SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
12 June 2023

Day 2
Tuesday, 13 June 2023
Shahzya Chaudhury

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14:00

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

MR DUNCAN: Indeed, my Lord, we have got Dr Shahzya Chaudhury ready to proceed.

THE CHAIR: Thank you. Dr Chaudhury. Good afternoon, Dr Chaudhury. As you will understand, you are about to be asked some questions by Mr Duncan. First of all, I understand you are prepared to affirm?

A Yes.

Dr Shahzya Chaudhury
Affirmed

THE CHAIR: Thank you very much, Dr Chaudhury. Now, I anticipate that Mr Duncan's questioning might continue until about four o'clock, but neither he nor I can be certain of that. Should, for any reason, you want to take a break before that, just give me an indication and we can take a break at any time. Any time you wish. The other thing I would mention, because I am hard of hearing and wearing hearing aids: if you could speak maybe a little louder than you would in normal conversation. The microphone should pick you up, and if you are close to the microphone, I would like to think it will not be a problem. Mr Duncan.

Questioned by Mr Duncan

Q Thank you, my Lord. Good afternoon, Dr Chaudhury. I wonder if we might begin by having you give us your full name, please.

A My name is Shahzya Shahrin Chaudhury.

Q Are you a consultant in paediatric haematology? Is that right?

A Yeah, I am.

Q I think we understand that you have provided a witness statement to the Hospital Inquiry, and you are content that that forms part of your evidence. Is that right?

A Yes, I am.

Q Thank you. Now, could you tell us where, professionally, you are based?

A I'm based at the Paediatric Haematology Department at the Royal Hospital for Children.

Q In Glasgow?

A In Glasgow.

Q You have been there since, what, September 2017 as a consultant. Is that right?

A Yes, that's correct.

Q You had a spell before then there. Is that right?

A Yes, I did six months in my final year as a haematology trainee between August 2016 until February 2017.

Q Now, you have given us, no doubt, just a snapshot of your CV, and if you will forgive me for making it even briefer, we will certainly be taking it into account. I think you had an academic career that started with a BA Honours in Cambridge. Is that right? And ended with a PhD in leukaemia at Glasgow University. Is that correct?

A That's correct.

Q Yes. I see you have won a number of prizes. Is that right?

A Yes. Yeah.

Q I am sorry, I cannot avoid asking this question: you had mentioned that you won something called the "3 Minute Thesis Heat."

A I did. Yeah.

Q Can you tell us what that is?

A It was when I was doing my PhD. It was three minutes to summarise your research, and I won the heat.

Q Thank you. Well, I shall try and be as succinct, but I am not promising to succeed. Moving on, then, I want to ask you some questions about your role as a clinician. I mean, primarily, how would you describe your role as a clinician?

A My role is primarily looking after children with malignant haematological diseases. So, leukaemia and lymphoma. I also look after children who are going through stem cell transplantation. So, those are my main roles.

Q Thank you. You also indicate that you perform roles that have a more managerial aspect, as you describe it. You mentioned that you are involved in something called the "Haematology Laboratory Management Team." Could you tell us a little bit about that?

A Yes, so that's a team with the laboratory team in the haematology lab and the adult haematologists. The aim is to ensure that the haematology laboratory runs efficiently.

Q You say also that you are involved in something called the "clinical governance and quality management meetings." Can you tell us what those are?

A Yes, so those are departmental based. So, based in the Schiehallion Unit. They are meetings that look at governance on a ward level and a departmental level, and

ensures quality at a departmental level and that the unit runs efficiently.

Q Thank you. Now, yesterday, in her evidence, Professor Gibson distinguished the roles of clinicians and the roles of management, and she said the role of the clinicians is to provide treatment safely and in accordance with guidance and protocols. She said the role of management is to provide a safe environment in which to do this. Is that a distinction that you would recognise?

A Yes, I would agree with that.

Q Thank you. Now, I want to go on and ask you now a bit about your patients. What is the patient cohort that you look after? How would you describe that cohort?

A In general, they are children going through treatment for leukaemia or lymphoma. So, cancers of the blood system. Usually, to treat children, they need aggressive therapy that can make them unwell. Myself, with the multi-disciplinary team, we support the patients and their families through that treatment. In addition, I also look after children going through stem cell transplantation from the initial counselling and work up stage through

to their inpatient admission and the follow-up thereafter.

Q Thank you. Now, you have given us a lot of detail on the experience of treating children with malignant conditions, and I am not going to ask you to go over all of that again having gone to all of that work and provided it in your statement. Just picking up on something that you have just said, I am interested in one aspect of that. In your statement, you talk about “working up” for transplant. What does that mean?

A So, any child that is being considered for a transplant, even before we meet the patient, we have to consider (a) if a transplant is appropriate, and if it will help. If it will help, then what sort of donor is available for that patient, what sort of preparative treatment they require, and what sort of preparative investigations they require. Once a donor has been selected, then the patient and their family needs to be counselled as to what a transplant entails and any risks of the transplant. So, that is before a patient or a parent even agrees for a transplant to go ahead. That can take weeks to months.

Q Yes. Just when you are speaking about that process of counselling and the discussion around

risk, I would be interested in your thoughts on this: would patients need to know if there was, for example, a particular risk from the hospital building, and would therefore the clinicians also need to know that in order to allow the counselling process to happen properly?

A Transplantation, and indeed any cancer treatment, incurs a risk of infection. There does need to be an understanding of what the environmental risk of infection is in order to counsel parents and patients effectively, but also for us to try and mitigate that risk as best we can.

Q Thank you. Now picking up, then, what you just said about infection. Again, I will try not to go over matters that you have already helpfully given us in your statement. We had this yesterday from Professor Gibson: this group of patients, I think, we understand to be particularly susceptible to infection. Is that right?

A Do you mean patients undergoing stem cell transplantation?

Q Yes. Well, even just the broad spectrum of, you know, from patients having chemotherapy through to patients having a transplant. Would that be fair? They are all, to some extent at least, susceptible to infection?

A Yes.

Q Again, we have had a lot of evidence from patients and families, from you in your statement, and from others about the impacts from infection. I mean, in addition to the obvious mortality risk, how would you describe the impacts of an infection for a child going through chemotherapy treatment or stem cell transplant?

A So, I mean, infection is very common in terms of how it impacts the patients and the families. Patients can become very unwell with infection. They need to come into hospital for treatment of the infection. Sometimes chemotherapy has to be delayed while an infection is cleared. If an infection is related to a central line, then sometimes that central line has to be removed, in which case they need to have a surgical procedure under general anaesthetic to remove that central line. Often, in order to continue with treatment, a further central line has to be inserted once the infection has resolved.

Q Thank you. Again, I will not ask you to repeat evidence we have already had, but we have had evidence about-- I think we now know that we pronounce it rigor. The way it was described by some patients and families in their evidence was that that

could be something really that was quite extreme in terms of the shaking reaction from the infection. Is that, again, a description that you would recognise?

A Yes, I think rigors can be quite a distressing thing for parents to see in their child.

Q Yes. In your statement, as far as the delay to treatment aspect is concerned, I think you say, at least in relation to some infections, that delay could be quite significant?

A In order to treat the----

Q Yes.

A It can be.

Q Yes. Thank you. Now, if we move on, then. I want to start asking you some questions about the hospital building. If we ignore for the moment concerns about water and ventilation and infection risk, and just ask you some other questions. Maybe just begin with overall impressions. I mean, when you first arrived in the hospital, whether in your ST7 post or as a consultant, what was your overall impression of the hospital and of the RHC in particular?

A My first impressions were that the hospital looked new and clean, very big. That Ward 2A and 2B, on the face of it, look like a good ward to

house children going through cancer treatment.

Q Yes. I mean, I think in your statement you say it looked like a state-of-the-art hospital.

A It did.

Q Yes. Again, if you will forgive me, I think, I take you to be identifying pros and cons as far as, as it were, the layout of the hospital is concerned. Would that be fair?

A Yes. I mean, it's very big, and that is good to have specialties on-site, but everything was very far apart from each other. There's a lot of walking to get from one department to another and, you know, our offices are quite far away from the ward, for example.

