's case, the review said. Just picking up there on something that you started to tell us a bit about, can you say whether the review met full cooperation, on the one hand, or resistance, on the other hand, from GG&C in relation to the production of records and information?

A They had significant challenges in relation to this, which was evident throughout, which was requiring of continued communication back to Greater Glasgow & Clyde in relation to their cooperation for access to documentation.

Q And just again to help us to locate that in your statement, evidence, is it paragraph 381? Just have a quick look at that. (After a pause): Is that right?

A Yes.

Q I'm just interested in what you say in the first sentence of 381:

> "You can reflet on the vastness of Greater Glasgow and Clyde Health Board and the very many datasets and the fact they don't have a system that actually considers all of the data sets."

What do you mean by that?

A Such is the vastness and different departments and organisations within it, I understood that there were separate and distinct repositories for information. Not all of those datasets would talk to one another and, indeed, this was a challenge for the independent case note review as to where they could find a document. So how could they navigate their way through to find Molly Cuddihy within those datasets? And this again is back to the point that I mentioned earlier about relevance and disclosure. They had to determine relevance and not everything was being fairly disclosed and so repeatedly they had to ask for access to datasets but also how to navigate their way through them. Thankfully, on the team they had the most tenacious individual in Dr Patricia O'Connor, who has a lifetime involved in paediatric treatment, so she would know where to find things. But also, in fairness, there was eventually a conduit of information that would assist them going forward and so it was not information that was being freely given. They had to fight for it and how do you know – we only know what we know – how do you know what you don't know? How do you know what you don't know? What's in there? And this is where you look for the trust again, for people to disclose everything that is available. Again how do you know you have everything when we look? And then once you formulate your report it's a challenge

and because I had experience of them not disclosing everything.

Q Now, as far as what was said in relation to Molly's case, the easiest way to do this may simply be to go to the relevant part of your statement rather than have you, as it were, do it by your recollection. Miss Callaghan, I wonder if we could have paragraph 300 of Professor Cuddihy's statement up on screen? (After a pause): Again, I think I'm having some issues with my own monitor but if everybody else has got paragraph 300 we'll just proceed.

A It's there now.

Q Thank you very much. So the supplementary report, that's the report that's specific to the patient. Is that right?

A Yes.

Q And you say "this report and the previous report", that would be the general report?

A Yes.

Q

"… made reference to disclosures around mycobacterium that totally contradicted that which I and my daughter had been told relative to her bacteria; specifically, that a paediatric patient had contracted mycobacterium in 2016 whilst an in-patient in ward 2A. I and my daughter had been told by those in GGC that she was the first patient from paediatric haemato-oncology at GGC to have contracted this rare pathogen. Indeed, I was informed only 4 cases had been recorded in the last 10 years, all within the adult population."

Now, just pausing there, was it your understanding that that was the adult population across the whole of the Health Board?

A Yes, yes.

Q And then reading on, if you're able to scroll down:

"The additional report made further disclosures that identified the bacteria from samples taken in April 2019 from four separate locations in ward 2A of the RHC. This was also significant in that this was during

> the time the ward was closed for some 12 months after my daughter contracted the bacteria."

I mean, just pausing there, Professor Cuddihy, and taking in the rest of what's said, that summary of all these reports, how did you feel when you read all of that?

A Well, sir, that was only made possible because I had provided another document to the review. There was----

Q Just pausing there. Sorry, this goes back to what you said a moment ago about it wasn't without its challenges. Had you not filled in that information gap, what you just summarised might never have been said. Is that what you're saying?

A Exactly. Molly had received an initial confidential report which reflected the findings but there was a section in it which highlights if they'd considered any other documents and any other information, and it said "unsupplied", and this is when, again, I go into disclosure revelation. They'd never been provided with a specific document that had been compiled, thirty-nine pages, in relation to mycobacterium chelonae.

They'd not been provided with this. And so I questioned this, questioned those within Scottish Government and others, as to why they didn't have this information. So whilst everyone was apologising to me, Professor Stevens requested the document. It was sent to him. It was from that document that it led him to other information and he was then able to be more specific in Molly's confidential report, relative to what you have just narrated there.

Q Yes. And you go on to say:

> "I had consistently requested samples be taken during 2018 but this was never done. This additional report also identified that of the four locations in ward 2A that tested positive for mycobacterium chelonae, two were rooms occupied by my daughter in April 2018; the time she contracted the bacteria."

Was that new information to you?

A (No audible reply)

Q Now, how did you feel about reading that?

A Again it's about openness and transparency. We consistently requested those samples to be taken and those within the hospital would take the view that absence of evidence is evidence of absence, because, of course, that's not correct, as we know. If you don't look, you don't find. And as they weren't looking, and indeed that was reflected by Mr Stevens' opine within the report, that had they have looked at the time then they may have been able to connect this to Molly's case. And so whilst samples were requested during 2018 they were never, ever taken, and only when the ward was closed – as I understand it, it was actually the microbiologists who then went in and conducted the sampling. And, as I say, to then find out that the room predominantly that Molly was in was positive for mycobacterium chelonae. Another room that Molly was in was positive for mycobacterium chelonae. Two other locations were positive for mycobacterium chelonae. 2016, a patient on that very ward, was positive for mycobacterium chelonae and, indeed, was part of the case note review. Also another mycobacterium chelonae, taken on ward 7D from a

shower head, which is in the adult hospital, 2017. They knew this. They knew that there was mycobacterium chelonae associated with ward 2A and the adult hospital. When I was asking for those samples to be taken, no one would take them. Then when the ward was closed, the microbiologists take the samples and we find, almost a year of a difference, there's mycobacterium chelonae found with that ward. This rare pathogen that had never been seen before is everywhere.

