THE SCOTTISH HOSPITALS INQUIRY

Closing Statement for the affected Core Participants: the parents and representatives of the children affected by their treatment at QEUH

Hearing Diet: 12 – 23 June 2023

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1. Introduction

1.1 The Core Participants represented before this Inquiry by Messrs Thompsons, Solicitors are patients and family members who were, or are still being, treated on the children cancer ward, on adult wards and in the neo-natal unit at the Queen Elizabeth University Hospital in Glasgow ('QEUH').

1.2 The stated purpose of the recent hearings was to enable the Inquiry to obtain evidence from the clinical and managerial staff at the QEUH. The purpose for the hearings was to identify: (i) evidence that might provide a basis for findings in fact by the Chair; and (ii) further lines of inquiry. It is submitted that the stated purpose has been achieved.

1.3 The evidence taken from clinical and managerial staff resonates with and supplements the evidence previously heard from patients and families affected by the issues under investigation by the inquiry.

2. The Closing Statement by Counsel to the Inquiry

2.1 The Closing Statement by outgoing Counsel to the Inquiry provides a detailed, accurate and thematic account of the evidence heard at the Glasgow 2 hearings.

3. Questions

3.1 Questions are posed in the Closing Statement by outgoing Counsel to the Inquiry. Each is addressed in turn:

(These apply to each section 1-3 and 5 and 7 and there are specific questions applying to sections 4 and 6)

Chapter 1: QUEH and RHC

(1) Do CPs accept that that the account of the evidence is accurate?

Yes

(2) Do CPs accept that the evidence itself is accurate (in material respects)?

Yes

Chapter 2: The cancer Journey – diagnosis and treatment of paediatric cancer

(1) Do CPs accept that that the account of the evidence is accurate?

Yes

(2) Do CPs accept that the evidence itself is accurate (in material respects)?

Yes

Chapter 3: Infections and mitigation of infection risk

(1) Do CPs accept that that the account of the evidence is accurate?

Yes

(2) Do CPs accept that the evidence itself is accurate (in material respects)?

Yes

Chapter 4: The history of (infection) concern

Questions aimed at establishing the history of concern

(1) Is it accepted that the narrative set out below provides a materially accurate summary of the evidence provided to the Inquiry – whether that evidence be in witness or in documentary form – about the history of concern?

Yes.

(2) Does the narrative provide, for the period it covers, a materially accurate account of contemporaneous expressions or examples of concern about the hospital environment and about infection link or risk?

Yes

(3) Insofar as any aspect of the narrative is said not to have been part of the history of concern at the time what is the basis for that challenge?

Not applicable

(4) What if any additional expressions or examples of concerns ought to be included in the narrative and considered for further investigation?

It is our understanding that air sampling took place from December 2018 and through 2019 in wards 4A and 4C. This should be investigated and included in the history of infection concern timeline. There are references to two cryptococcus cases, but it remains unclear which wards they occurred in and the families are seeking clarification on this issue. The families affected by the issues around the Neonatal unit feel very strongly that it should be a fundamental part of the Inquiry. No evidence has been provided about when, why and how Neonatal was refurbished including the ventilation systems. The Terms of Reference (6) refers to training in place for the key building systems that applies across the board in relation to infection prevention control.

Responses to concern

(5) Does the narrative and the timeline set out a reasonably comprehensive history of the response by GGC and other organisations to concerns that the built hospital environment gave rise to a risk of infection on the part of vulnerable patients?

Yes, but only insofar as it relates to the clinicians and management who have given evidence orally or by way of statements. The glaring omission so far has been the remarkable and complete lack of any response from senior management and board level at GGC. In addition, we still have a lack of candour, openness and transparency from GGC about certain key information. Why do we still not have a voluntary statement or clear disclosure from GGC about the 2015 DMA Canyon report, when it was received by them and what steps, if any, were taken about the warnings/advice within that report? This is a matter within their knowledge and it should not require proactive steps by the Inquiry for GGC to force an open and honest response.

(6) Should consideration be given to other measures; and if so which ones?

It is unclear what "other measures" would be.