Q Yes. Now, I do not want to go through all of those issues but there is one that I am just going to maybe ask you to just help me with a little bit. One of the issues that you mention is the smell from the nearby sewage works, and we have had a lot of evidence of that, and you tell us that that is something that you are aware of. One of the things you say in your statement is that you understand the question of whether the sewage works themselves pose any infection risk to have been looked into, and that it is

not thought to pose a risk. Do I understand you correctly?

A You do. I can't remember where I heard that, but I remember that being discussed as a cause and it being said that it wasn't linked to any infections.

Q Yes. Thank you. Now, another matter which I am not going to take up a great deal of time on with you is the ventilation system. I obviously understand that you are not a ventilation expert, and nor are you a microbiologist, but you do mention something in your statement that I just want to pick up on. Is it your expectation that transplant patients, and also chemotherapy patients, would be nursed in positive pressure rooms?

A Certainly a stem cell transplant patient should be.

Q Yes. Are you able to say what your expectation is as regards patients who are having chemotherapy and not having stem cell transplantation?

A I can't really comment on what the current recommendations are, but certainly the most immunosuppressed children should be in a positive pressured room.

Q Again, is that just your understanding of what is said in

guidance or is said by whatever expert advice there is in that particular area?

A Can you ask the question again?

Q Well, let me try and put it more succinctly then. You, yourself, do not have any understanding, I take it, of what is or is not actually required. It is just that you have an understanding of what may be said in guidance in relation to this.

A Well, there are JACIE guidance regarding stem cell transplant patients. So, I know for stem cell transplant patients positive pressured ventilation is desired to house them. The children going through the most aggressive chemotherapy, it is best if they are housed in a positive pressure room. So, aside from stem cell transplant patients, the patients I look after that are the most immunocompromised are those going through relapsed leukaemia treatment or who are going through induction chemotherapy for acute myeloid leukaemia. So, from my understanding, those would be the most at-risk patients.

Q Your expectation would be that those patients would be housed in positive pressure rooms. Is that right?

A Yes.

Q Thank you. Now, the next thing I want to ask you about is how information about concerns, whether about the building or about patients or anything really to do with clinical care, is exchanged among colleagues within the hospital. If we begin with the verbal exchange of information, i.e. discussions, I would just be interested in knowing what the standard approach is for how you and your clinical and other colleagues, as it were, join up your knowledge through discussion. Now, you have mentioned the clinical governance and quality management meetings, but I wonder if you could just give us an idea of the sort of, as it were, usual meetings. I am not thinking about ad hoc or emergency meetings or anything like that, just the sort of usual weekly or daily meetings that happen that enable the exchange of information on issues that may be of importance or of concern?

A So, I guess, at a very basic level, we have handover meetings twice a day, and some immediate concerns may be raised at those meetings. We have a consultant meeting once a week, which is a bit more formal, and we might speak about specific clinical concerns or clinical issues, such as workforce

planning, for example. Then there are the formal unit meetings and clinical governance meetings that are every two months, which is not just medical teams, but also other multi-disciplinary teams and management as well.

Q Is it essentially a mixture of formal and informal meetings then really, and the exchanges, is that how it works?

A It is, yes.

Q Now, staying just with verbal discussions and then moving to think then about forums that arise in a more ad hoc manner or are perhaps triggered by particular incidents. We have had evidence yesterday about something called PAGs and something called IMTs, and that those are triggered by Infection Control when particular concerns arise. Is that right?

A Yes, and they'd be infective concerns.

Q Yes. Now, I am going to focus particularly on IMTs, which we understand to be Incident Management Team meetings. Is that right?

A Yes. Yeah.

Q I think what I take from your statement, if you forgive me just sort of leading a bit on this, but just to get through it, we are just interested in the generalities here. I take it from

your evidence that not all treating consultants would attend these meetings, but the consultant from the treating clinicians who did go would cascade, I think is the word, the information back to those on the ward. Is that how it works?

A Yes, that is how I worked. That was a practical way of doing that because you still need consultants on the ward doing the work of looking after patients, so we couldn't all attend each meeting.

Q Yes. I will move to the specifics of 2018 and 2019 in a little while, but was it your expectation then, or indeed understanding, that it was the duty of the consultant who went to come back from the meeting and set out what had happened and what had been said and decided? Is that right?

A Yes.

Q Yes. As far as you can recall, is that how things worked within the ward during the period of 2018 and 2019 in particular?

A Yeah, I think it is how it worked. The consultant would either send an email or they would gather the other consultants after the IMT and disseminate the information of what had been discussed.

Q Yes. I think in your statement you also say-- you reference

this to 2018, you say that an Infection Control representative from the IMT would often come to the ward as well and explain.

A Yes, that's correct.

Q Yes. I think you say in your statement that-- We see that you are more involved in IMTs in 2019, and that you too proceeded in that way, that you would go back to the ward and say what had happened and share it with your colleagues. Is that right?

A Yes, I would.

Q Yes. That process of sharing the information, would that be with doctors and with nursing staff?

A It was primarily with doctors. There was usually a nurse, a senior nurse at the IMTs as well who would disseminate the information to the nursing staff.

Q Yes. Was the expectation that the clinical staff, the doctors and the nursing staff, would then, as they saw appropriate, communicate information to patients and families?

A From the IMT?

Q Yes.

A So, IMTs are meant to be confidential and often discuss works in progress and often discuss clinical cases, so it cannot be the same dissemination of information to parents

as it can be to staff. Updates from the IMT tend to be via official channels or when there was a recommendation from the IMT that was going to cause disruption to parents and patients.

Q Yes. Thank you. Now, moving on, I want to start to move through the story of the concerns that there were in relation to infection in the Schiehallion Unit. Now, I am going to take this in stages, and I am going to begin with infection concerns up until September 2018. Now, very fairly, you say in your statement that you cannot recall the exact timeline. I am not going to ask you to try and do that this afternoon. I do know you have been provided with some of the IMTs and other material from that time. Have you had an opportunity to look at those and refresh your memory on at least some of it?

A Yes, I have.

Q Thank you. Now, I wonder if I might just suggest a summary of the chronology that might be taken from those, and you can just indicate to me whether that is something that you broadly agree with. Now, as I emphasised many times yesterday, I think it is important that you understand, and that everybody else understands, that I and the rest of the Inquiry team do not take the events

described within the IMTs to be proved. We simply take them to be a record of what was being said at the time, and what we are interested in is knowing whether what is said there as regards the record of what was said accords with the witness recollection, if that makes sense.

A Yep.

Q So, as regards the infection patterns, thinking about that period of time that ends in September 2018, going back to the very beginning of what we understand to be the point at which something starts. The evidence we heard yesterday was that a concern about infections, at some point in 2016 and 2017, arose, but with no hypothesised link to the environment at that time. Does that accord with your recollection?

A I wasn't there in 2016 so I can't-- So, if that's what the record is then I have got no reason to doubt it.

Q In terms of what you understood the position to be when you came in later, and in terms of any discussion about the pattern of infections, is what I have set out in accordance with what you understood the position to be?

A Yes, yes. Yeah.

Q What was said yesterday was that that was followed by further concerns about infections, beginning in 2018 – quite near the beginning of 2018 – in relation to which there was a hypothesised link to the environment. Is that right?

A Yes, I think from about March.

Q Yes. Now, we will take all of that in stages, but just to get some general context before we do that – and you have already touched on it – in terms of the perspective of treating clinicians and their ability to notice whether or not there is something odd going on in relation to a pattern of infection, are there particular challenges in this group of patients around distinguishing between the norm and the unexpected?

A So, infections are really common in this patient group, and sometimes I think almost every single patient that I look after going through cancer treatment will have an infection. In a proportion of those patients, an actual organism is cultured, but probably in a minority of those patients, and there are organisms that we commonly see cultured. But there's also the occurrence of more unusual

organisms, and trying to tease out what is an expected rate of more unusual organisms being detected is very difficult because there is no background standard rate that we can refer to. So that is very difficult.

Q I think one of the other things you say – just picking up on something you just mentioned about the unusual nature of some infections – something in your statement that you do say is that even the uncommon infections do arise. Is that right?

A That is correct.

Q Yes.

A Some of the unusual infections that were being considered during this incident are organisms that I have seen in patients in my previous jobs – rarely.

Q I wonder if you would consider that all of these considerations suggest that the questions of causation and association require epidemiological or microbiological analysis rather than the analysis of the treating clinician.

A I would absolutely agree with that. I would not say I'm an expert in this.