Q Just unpacking that a little bit, Professor Cuddihy, you're indicating that in relation to the finding in the adult hospital, that was found in, did you say, 2017?

A 2017, in a shower head in ward 7D.

Q And in relation to the finding in the room that Molly was in, on 2A----

A Yes.

Q -- as far as you understand it, does that come from the sampling in April 2019?

A (No audible reply)

Q And we heard from you yesterday, and from Molly, that it looks as if certainly in May there were signs of infection – May 2018 – there were signs of infection on the part of Molly. I think you've each put it slightly

differently but Molly put it memorably when she indicated that the sort of April/May, April into May stage, there was a sense of something coming, you know, sort of hovering. Now, it was September 2018, so four months later or so, that ward 2A was closed and I presume the room that Molly had been in when she contracted mycobacterium chelonae had been occupied by other children in the interim period. Would that be right?

A Yes.

Q And you're indicating that almost a year later, when Molly may have contracted that infection, mycobacterium is present in the very same room. Is that right?

A (No audible reply)

Q I was now going to move, Professor Cuddihy, to think about your reflections on the Oversight Board and I think we understand that its final report was issued round about the same time, I think, as the independent case note review report. Would that be about right?

A The same day.

Q Yes. Now, I'll come to your reflections on it perhaps a little later but, first of all, I would be interested, as somebody who was a member of Oversight Board and had an active role on its work, I was wondering if you could tell us a little about or maybe picking up on where you were around about the time of the BBC programme, I wonder if you could tell us something about the Board's engagement, the Health Board's engagement, with the Oversight Board process during the remainder of its work up to the issuing of its final report?

A So from that point of the Disclosure Scotland programme, the Oversight Board, as were others, were impacted as a consequence of Covid, so the physical meetings had been replaced with online, so the communication with the Oversight Board to consider papers and the likes was through Teams or I presume one of those applications. And ahead of anything, the papers would be shared with you. You had the opportunity to consider those and make comment and I often did and challenge the detail within them. But specifically, PricewaterhouseCooper had been retained to develop an analytical process in terms of governance to produce various products in relation to this, a timeline of events from '15 through to 2020, to consider aspects of governance and the timeline; to consider and overlay aspects of infection; to consider and overlay

aspects of communication, and specifically, when I reviewed the governance, and the large number of internal governance groups that applied to GG&C, I noted a number of things from my own investigations. First and foremost, there was pertinent detail missing from those timelines in that when it came to 2018 Molly Cuddihy didn't exist. She didn't appear on that timeline at all. Mycobacterium chelonae did not appear on that timeline. But also, importantly, certain documents that would be referred to that enabled compilation of this analytical document, those documents didn't appear. I had concern about that. But also what didn't appear, certain internal governance groups didn't seem to be reflected. That is no criticism of the individual that is engaged in the data acquisition, the data collation and the data analysis. You can only deal with that which you have. So I challenged this specifically and the Chair invited me to then prove the point. I proved the point and I submitted to them a 39-page report in relation to mycobacterium chelonae, involves the report as the process and procedure that NHS GGC should follow in relation to when mycobacterium chelonae is either

suspected or identified, and that is you should take water samples. And, indeed, reflected in information from the Oversight Board and others, it was to canvas the rest of Scotland, all of the other Health Boards, "What do you do in relation to mycobacterium chelonae?" You sample the water. And yet Greater Glasgow and Clyde hadn't done so.

So I had within this report reference to those guidance documents and recalling that Jennifer Armstrong, Medical Director, had told me in her letter to me in 2018 that they had followed all of the guidance and all of the protocols. Not here you haven't. Not here you haven't. And so I put this document together from an amalgam of sources that I had managed to gather and I presented that report to the Oversight Board, and it was accepted as a document to the Board, and as a consequence it influenced the final iteration of their oversight overview report.

What also was within the timeline, highlighted who had access to what and when. Hugely important information is missing from those corporate documents and so I would contribute in relation to it, and the Oversight Board were accepting. Again, it demonstrates their

transparency, it demonstrates their inclusiveness, that I provided this report, and also that times when I would challenge other aspects and they would come back and if they had a contra-view of it, fantastic. We wouldn't always agree. I could be wrong in my assumptions, I would be wrong in certain things. Fantastic. Tell me now. I need to know because it will help my head and it will allow me to make better informed decisions. So I found it, from my personal experience, to at that point do what it was intended within the faith of the terms of reference and to consider information that was presented to it. But could we have a collective confidence that that which they were reviewing was the sum of all its parts? And it goes back to the point that I had raised to the cabinet secretary, which Fiona McQueen, the Chair of the Oversight Board, was at, "Do you have confidence in the information that's been provided to you?"

Q Thank you, Professor. Now, just two very brief points before lunch on that. Just on the general point that you've just made, and that you made before, about I think what you're saying is that provision of documents and information by GG&C to the Oversight Board, is that right?

A Yes, yes.

Q Did the Oversight Board have powers to compel the production of information or were they simply dependent on what GG&C considered was relevant to its terms of reference?

A Very much so, yes, it was.

Q And just one specific brief point, again just to help us when we come to consider your evidence, look, please, at paragraph 380 of your statement. That's where we see the reference to the report prepared by PricewaterhouseCooper. Is that right?

A Yes, that's so.

Q And are you indicating that among the concerns you had, even at this stage, was that the Oversight Board is not being provided with the totality of all infections, or even infection types? Is that right?

A Absolutely.

MR DUNCAN: My Lord, I've gone slightly past one o'clock but I have now concluded that chapter.

THE CHAIR: Thank you, Mr Duncan. We'll take our lunch break and sit again maybe just a little after two o'clock. Thank you.

13:10

(End of the Morning Session)