Objective validity for concerns

(7) At any point since patients arrived in the QEUH/RHC, has the water system given rise to an increased avoidable risk of patients being exposed to infections?

(a) Is it accepted that the 2015 DMA Report identified deficiencies in the water system that without remediation had the potential to give rise to such a risk?

Yes

(b) Were these deficiencies addressed prior to the report being "discovered" around June/July 2018?

No, based on the evidence available thus far.

(c) Did the events of March/April 2018 identify widespread contamination of the water supply throughout the RHC and QEUH per the evidence of Professor Gibson and the Full IMT Report of 13 April 2018?

Yes

(d) Did that contamination have the potential to be harmful to vulnerable patients coming into contact with untreated or unfiltered water?

There seems to be no basis for doubting that contaminated water in a hospital environment would have the "potential" to be harmful to patients, particularly vulnerable patients. The nature and extent of that harm is obvious from the evidence heard by the Inquiry in the Glasgow 1 and 2 hearings.

(8) At any point since patients arrived in the QEUH/RHC, has the ventilation system given rise to an increased avoidable risk of patients being exposed to infections?

(a) Does the Innovated Designs Report of 24 October 2018 identify any features of the ventilation system on Ward 2A that could have increased the risk of infection to patients?

Yes. We are still in the dark nearly two years after the first hearings as to precisely what was lacking in the ventilation system installed in wards 2A and 2B to warrant a £10 million refit. That is astonishing. As stated already, there ought to be an honest and candid account given of the full reasons for the new ventilation system. In addition, we are seeking early disclosure of the relevant documents in relation to this issue.

(b) Did the features of the ventilation system discussed in the SBAR of 12 November 2018 present an increased risk of infection to patients?

Any deficiencies in the ventilation system presented a potential for increased risk of infection to patients, particularly vulnerable patients.

Chapter 5: Impacts

(1) Do CPs accept that that the account of the evidence is accurate?

Of the Core Participants represented by Messrs Thompsons those involved in the adult cases believe that further work is required to clarify and investigate the adult wards. They remain

concerned that the impression of the recent evidence is that the problems only lay within the Schiehallion wards and ward 6A. Otherwise the patients and families generally accept that the recent evidence is accurate in material respects. They are concerned that they have not had sight of all of the relevant material.

(2) Do CPs accept that the evidence itself is accurate (in material respects)?

See above.

(3) If the answer to (1) and/or (2) is in the negative, what is the reason for disagreement and what is the CP's position on the matter at issue (with references to any supporting evidence)?

See above.

Chapter 6: Communication – Questions

Organisational Responsibility

(1) Which organisations had responsibility for directing or had input into communications during the periods covered in the above narrative?

That is a matter for the Inquiry to determine. As outlined below key witnesses have yet to give any evidence in relation to communication issues.

As regards practicalities

(2) Is it accepted that the practical arrangements for communication were as described?

Yes

(3) To what extent did those practical arrangements operate successfully?

There was a hopeless lack of a proper, thought-through communication plan at the start of the infections in 2018 from the management team at GGC. It appears that no one person at the highest level at GGC assumed control and responsibility for the communication strategy. It would, or in any event should, have been obvious to senior management at GGC that this was a very large problem developing amongst some of the most vulnerable patients. This lack of a communication plan led to a fundamental decline in the trust and confidence of the patients and families that the hospital was a safe place.

(4) Is it accepted that the practical arrangements for communication were to any extent sub-optimal? If not, why not?

Sub-optimal is an understatement. The patients and families' view is that it was much worse than sub-optimal.

(5) Is it accepted that changes were made between 2018 and 2019 to improve the arrangements for communication; what were they and to what extent were they effective?

Yes, there were changes, but only to the extent that patients and families were given more information than previously. The fact that the communication plan was based on only providing information about water and infections if a patient or family asked for it simply beggars belief in an organisation the size of GGC operating the largest hospital in Scotland. It was patently obvious to everyone that there was a problem with the water supply yet no one at GGC seemed to grasp that they ought to be advising patients and families quickly and clearly about what was happening and why. The perception of families that the media were a higher priority than them in terms of communication is supported by the documentary evidence considered in detail at the recent hearings.