Q Well, what I am getting,

though, to is this. I still wonder whether there is value in the evidence of clinicians who have experience of seeing infection on the ground, in practice, and I wonder if that experience permits you some sort of informed view as regards to what is or is not usual.

A I think it does. I think we can say that what we are perceiving is unusual. I then think it is in the hands of microbiology and epidemiologists to tell us if what we are seeing is truly unusual.

Q Yes. Now, thinking then, again, 2018 and the pattern of infections that, on and off, you noticed from that period. What was it about the nature of, or the pattern of, the infections that arose that was notable?

A So, the first thing was that some of the organisms were these rare organisms that perhaps hadn't been seen very often in our patients and that there seemed to be more of these sorts of organisms than we thought we had seen in the past, and that-- I think I should say is that it wasn't just the haemato-oncologists that were noticing this; the microbiologists that came to the ward and used to come face-to-face as a routine to discuss new blood

cultures and to give advice on how to treat infections around the ward also commented that they were noticing an unusual spike in these infections as well. So it wasn't just us, it came from microbiology as well.

Q And thinking about your own particular, as it were, comparative perspective on that, i.e. comparing what you were noticing in 2018 with what you may have seen in the past. You had not previously worked at Yorkhill. Is that right?

A I hadn't.

Q To what extent----

A I'd done a couple of shifts as a locum but----

Q In terms of doing that comparison about whether you were seeing something unusual compared to what you had seen before, did that place you in any disadvantage compared to your other colleagues?

A I mean, I certainly couldn't compare the same cohort in the same department. I didn't have that experience. I could describe what I'd seen in other hospitals in Scotland, and from my experience, I hadn't seen that, but I had only been in six-month blocks before

starting on my consultant role, so I didn't have the experience of working in a department for years to observe background rates of infection over a longer period.

Q But are we to understand that, in those other departments, you had been dealing with a similar cohort of patients? Is that right?

A Yes, yes.

Q And are we to understand that you too felt there was a difference between what you'd seen previously what you were seeing now?

A Yes, yes.

Q Now, let us move on then from what it was you were seeing and what the microbiologists were also saying they were seeing. Let us move on, then, to the question of hypotheses. I am going to try and take this chronologically, but we will take it in fairly broad strokes, so again, I emphasise I am not going to expect you to give us a detailed recitation of the chronology. If we begin with the IMTs that took place over the period of March 2018, what did you understand the hypotheses, or hypothesis, to be, at that time, around what might be causing this pattern of infections?

A My understanding was

that there was potentially contamination from the water system that was potentially causing these infections in our patients, which led to the installation of point-of-use filters on taps. I believe, at the beginning, the hypothesis was that there was contamination from human contact to the taps, but later organisms were found in the water in other wards where our patients or our staff hadn't been, so a more widespread concern about water contamination was hypothesised.

Q Yes. Well, you anticipate the question I was about to ask you which was what your understanding was at that time as regards the extent of the possible contamination of the of the water. What was your understanding of it?

A My understanding was that it wasn't just confined to our unit, that it was more widespread.

Q Yes. I mean, I think the IMT that more or less concluded this particular episode, which was on 27 March 2018 – I do not think we need to turn it up – that does indeed record it being said that there was thought to be a widespread problem. So, would that accord with your recollection of events?

A Yes.

Q And by "widespread problem", are we to understand that it was, in addition to the concern about the pattern of infections within the Schiehallion units, sampling was disclosing widespread signs of pathogens being found within the water? Is that right?

A Do you mean within the Schiehallion Unit, and outwith the Schiehallion Unit?

Q Both, I think.

A Yes, that was my understanding.

Q Now, I would wonder if we could just maybe have you clarify one aspect of your evidence at this stage, and I wonder, Mr Castell, if we could have Dr Chaudhury's statement up on screen, please. It is at page 155 of the statement bundles. Statement bundle. Thank you, and it is paragraph 53 that we want, and if we just enlarge that. Yes. If you have that in front of you, Dr Chaudhury, "Concerns about Stenotrophomonas in 2018," reference to an SBAR, and a review. Paragraph 53, you say:

"When it was apparent that there was an increased incidence of gram-negative infections, Professor Gibson wished to retrospectively review gram-negative infections that had occurred prior to 2018. Microbiology provided a list of patients who had gram-negative blood infections at the end of 2016 and 2017. Professor Gibson asked if I would provide clinical context to these incidents."

I am not going to go into this in any detail; it is really just to get an understanding of what this is about, and I think, probably, resolves itself into these questions. First of all, what was the concern that led to this request for a review?

A I believe there was a concern that the water system was contaminated and that might be linked to infections that we were currently seeing, and so Professor Gibson wanted more information about previous gram-negative infections, from my understanding, in case they were also linked to the environment.

Q Yes. The second question is about this; am I right in understanding, in terms of your contribution to this, and I have seen this from your evidence, I think, that your contribution was around, essentially, gathering data in

relation to the impact of infections on patients? Would that be right?

A Yes. So, information about the infection, whether patients were neutropenic at the time, and what the outcome was.

Q Yes. Thank you. In particular, though – sorry, maybe just to clarify that – essentially, I think what you did was a review of patient case notes to identify data that would be relevant to the points that you just mentioned? Is that right? I do understand that, in particular, you were not yourself doing any investigation into whether there was or was not a link between infections and the water system.

A I wasn't doing any of those sort of investigations. I was collecting data on whether lines were removed and if the patient was admitted to PICU and if they survived or didn't survive.

Q Thank you. We can put that to one side, Mr Castell, thank you. Now, if we move, then, a little bit further forward in time to the summer of 2018, and again, if you will forgive me, I will just reprise the evidence that we had yesterday as regards the pattern of infection and as regards hypothesis at that time. What we heard yesterday was that,

notwithstanding the remedial measures that had taken place in March, there was a return of concern about infection in May and in June 2018. Does that accord with your recollection of things?

A Yes, it does.

Q In particular, I think there was a return of gram-negative infections, but also a case – or cases – of atypical mycobacterium. Would that be right?

A I'm sure that's correct; I can't exactly remember when the case of mycobacterium occurred.

Q Okay, thank you. Again, the evidence that we had was that drain swabbing around this time disclosed various gram-negative bacteria within the drainage system. Is that your recollection?

A That is.

Q And that the advice – again, just thinking about what was said in IMTs, and not taking it to be proved or disproved – the advice at the time appears to have been that it was a site-wide problem. Is that what you recall being said?

A It was definitely within our unit. That was quite a long time ago, and I've read lots of IMTs now. It was definitely within our unit. I can't remember if it was on other

wards, but I think so.

Q Thank you. Professor Gibson's evidence was that, by around September, staff were concerned that the unit was not safe. Is that your recollection of how you and your colleagues felt at the time?

A That is my recollection. We were all very concerned. I think, by September, there were three instances where IMTs were called because of a cluster of gram-negative infections, and we were seeing that remedial actions would reduce rates temporarily, but then the rates would go up again and we would see a re-emergence of these cases. So we were concerned.

Q Thank you. Now, if we move, then, a little further forward in time to the decant, and I'm going to ask you two things about that. The second thing I am going to ask you about is about the effect of the decant on your patients and on you and your colleagues. But before I do that, I want to ask you a bit about the reasons for the decant, and again, if you will forgive me, I am just going to replay what we took from Professor Gibson yesterday, allied to what is in the IMTs, just to ensure that it chimes with your

understanding. I think, in part, you have already answered this, but is it right that there was a concern that there were new cases of bacteremia still emerging? Is that right?

A That's correct.

Q And the IMTs would indicate – and, again, I do not say whether this is correct or not correct – but the IMTs indicate 23 patient cases of gram-negative bacteria since March 2018. Do you recall it being said that that was the sort of level that you were at by then?

A Yeah, it does. I don't remember the exact number, but that sounds like it's about right.

Q And advice that other investigations still needed to be done, but could not be done with patients still there? Is that right?

A That was my understanding, yes.

Q Those were reasons for the decant. Is that right?

A Yes, my understanding was they had to investigate the ward further and they'd done all that they could with patients still on it.

Q Yes. Can you remember whether, at that time, there was still a hypothesis that there may be an environmental cause for this pattern of infections?

A Do you mean a hypothesis that something in the hospital environment was-- Yes, I believe that was still one of the hypotheses.

Q Yes, thank you. Now, if we move, then, to the effect of the decant. I think it is important to remember it was a decant, not just to Ward 6A, but it was also Ward 4B. Is that right?

A That's correct.

Q Yes. Now, you deal with this in your statement, and again, I will not go into it in great detail, but you must feel able to do so if you wish. If we just think about the ability to care for patients, first of all, and put infection concern to one side, what was the impact on the ability to care for patients from your perspective?

A I think the impact was huge. It was still the same doctors and nurses that were looking after patients, but we lost beds, so we had fewer beds for in-patients and for our and for our daycare out-patients. We were on two floors, so we had to split our staff to cover to cover both floors. You know, our children potentially can become very sick, and we were a fair distance away from the from the

paediatric hospital-end, from other paediatric specialties such as Radiology, theatres, Paediatric Intensive Care.

We are a specialty that relies heavily on other specialties to consult on our patients, and they would still come and consult, but they might do it at the end of their ward round or the end of the day because they had to trek 10 minutes to the adult hospital to see our patients. So it had a huge impact on how we were able to deliver care to our patients. There wasn't much space; there was one small doctor's room. It was quite difficult; it was a difficult time.

Q What about the impact on your patients and their families?

A So, when we first moved over, it was never designed to be a paediatric ward, so initially, there weren't parent facilities, there wasn't a playroom – later, they did make a playroom – there were still single-- a single room, so in terms of being able to isolate patients, we were still able to do that on Ward 6A. For the children going through transplant, the control measures were in the Adult Transplant Unit and their control measures are a lot more restrictive in terms of visiting, and

you can come onto the ward and-- We had to abide by their rules, because we were on their unit, but that was a lot more restrictive than how we would-- You know, it was a lot more restriction than we would impose on our parents, so it was difficult.

Q One of the things that the patients and families stressed about Ward 2A and Ward 2B and is also mentioned many times in your statement and in the statement of your colleague is the holistic nature of care that is provided to paediatric cancer patients, that it is not just about doctors. Is that right?

A That's correct.

Q Yes, and one of the recurrent – indeed, constant – themes in the evidence from the patients and families about Ward 6A was about the effect upon that holistic aspect. Thinking about what you have said about the impact on the clinical aspect, or about the impacts on those other aspects of the Schiehallion Unit that try and enable treatment to be a little more bearable.

A I believe it was restricted. It's difficult to know how much was being on 6A and how much was COVID, because we did go through

COVID at that time as well.

Q If I maybe help you, while you think, that-- If it helps you at all, this issue also arose yesterday in Professor Gibson's recollection of matters, but the decant was in September 2018, and of course you would not have had COVID to worry about at least for-- well, some of 2019. So, I wonder if you are able to cast your mind back and think about what it was like over that period prior to COVID?

A Well, I know the parents found it difficult. I mean, they said that it was difficult. I think what I'm having trouble remembering is if, in part, some of that difficulty came when Ward 6A was closed and a lot more restrictions were placed on parents at that time when we were asking for less thoroughfare on the wards and were minimising people coming on to the ward to try and minimise infections. But my recollection at that time is a bit hazy in terms of what was due to the ward being closed and what was due to restrictions being put in place to try and minimise footfall for the ward.

Q Mm-hmm. I mean, one of the-- I understand the difficulty because not only is there the

COVID aspect, but even if we just go back to 2019, we know that there is – and we will not go into the detail of any of this – we know that there is evidence of a serious concern about a particular infection at the end of 2018, and in the beginning of 2019, called Cryptococcus. We also know, from evidence yesterday, that there was, about the same time, a concern about fungal counts, and a problem with the showers, and the requirement to decant the children again to the CDU, back to the children's hospital. We also know that, later in 2019, from your evidence, there was then a further concern about infections back on 6A. So, yes, I can understand why you find it difficult to give an overall view of life on 6A. Is that the point that you are making, really?

A I think that's fair, and I think-- I wasn't there for the first quarter of 2019 because of bereavement, so I also wasn't-- I just wasn't there.

Q Yes. One further aspect I want to ask you about 6A is really about safety aspects. Did you have any concerns as regards to the prospect of patients going to 6A? Safety concerns, I mean, thinking

about the problems that there had already been in the Schiehallion Unit.

A From an infection point of view----

Q Yes.

A -- or just in general? Well, I knew that it wasn't a ward that was designed for immunocompromised patients, but we had to take advice from Control of Infection to say that it was safe enough for our patients on a temporary basis. I think, by this point, I think we all – you know, clinicians, nursing staff and parents alike – wanted some clarity as to whether Ward 2A was safe or not. So I think a lot of us were quite practical about moving to 6A. I think we all had some reservations about 6A from all aspects, you know, the fact that it was far away from the children's hospital, the fact that it wasn't designed to house immunocompromised patients. But I believe that Infection Control measures were being put in place, such as filters on the taps, and we all wanted to have clarity as to the state of our unit.

Q Just to clarify what you have just said, there were point-of-use filters in Ward 6A.

A Yes, I think that was a prerequisite for us moving.

Q Just picking up on another aspect of the possible concern of risk of infection in Ward 6A, something that you say in your witness statement is that you understood, or rather, indeed, that you were informed that there was a separate water supply to Ward 6A. Is that right? Or to the adult hospital?

A From my recollection, yes, somebody told me that.

Q Do I take from your answer that you cannot remember who that was? Or maybe you can?

A From recollection, I think it was Teresa Inkster but, again, it's several years ago and----I can't be sure that that's who it was.

Q Okay. Is it possible that you could be mistaken about that, then?

A I could be. That's just from recollection.

Q Yes. Can you remember whether it was ever confirmed or clarified as to whether that was the correct position or not the correct position?

A I don't think it was. It's not been in any of the documents I've read either.

Q Okay. Now, I want to move on, then, in the chronology, to summer 2019. In your statement, you describe a return of a disproportionate – as the clinicians saw it – amount of gram-negative infections. Is that right?

A Yes.

Q Yes. Are we right in understanding that admission to Ward 6A was restricted, in some sense, at that point?

A Yes. I can't remember exactly, maybe about August, 6A was closed to new patients.

Q Yes. I wonder if we could just have a look at one or two of the IMTs just to help us a bit with the chronology at this point. Mr Castell, I wonder if we could go to bundle one, please, and page 320. So, bundle one, page 320. I think we have got an IMT minute there of 19 June 2019. I think you were one of the attendees. Is that right?

A That's correct.

Q Yes. I think we can see, underneath "incident update," there is a reference to GNB cases. Is that right?

A Yes.

Q Yes. Mr Castell, could you take us, please, to page 323? I wonder if we might just enlarge the top half of the page. I would ask you to

just look at a few aspects of this, please. I think that we see from the top of that page that there is a reference to GNB and, indeed, above it a reference to something else, "Atypical Myco." Would that be atypical mycobacterium?

A Yes.

Q With a reference to the patient being exposed to unfiltered water source somewhere on site. In relation to the GNB, it says, "Possibly acquired outwith the healthcare setting given negative water sampling," and underneath "communications," it says, "Parents not to be informed of GNBs at present as no conclusive evidence that it is due to healthcare environment." Then, if we go to "communications – staff," it says, "The nursing and medical staff will update clinical teams. Staffing brief will be prepared by Dr Chaudhury. TI happy to review prior to it being issued." Now, yesterday, Professor Gibson warned us that minutes are just minutes, and they are not always accurate. So, again, I give you that assurance that we do not proceed on the basis that any of these documents is necessarily the gospel of what happened, but can you confirm whether what is set out there accords with your recollection of what was discussed at this time?

A I definitely remember the atypical mycobacterium being discussed, and about communicating that to the patient and their parents. I also remember that I was asked to prepare a staffing briefing, but I wanted to make sure that it was accurate. I don't think I'd been to the IMTs just prior to this, so, like I said, I'd come in in the middle of the story. So that's why I asked Teresa Inkster if she would help me with staffing briefing, which she did.

Q Yes. Now, I am interested in the bit that says, "Parents not to be informed of GMBs at present as no conclusive evidence that is due to healthcare environment." Do you have a recollection of something like that being agreed at the meeting?

A I don't have a recollection of it. What I know is that our normal practice would be that if a patient had an infection and they had cultured something, then we would tell the patients or the parents that a bacteria had been isolated. So, I think all these parents would have been informed that their child had an infection.