(6) What are the current practical arrangements for communication should an event of a similar nature reoccur?

That is a matter for GGC to answer.

(7) What more is needed to complete the investigation into the arrangements for communication?

We have heard evidence from a manager about the communication during the relevant period, but we have yet to hear from anyone in a senior management position at the time who had overall control and responsibility for the communication strategy. This lack of evidence almost two years from the first hearing is deeply frustrating for the patients and families. In addition, we have yet to hear any evidence about the role and involvement of the Scottish Government in communication. What did they know and when did they know it? That is something that ought to be disclosed by the Government now without the patients and families having to wait for evidence at the Inquiry at some indeterminate date in the future.

As regards effectiveness

(8) What comments do CPs have to make on the discussion on the effectiveness of communications as regards: timing of communication; content of communication; and media briefing?

We agree with the comments made by counsel to the Inquiry about the effectiveness of communications or lack thereof.

(9) Are the criticisms made by witnesses justified?

Yes

(10) What more is required to complete an evaluation of the effectiveness of communication?

We need to hear from the person at the very top of the communication tree in GGC. Why did they do what they did and when they did it? What considerations were given to providing patients/families and staff with honest and candid advice about the prevailing circumstances?

Is there any evidence of a positive decision being taken to withhold information from patients/families and/or staff? Was a positive decision taken to provide the media with information prior to patients/families/staff? The documentation considered at the recent hearing was looked at in a comprehensive and detailed way.

As regards standards of communication

(11) What ought the hallmarks of good communication in the healthcare setting to be?

There ought to be candour, openness and transparency demonstrated in the information provided. Information should be provided in a controlled, thought-through and informative fashion to those most directly affected.

(12) What is the threshold for communication about the cause of an infection?

Again, there ought to be candour, openness and transparency, particularly in the event of something "unusual" and where concerns/infection patterns might impact upon the health and welfare of patients and the treatment they receive in light thereof (such as the use of prophylaxis)

(13) Was there a duty of candour conversation/communication with the Cuddihy family until prompted by Professor Cuddihy's email to Mr Redfern; was it intended that there should be one; who had responsibility for that; what is the explanation for that not happening?

No, it is not possible to say on the evidence what the intention was; nor is it possible to say clearly who had responsibility for that other than to say that Mr Redfern was delegated the direct contact with Professor Cuddihy. It was surprising that there was no evidence from Mr Redfern's superior at the time. In any event, it seems plain on the evidence that there was a failure on the part of Mr Redfern's superior to provide Mr Redfern with clear advice and instructions. The explanation for the failure to have a duty of candour conversation is a matter for GGC. It was not forthcoming from Mr Redfern.

Chapter 7: The present day Schiehallion Unit

(1) Do CPs accept that that the account of the evidence is accurate?

Yes

(2) Do CPs accept that the evidence itself is accurate (in material respects)?

The evidence from the clinicians was clear.

(3) If the answer to (1) and/or (2) is in the negative, what is the reason for disagreement and what is the CP's position on the matter at issue (with references to any supporting evidence)?

Perhaps the most worrying feature is the fact that GGC do not appear to have in place a detailed contingency plan to deal with a similar scale of infection or series of infection events at the hospital if they were to occur in the future. Moreover, the Closing Statement provided by outgoing Counsel to the Inquiry states that, since the Schiehallion Ward reopened in March 2022, there have been no clear infection issues. No evidence of this has been produced and what has been stated in evidence appears to run contrary to the current experience of patients and families. It is noted that building works around QEUH are still ongoing and impacting on those attending the hospital.

4. Prophylaxis

4.1 The overwhelming feedback from patients and families is that they were not advised clearly and openly about the use of prophylaxis. That was the evidence of some in the Glasgow 1 hearings. Some say they were not told at diagnosis or afterwards, others say that it was packaged as being "part of treatment". Some do not recall being told that their child required to be put on 'extra' medication because there was a risk of infection due to environmental factors at the hospital.