Q Yes. I mean, it is very difficult to know what these words are supposed to mean. I mean, another interpretation of them could be that

they are not necessarily referring to the parents of the patients in question, but they might be directed at the other parents of children on the ward. I wonder if it might be taken to mean that those other parents are not to be informed of the existence of gram-negative bacteraemia because there is no conclusive evidence at the minute that it is to do with the healthcare environment.

A That could be an interpretation of what was said.

Q Yes. I mean, maybe just if we take things in this way: from your own personal experience of how you dealt with your patients and their families throughout this period, at any point did you ever tell patients anything less than you ought to have told them, if I can put it that way?

A I don't think I did. I didn't try to hide anything. Sometimes the conversations that were very difficult were, firstly, parents asking me, "I've heard so-and-so has an infection. Is that correct?" I'm not going to break the confidentiality of another patient if another parent is asking me that. So, I wouldn't discuss that with them. The other thing that parents always ask me is, "Is the ward safe?" I couldn't answer them because I didn't know. So, for me, in terms of daily

communication with parents, those were the kind of questions I found the most difficult.

Q Yes. From your perspective, and from what you saw of, also, your clinical colleagues, are you satisfied that what was said to patients was at all times as candid as it was able to be?

A I think from the point of view of the clinicians, yes, it had to be candid but also accurate.

Q Yes. Now, I wonder if we might move on a little, please, Dr Chaudhury. Mr Castell, could you take us to page 325 in this bundle, please? So, we now have an IMT of 25 June 2019. Again, I think we see that that is one that you attended. Is that right, Dr Chaudhury?

A It is.

Q Could you take us to page 328, please? If we just enlarge the section underneath "Hypothesis." It says, "Hypothesis for the GMBs is now contaminated drains." It says, "The M.chelonae patients have had contact with unfiltered water. It is built up in the water system as it takes years for biofilm to be created," and so on and so forth. Again, I would just ask you whether that broadly accords with your recollection of events?

A Yes, it does.

Q The way that that is set out, where it says, “The M.chelonae patients have had contact with unfiltered water,” would you think that that indicates more than one patient?

A To me, yes.

Q Yes. Do you have any recollection of that, of whether there was more than one patient being considered in that context at that time?

A In that context, yes, I think there were.

Q So, is it your recollection that what is said in that paragraph applied to more than one patient, in other words?

A Yes, I thought it related to all patients in whom this bacteria had been isolated.

Q So, was it your recollection at the time that, at least what was being said at the time of this IMT, was that patients who were understood to have had mycobacterium chelonae were understood to have had contact with unfiltered water. Was that the thinking?

A That was my understanding.

Q Thank you. You can put that to one side, Mr Castell. Thank you. Just to move us a wee bit further through the chronology, I will not ask you to turn this up, but there was a further IMT on 3 July. It is not one that you were at, but it indicates a concern among staff that there was something “fundamentally wrong with the campus.” That is the way it is recorded in the IMT. Can you remember whether, at this time, that was how you and your colleagues felt about things?

A At the time, I think we had growing concerns about the hospital environment.

Q Did it go as far as being fundamental concerns, and fundamental concerns about the whole hospital environment, the whole hospital campus?

A I think that’s fair.

Q I am going to ask you some questions about the IMTs that took place over summer 2019, and we know that there were further IMTs in August 2019, and we know that there were IMTs at which Teresa Inkster was the chair, and then that that changed on 23 August. I do not think you were at those IMTs. Would that be right?

A I don’t think I was.

Q Yes. I will ask you some questions around the IMTs in a minute, but just, if you are able to do so, thinking about how clinicians felt, July

and into August. Up until the point of that change at the IMTs, did you and your clinician colleagues remain concerned about infection rates or patterns?

A I think we were still concerned that there was a potential problem on the ward that we hadn't identified, or a problem that we hadn't identified the cause of.

Q Well, if I maybe frame the question in a different way: up until the point at which there was a change to the chairing of the IMTs, were you and your colleagues persuaded that rates and levels of infection were at normal levels?

A I don't think that had actually been put across that way.

Q Certainly, if we think about the period when Teresa Inkster was chairing the IMTs, you do not recall it being said that rates and levels were within normal levels. Would that be right?

A I don't remember that.

Q Well, I mean, would it be consistent with what you thought at the time, if it was being put that way?

A What I'm saying is I don't remember, from the IMTs, we were being told that the rates were normal. I don't remember that being said.

Q I see. In other words, that would not have been your understanding at the time.

A My understanding was that there was something unusual about these infections, and ongoing investigations were ongoing.

Q The unusual thing, would that be the amount or the nature or the clustering, or combination of all of those things?

A The combination, but in particular the types of organisms that were being isolated.

Q Another point at this stage of things: thinking about the IMTs that we have just looked at, and the discussion about not just the gram-negative bacteraemias, but also the apparently more than one case of mycobacterium chelonae. At this point, did you feel that there was anything that pointed towards a connection with the environment as far as infection was concerned?

A Sorry, can you ask that again?

Q Well, if you think about the IMTs that we just looked at and the concerns that you had around the gram-negative bacteria, and also the fact that it seems to have been said that there was a hypothesis, at least, that cases of mycobacterium chelonae

could be linked to unfiltered water. Against that background, would you have said that, by about August, would you feel that there was anything that indicated a connection between infection and the hospital environment.

A I can't remember at the time, but having read some of the IMTs, I don't think that had been proven, but it was still a concern. That was my understanding.

Q Again, then, if we just put it the other way around: up until the point that there was a change to the chairing of the IMT – up until late August, in other words – were you aware of anything that demonstrated to your satisfaction that there was no connection between infection and the built environment?

A No, no.

Q Now, I am going to seek some clarification about aspects of the IMTs, and I am going to take this at a very high level, and I think we will try and tread warily here. The microbiological staff who were part of the IMT processes both prior to and after the changing of the chairing of them will not be giving evidence at this hearing, and so I do not want us to, if we can avoid, discuss too much what they and others were saying at the time. But there are a few things in

your statement that I would just like to have you clarify. I wonder, Mr Castell, now, forgive me, I cannot remember if I have given you the references for this, but could we go back to the statement bundle, please, and go to page 166. I would like you to look at paragraph 91 and 92, please. Now, it is the bit at the foot of the page, Dr Chaudhury:

"When I attended IMTs, I did not always feel I had all the information as people refer to discussions held at previous meetings or they would refer to documents that I had not seen before or that had not been circulated to me. I do not think information was purposely withheld, but rather we did not always know in advance of the meeting which consultant would attend, so the meeting organiser did not know which consultant to circulate the documents to."

I then will take you to paragraph 92.

Thank you:

"As clinicians, we wanted proof that ward 6A was safe. We did not want to make that decision ourselves because we all recognised that we were not microbiologists or members of the IC, and assessing whether a

ward posed an unacceptable infection risk was out-with our expertise."

Now, if I could ask us just to go down, please, to, you see the bit that starts on the left-hand side, "IMTs, when we had them. I was not discouraged…" That is where the cursor is just now. You see it?

"I was not discouraged from raising concerns, and I felt able to do so. I do not think anyone expected the clinical staff to make the final decision to reopen the ward, but there were certainly meetings where I said, 'I am not going to make that decision,' or I said that I could not agree something without discussing with my consultant colleagues. I did feel I was taken seriously. I do recognise that. I do not have much experience with IMTs, nor in using the HIIAT score."

Now, just pausing there, the question I have got for you is really just to understand the period that these observations about the IMTs cover. Do they cover the whole of the period that you were involved, or did they cover the period up until August – the end of August – or the period after that, or what is it?

A It's 2019, and when I started to attend IMTs, both with the previous chair and the new chair.

Q Yes. Are we to take these comments, then, to apply to both stages?

A Yes.

Q Thank you.

A I'd say, in particular, the latter half of 2019.

Q Right. Could you explain what you mean by that? Sorry.

A Well, probably after the change of chair.

Q Okay. Thank you. Now, another thing that I would quite like you to help us with a bit, please, is at paragraph 89 of your statement. So, if we could go back to page 166, please, Mr Castell. You say, "Root Cause Analysis (RCA) was introduced in this period," and I am not entirely clear what period that refers to. I think it is sometime during summer 2019.

Then, if we go to paragraph 110, which is at page 173, and I am going to help you a bit with the timing on this. Yes, thank you, Mr Castell, you have done it for me. We see that paragraph 110 is concerned with an IMT on 5 November 2019. Then, if we go over the page. Do you see that, Dr Chaudhury, "Adoption of RCA," final sentence, "Adoption of RCA on every

single infection was recommended by IC to help identify any environmental concerns…" Now, I am not going to ask you for precision on this, or I am certainly not going to ask you to explain to us what root cause analysis is, but I am just interested to know, if you are able to, when it is you say that the application of root cause analysis in relation to all infections became a recognised practice.

A So, root cause analysis was done retrospectively at some point in 2019. It was done on all the cases of gram-negative infection that occurred after we had decanted to Wards 6A and 4B. Then, as part of us reopening the ward, root cause analysis was applied in real time for any new case of gram-negative infection that occurred.

Q Thank you. Now, we can put that to one side. Thank you. Now, a little further on in time, and again, we do not need to turn these documents up because we looked at one of them yesterday. We saw yesterday that, at the end of August 2019, you and your consultant colleagues wrote to the chief executive requesting an external review. Do you remember that?

A Yes.

Q What was it that you were looking for an external review of, as you recall it?

A I think we wanted to know whether there was a problem on the ward. We had had a change in chair in the IMT, and what I perceived was maybe a change in ethos in the IMT from one that came from a viewpoint that there was a potential problem and was looking for the cause to one where perhaps there wasn't a problem at all and it was to prove that there wasn't a problem. So we didn't really have clarity as a consultant group as to whether what we had perceived, and what we had been told by some members of Infection Control was a problem, was truly a problem that was recognised by management. So we wanted an external review to be independent and to tell us, "Are these infections that we should be worried about, and is there a problem with our environment?"

Q Thank you. Now, if I can just maybe break that down a bit into two parts. So, in terms of the change of approach, if I am understanding what you have said. The approach up until the change of chair, I take you to be saying, was, "There is a suspicion of an infection concern, and that suspicion remains until it is disproved."

Then the approach changed to being one whereby, "No, the suspicion needs to be proved." Is that roughly----

A That's how it felt.

Q That is how it felt. In terms of the external review, was what you were looking for external expert review on whether or not the patterns of infections were linked to the built hospital environment, is that what it came to?

A That and also if there was truly a problem or whether these are infections that can be expected in an immunocompromised group of patients.

Q Yes. So, in other words, in two parts. Part one being, "Was this pattern----"

A Unusual.

Q Yes. The second one being, "Why is it unusual?"

A If it is unusual, yeah.

Q Now, we can see from our bundle of documents that the chief executive responded to that letter on 4 September 2015. We do not need to turn it up. She said that efforts were underway to source external advice. Do you recall seeing that response?

A I don't recall seeing it, but I remember that management were seeking an external review.

Q Do you know whether they ever obtained one?

A I don't think they did. There was a case note review, but this was looking at something slightly different. I think there was a difficulty in finding people to conduct the review.

Q When you say "you think" there was, why did you put it in those terms?

A Because no one told me.

Q You had heard that there was a difficulty, is that what it comes to?

A Yes, yeah.

Q Now, moving a little on, then. Are we to understand that by this stage, so that is the end of August 2019 into the beginning of September, the restriction on admission to 6A remained in place. Is that right?

A That's correct.

Q I want, then, to move forward to the events that led to 6A being opened up again. Again, we have had evidence on that already, and we have got your position set out in your witness statement. I will summarise what I take you to be saying, and please say whether you agree with it or not. Is the overall position that clinicians continued to have a concern about unusual infections and were resistant to

restrictions being lifted, and that you wanted absolute clarity that the ward was safe.

A I think that's correct.

Q Yes. The "absolute clarity," I think, is the phrase you use in your statement, so-- Now, just to put some detail on that, I wonder if you might look at another of the IMT minutes, please. You do refer to it in your witness statement and we will look at that in a minute, perhaps. But if we begin with bundle 1, and I would like us to look, please, at page 365. We should hopefully have in front of us – and indeed we do, thank you, Mr Castell – a meeting note of 18 September 2019. You got that in front of you?

A Yeah.

Q And, again, that is one that you seem to have attended. Is that right?

A That's correct.

Q Even before we turn to it, do you have a recollection of this meeting?

A If it's the one that I discuss in my statement, then yes.

Q Yes. So, if we move, please, to page 367, and we are going to look at bits of-- pretty much from the whole page. So, I think the easiest way to do this is just to begin by

enlarging the upper half of the page – thank you – and if we take the third paragraph, we see a discussion of a peer review of Great Ormond Street Hospital. Is that something you have got any recollection of?

A Vaguely, but not in any detail.

Q Is the peer review the same as the external review, or are you not able to say?

A I can't remember. I think this is something different.

Q Okay, and then, in the next paragraph, there is advice being given that "… the median rate of CLABSI is now lower than it has ever been before…" and then, it is then raised that there was:

> "…a reported reduction in gram positive but not gram negative and therefore CLABSI rates may not be the best indicator for an IMT called in response to issues related to gram negative/environmental organisms."

Now, do you have a recollection of a discussion along those lines?

A Yes, I do.

Q And are you able to help us a bit with (a) what that means, and (b) what your reflections on it were at the time?

A Yes. Again, I hadn't been to all the IMTs up until this point, so this was new information that's being presented to me at that IMT. CLABSI is central line associated bloodstream infection, so it looks at central line-associated infection, essentially.

Q Dr Chaudhury, can I – sorry – just pause you there? I wonder if you could just move a wee bit closer to the microphone.

A Oh, sorry. Yeah.

Q Thank you. Sorry, can I get you to start that again?

A Yeah. So, CLABSI stands for central line associated bloodstream infection. So, it's infections with an isolated organism that is associated with a patient who has a central line. CLABSI rates take into account any infection that is associated with a line, be it a gram-positive infection or a gram-negative infection. There is a CLABSI working group that had worked very hard to bring the rates of CLABSI down by improved aseptic technique by using different covers on the lines, and that had driven down our rate of gram-positive infection, and the majority of infections that usually are associated with a line are gram-positive. So, if you bring the rate of gram-positive infections down, then you will probably bring down the entire rate of CLABSI rates as well. But if it's not separating out gram-positive and gram-negative rates, then it is, in my-- What I took to it is it's maybe not the best marker of-- or the best evidence that gram-negative infections are declining.

Q And is-- Sorry, had you finished speaking?

A Yes.

Q Is that the point that was being raised there, towards the end of that paragraph?

A Yes.

Q We will not jump about documents, but if I just read what I take you to say in your statement about this – and, Mr Castell, there is no need to get the statement up on screen, but for those who want to note it, it is paragraph 106 – I will just read this to you, slowly:

> "I was not confident that data had been separated, nor was I confident that everyone at the IMT was aware that the concern was with the rate of gram-negative infections rather than overall infection rates. I felt it was crucial that we had proved that gram-negative infections

had not increased, not that overall infections had reduced."

Is that the point that you have just made, essentially?

A Yes.

Q Thank you. Going back, then, staying with page 367, in the next paragraph, there is a reference to a report that some of the organisms found in Ward 6A were also found in the Schiehallion Ward at Yorkhill:

"In 2018 there were 24 patients with positive gram negative organisms from blood cultures. It was noted however a number of these cases were as a result of the water & drain incidents during 2018. In 2019 so far there have been 11 cases."

It may be obvious, but just so we are clear on this, was essentially the point that was being made here that, to some extent, this has been seen before in Yorkhill, and also that you need to separate out the 2018 incidents from the 2019 incidents?

A Yes.

Q Thank you. Then we see in the next paragraph information being given to the IMT that "Ward 6A is microbiologically safe." Is that right?

A Yes.

Q Do you recall that being said?

A I do.

Q Yes. Further down the page, we see – thank you – there is a reference to an SBAR. See that?

A Yes.

Q And there is a discussion recorded around that. Then, at the foot of the page – yes – we see there is a reference to an impasse. Is that right?

A Yes.

Q And then, if we go over the page, please, to page 368-- What I am doing here, to be clear, is I just want to pick up some of these references, and then I will ask you some questions. So, on page 368, underneath the heading "Healthcare Infection Incident," so the bottom half of the page, the paragraph that begins, "Members of the IMT agreed…" Do you see that? The reference to the HIIAT score, in other words.

A Yeah.

Q And a discussion that ends up with the HIIAT score being green. Then, in the bottom paragraph, "Further analysis of the epidemiology will be carried out by splitting the cases of gram negative and gram positive bacteraemia over the past 5 years." Then, if we go over, finally,

please, to page 369, “Advice to Professionals”: “After Mondays meeting with the clinicians there was no consensus to accept the information to reopen Ward 6A to new admissions.” Okay?

Again, I will just ask you the question again, if I may. All of the passages that I have just drawn to your attention, do you have a-- with one exception, possibly, do you have a recollection? Sorry, that was not a very-- I will rephrase that question. If we put the IMT minute to one side, now, please, I will ask you some questions about it. That is the better way to proceed, I think.

Going back to the section in your statement that I asked you to help me with about the IMTs and the clarification – and I think you have already answered this – was this the IMT that you felt that you did not have much notice of?

A I didn’t have much notice on any of the IMTs, but this is the one where a lot of data was presented that I hadn’t seen before, yeah, but it may have been that nobody in the IMT had seen that data before.

Q Yes. As regards the conclusion that the ward was microbiologically safe, how did you feel about that? What was your reaction to

that?

A So, we had spent several months either attending IMTs or hearing from IMTs that there was a problem that we had to try and find, and this was the first time that I was being told that there wasn’t a problem, and it came to me quite suddenly. I needed time to digest that information. I wasn’t comfortable with the ward opening without my consultant colleagues having had a chance to also hear the same information and have an opportunity to understand it and have that explained to us as a group. So, the conclusions were surprising to me, and I didn’t feel comfortable with the ward opening immediately. To be fair to the IMT, they did respect that; the ward didn’t open immediately after the IMT.

Q Yes. The issue about the HIIAT you pick up on in your statement, what, if any, concern did you have about the HIIAT scoring?

A I thought the anxiety level was higher than a minor.

Q I think, in your statement, that you indicate, overall, you felt there needed to be 100 per cent consultant approval before the ward reopened. Is that right?

A Yes.

Q Are you indicating to us

that you did not feel, at this point, certainly, that you were in a position to, yourself, as it were, sign up to that?

A No, I did not.

Q Yes. Okay, thank you. Now, we will just complete the chronology, and I think the next stage – and you touch on this in your in your statement – is an IMT on 5 November 2019. I am not certain that you were at it. Can you remember whether you were you were at it?

A I can't remember if I was at it. I was at other meetings about reopening the ward.

Q Yes. I think the way you put it in your statement is that there remained high concern on the part of the clinicians at that point. Is that right?

A That's correct.

Q The – and we will not turn it up – IMT minute indicates that, ultimately, it would be the chief nursing officer who would have the final say as regards whether the ward opened. Can you remember that?

A I can remember that it wasn't us that would agree to it, yes.

Q Say that again, sorry.

A I remember that it was not going be down to the consultants to decide if the ward opened or not.

Q Are you indicating that, as to who it would be, you yourself don't know?

A I do now. I just can't remember if I did at the time.

Q What is it that you know now?

A That it was a chief nursing officer who would have the final sign-off.

Q Thank you. I think we can see that there was, on 11 November, however, a meeting with the consultants to discuss reopening. What was ultimately the position of the consultants as regards to the question of the ward reopening?

A I think, finally, the consultants did agree. I think, for us to be completely reassured that the ward was safe to open, we would have had to have found something that caused a spike in infections that was removed, and then we were told the ward was safe. We'd need to have-- had found a dirty pipe that was removed and reinstalled. That wasn't possible because-- and that's not because a lot of investigations weren't done. A lot of investigations were done to try and find a cause of the infections and to link them to the environment or not. So, we couldn't be completely reassured.

On the other hand, we were in a terrible position that was not tenable. Our ward was closed, we were sending parents and families away, and we were having to-- I was having to give patients cancer diagnosis and immediately transfer them to another hospital. You know, it was not a tenable situation. I think, as more and more investigations were done to prove that there were no linked cases to the environment, as more remedial actions were, nonetheless, put in place on the ward, and as strategies were introduced to try and pick up on any new cases, any new problems should the ward reopen, I guess we could not justify the ward remaining closed, and we felt as reassured as we could be that we had a safe plan to open the ward with contingencies to investigate if problems re-arose.

Q Thank you. I do not think it is right to stop the story at November 2019. The ward was reopened. Can you say whether, for the duration of the period that the patients remained on Ward 6A, did you see a return of concerning infection patterns?

A Don't remember that, no.

Q And----

A As in, no, I didn't see.

Q Yes, and as regards the period since the Schiehallion Unit itself

was reopened, what has the position been as regards patterns or incidents of infection?

A So, infections still happen in patients, and gram-negative infections still happen in patients, but I haven't seen the spike in unusual infections that we were seeing in 2018 and 2019.

Q Just to be clear, you have not seen them at all since the end of 2019. Is that right?

A I haven't, no.

Q Yes. What about your other clinical colleagues? From discussions with microbiologists, have you seen anything akin to what you saw before?

A No, no. Not from discussing with my colleagues or microbiology, no.

Q Thank you. Now, I am going to, as we move towards the conclusion of your evidence, Dr Chaudhury-- We will, I think, finish it fairly soon. If you wanted to take a quick break just now, we could, but equally we can keep going. What would you prefer?

A I'm okay to keep going.

Q Thank you. There are just a few things I would like to ask you about, and I am very keen to get your reflections on all of this. The first thing

I would like to get from you, if I could, was just really your understanding, your perspective on the impacts on the issues that you and your colleagues, and your patients and their families, witnessed and experienced over the course of the chronology of issues that we have just been discussing. So, I wonder if you could give me some thoughts on the overall impacts as you see them.

A Well, for the impact for parents, I guess, if we step back, these are parents who have been told that their child has cancer, which is probably the worst thing that a parent can go through, and they have to embark on a journey of treatment that is sometimes very grueling and very intensive, with the ultimate aim, often, to cure their child. But that is a difficult journey, a very stressful journey, and for that they need absolute trust in their medical and clinical team. In the events of 2018 and 2019, the uncertainty as to whether the ward was safe or not put an additional burden on the parents over and above the very distressing time. I have to say, I've heard some of the parent testimonies. I think they can speak to the impact more eloquently than I can, but it was very difficult for parents, and-- Obviously, a lot of the remedial

actions were very disruptive and annoying for them, but I think that additional stress and fear as to whether the ward environment was safe or not was extremely stressful and traumatic, I think, for parents.

In addition, because we communicate with parents all the time and have very good relationships with our patients and parents, but the fundamental thing they asked us and they asked me was, "Is the ward safe?" and, "Are these measures going to make the ward safe?" I couldn't tell them that and I couldn't reassure them, and then they would look to other places for reassurance or for information. I think, not being able to tell them that, it did impact on the trust between patient and doctor, and that was very difficult.

In terms of the staff, we were also very concerned about the ward. We want to-- We have always wanted to do the best for our patients and their parents, and that uncertainty also made us very anxious. You know, these IMTs take a long time. They take a lot of time out of our normal working practice, so that has an impact on how we were able to-- Well, it took us away from doing our clinical roles. You know, there was four years where either the ward was closed or we were

on a different ward, and that's four years that we were not able to expand our service, to develop our service, and had a huge impact on the morale of the staff, and we're still recovering.

Q Are you recovering?

A Well, we're recovering.

Q It is an ongoing process.

A It is.

Q There is one specific impact that I am just going to ask you about quite briefly. It is something that a number of the patients and families spoke about, and you and your clinical colleagues also speak about it, and you have got quite a lot in your statement about it, so I do not want to take up too much time on it. It is about the prescription of additional prophylactics. I wonder, if you will permit me, if I could just set out what I take your position to be on this, and I will ask you one or two questions about it. I think we understand, from you and your clinical colleagues, that prophylactic medication is prescribed to children going through cancer treatment where indicated and in accordance with standard protocols. Is that right?

A That's correct.

Q Yes. Is it also correct that, as a result of the concerns that there were over the period we've been discussing, that from time to time additional prophylactic medication was prescribed?

A That's correct.

Q Yes.

A Always in the best interest of the patient.

Q One of the drugs or treatments that is referred to in a lot of the evidence is ciprofloxacin, and you mention it in your statement. Did the prescription of that medication at some point come to be replaced by something else? TauroLock? Or am I misunderstanding the evidence?

A It did. So, there is very little evidence in the use of ciprofloxacin in reducing the rate of line-associated infections. This was a very unique situation, so you're unlikely to find evidence out there in how to prophylax against these sort of infections. I think we were all uncomfortable about not giving something, and there was some evidence for TauroLock, which is not a drug, as such, as a device. But it's something that is inserted into the dead space of a central line or a port-a-cath, and it prevents the-- It's antiseptic. It prevents bacteria colonising the line.

Q Thank you. Next thing I want to ask you about that is in relation

to communication with patients, or rather, more realistically, the families, about the provision of prophylactics. One or two of the witnesses indicated that they felt they perhaps had not been told about the prescription of prophylactics. I am just going to ask you a question at a general level. From your experience, did you and colleagues communicate candidly and effectively as regards the prescribing of additional prophylactics?

A I think we did. I remember having many conversations about the use of ciprofloxacin with my patients.

Q And about the reasons for it being used?

A Yes.

Q Are you able to say a little bit more about that, as to what those reasons would have been?

Q There was a written statement as well that was given out, so a lot of what I said was based on the written statement, but essentially it was to reduce the risk of gram-negative line-associated infections.

Q Thank you. Now, that maybe takes us on, then, to think about a further matter I would quite be interested in having your reflections on, which is communication, which is a recurrent theme of the evidence from

the patients and families. You have got quite a bit in your statement about this, and I do not want to go into too much detail with you unless you wish to yourself. Maybe if I just ask this question: looking back from your perspective in terms of communicating with patients and families, what worked and what did not work?

A I think communication got better as time went on. For me personally, I think having written communication was helpful. You know, as I've alluded to before, sometimes things that were presented at the IMT were things that I'm not an expert in. I'm not an expert in drains and taps and the different cleaning methods, so I felt much more comfortable relaying that information to parents if I had written information that I knew was accurate because it had been signed off by the chair of the IMT that I could refer to. I think written communication also means that every parent is getting the same information and no one's getting more or less and that it's uniform. I think what also worked was when it was not just nurses or doctors communicating with parents. They really valued when Infection Control or management came to speak to them, and certainly the chair of the IMT at that time and our

direct managers were very available to speak to parents if they wished to speak to them. So that worked well.

Q If I might just interject, when you refer to management and direct management, are you thinking in particular of Jennifer Rogers and Mr Redfern?

A Yes.

Q I take you to be saying in your statement that, from your perspective, you thought they communicated effectively and openly with the patients on the ward. Is that right?

A Yes, they did. Yeah.

Q What were the challenges in communicating with patients and families?

A Well, the main challenge was not knowing the answers. Their question was always, "Is the ward safe?" and my answer was, "I don't know," which is very-- I felt very unsatisfied with that answer, so I'm sure they felt very unsatisfied with me as well. I think sometimes they perceived there was maybe a lack of communication because there were a lot of IMTs happening in quick succession, but a lot of the IMTs, they didn't conclude anything. I think, laterally, things that helped was that every so often, there was an update from the IMT, even if it wasn't an update that was going to directly affect parents. I think that helped. At some point, I can't remember exactly when, but someone was appointed by the Scottish Government to act as a liaison for parents so they had someone that they could refer to if they had queries. I think you'll have to ask parents if it helped them, but it certainly helped us because they could direct their questions regarding, you know, infections and the environment to someone other than the clinicians so that we could then have conversations about the patient's treatment or how they were doing from a clinical point of view, and we could plan their treatment.

Q I think you are alluding there to the appointment of Professor Craig White.

A Yes.

Q Certainly, from the clinician's point of view, you are saying that you found that a helpful thing?

A I think it was helpful.

Q Yes. One of the things that you mentioned in your statement is that, again, maybe thinking about the things that did not work, you felt there could be a delay in communication from conclusion of the

IMT to the messaging going out to the patients and families. Is that right?

A Yes, a perceived delay.

Q What do you mean by a "perceived" delay?

A It may have been that the Comms team were furiously working on a statement, but parents knew that the IMT had concluded, and they were waiting for a statement. So, if you're waiting for it, then it feels like a long time.

Q Thank you. Now, the last thing I want to ask you about is the question of the response to all of this from the senior levels of management within the Health Board. Are you aware of the evidence that Professor Gibson gave yesterday on that matter?

A I'm aware of some of it.

Q What she said yesterday was that she tried everything she could to bring the concerns to those above her, and that she tried to get explanations from the most senior levels of management, and that she had never been provided with an explanation for what had happened. Have you got any observations on that?

A I'm a much newer consultant than Professor Gibson, and she as head of department would have taken on that role of trying to get

answers more than myself or any of my colleagues would. I still don't know if there was a problem. I've not had really very much direct contact with senior management, but then I don't know if I'd expect to as a working consultant on the ward.

Q In your statement, you have got a section where you talk about what management did or did not know, and you speak a bit about the response. Reflecting on what you understand Professor Gibson to have said, and reflecting on her role as the lead clinician, can you say whether that ultimately, on the question of whether or not there was an adequate response, is that something that you would defer to her on?

A I would.

Q Can I ask you this question, just to conclude? What I take from your evidence today is that your understanding of what was being said from March 2018 includes the following features: that in March 2018 the advice to the IMTs was that there was a widespread problem with the water system. Is that right?

A Yes.

Q That in the summer of 2018 there was a site-wide, or I think you were perhaps not sure how

widespread it was, but an issue with the drainage system. Is that right?

A Yes.

Q That there had been a pattern of unusual infection beginning in 2016 and 2017. Is that right?

A That's my understanding.

Q Yes. There was a requirement to decant from the ward in 2018. Yes?

A Yes.

Q As we touched on earlier: as a result of further concerns with the environment, there was a requirement to decant from the ward to which the children were decanted at the beginning of 2019. Is that right?

A I believe so. I wasn't working at that time.

Q There was a return of unusual infections as you saw it, and as the advice at the time to you saw it, in 2019. Is that right?

A Yes.

Q There was a further restriction on the ward at that time, and I think you have indicated that that there was essentially a concern that there was something fundamentally wrong with the campus. Is that right?

A Well, there was restrictions and there was concern. There was concern, yes.

Q We understand from the evidence we got yesterday that there has been treatment of the water system and a multimillion-pound refurbishment of systems within the hospital, including the ventilation system. Is that right?

A That's my understanding, yes.

Q Yes. Do you yourself feel you have ever had a clear explanation from the highest levels of the Health Board of why that all happened?

A I haven't. I presume that's why we have this Inquiry.

Q Can I ask you this question, then? Do you think it is acceptable that you have not had that response or explanation?

A I don't know. I'm just trying to do my work.

Q Thank you, Dr Chaudhury. I have no further questions.

THE CHAIR: Thank you, Dr Chaudhury. What I propose to do now is take a break for about ten minutes just to allow the legal representatives in the room to conclude whether there are any further questions they would like to be asked. So, I would hope to be in a position in about ten minutes either to confirm that you have been

asked all the questions you are going to be asked or for the opportunity to ask additional questions. So, if you will bear with us for another ten minutes or so. Again, if there are any questions which have not been anticipated, if you could perhaps first of all discuss the matter with Mr Duncan.

(Short break)

THE CHAIR: Mr Duncan.

MR DUNCAN: My Lord, I do not understand there to be any further questions.

THE CHAIR: Thank you. Could you ask Dr Chaudhury to join us? (After a pause) Dr Chaudhury, we have no further questions for you. Accordingly, you are free to go. Before you do, first of all, can I thank you for coming here this afternoon and giving your evidence in person? Can I also thank you for what I am sure will have been the more time-consuming task, and that is preparing your witness statement and doing the necessary review of documents? I am very much aware you are a very busy person doing very important work, and assisting with the Inquiry will have taken away from that. Can I thank you and just underline how appreciative of how much work that will have involved? As I say, you are now free to go.

A Okay, thank you.

(The witness withdrew)

THE CHAIR: Well, thank you, ladies and gentlemen. We will sit tomorrow at ten, I think, and there will be two witnesses in the course of the day. Am I right? Tomorrow at ten.

(Session ends)

16:20