4.2 One Core Participant has given evidence that she and her family were not advised about the long term risks of being put on prophylaxis. Another Core Participant gave evidence that when her son travelled to America for treatment, the hospital there (which also had building works ongoing at the time) gave advice to take him off the prophylaxis prescribed to him at QEUH. The day he returned to Glasgow, however, he was required to start it again.

4.3 The patients and families look forward to hearing from the expert witnesses on this matter in due course.

5. Adult Patients

5.1 Adult patients and their families have concerns, with some justification, that adults affected by infection at the QEUH are being overlooked by this Inquiry. There has been a failure to communicate with them and to keep them advised as to developments with the statements they provided to the Inquiry Team some time ago. Statements have not been published on the Inquiry Website. No explanation for that has been provided.

5.2 Adult patients and their families feel that they are being overlooked and the issues that affected them and their loved ones ignored. It is inconceivable that infection present in the paediatric population on Ward 4 would not affect the similarly vulnerable adult patient population housed in the same Ward, at the same time. Serious infections have occurred on the adult wards as well. This should not be ignored by the Inquiry. There has been evidence about problems with window seals in Ward 6A while no examples of issues arising in Wards 4B and C have been incorporated within the timeline or the Closing Statement of outgoing Counsel to the Inquiry. That may give the impression that there were no problems with Ward 4. Such an impression would be false.

5.3 Is there to be a further evidential hearing in connection with the impact on adult patients in adult wards?

6. Aims for the Inquiry

6.1 The patients and parents of the children affected still wish answers for what happened, what went wrong and why.

6.2 Many of them have lost all faith in the hospital itself as a safe place to treat their children. That is an unacceptable state of affairs.

6.3 Their faith in this Inquiry has been adversely affected by the late disclosure of statements and documentary evidence, factors that have had a detrimental effect on preparations being made on their behalf. This is exacerbated by the fact that documents referred to by GGC in their draft closing statement, which they say have been provided to the Inquiry, have not been shared with the patients and families.

6.4 Their faith in the Inquiry has also been adversely affected by the standing down of Senior and Junior Counsel to the Inquiry, a Team they had developed faith in and trusted. No candid or transparent explanation whatsoever has been provided for their departure. The news of the resignations of Counsel to the Inquiry was first announced in the media rather than by the Inquiry to Core Participants and their representatives. There has been speculation in the media as to the reasons behind those resignations. Nothing has been said about the consequences, if any, of the departure of Counsel to the Inquiry. No information has been made forthcoming about the identity of their replacements, when they are likely to take up

office and whether they intend to lead evidence in this Inquiry in the same manner as their predecessors (effectively running the Inquiry as if a Commercial Action). Nothing has been said about the likely impact, if any, on timetabling and the further progress of this Inquiry.

6.5 Patients and families were advised that there would be a Paper produced in connection with the issue of site selection/location for the QEUH and that it would be made available in the first 6 months of 2023. The Paper has not been produced. No information has been provided as to why or when it might be expected.

6.6 The failure to communicate about all of these matters is extremely unhelpful and counter productive. It has seriously undermined the trust and confidence of the patients, parents and families in the ability and desire of the Inquiry to expedite progress towards a conclusion and to secure answers for them.

6.7 Nevertheless, it remains the hope of those whom we represent that this Inquiry will go towards:

(i) The learning of lessons about the protection of patients and the families of patients of who rely on NHS Greater Glasgow and Clyde, the Scottish Government and other publicly funded bodies for safe and appropriate treatment in a safe and suitable environment. Why did they experience what they did? What could have been done to prevent those experiences? What can be done, has been done or is being done to ensure that nothing like it ever happens again?

(ii) Calling those responsible for any failings to account and providing them with an opportunity to: (a) acknowledge and accept their responsibility for any wrongs that were done by them and/or on their watch; and (b) apologise for their failings and the consequences of those failings

(iii) Exploring the duty of candour owed to patients and their families (by healthcare professionals and hospital management boards)

(iv) Achieving accountability, blame and retribution

(v) Addressing the issues of patient autonomy and the risks posed by a ‘doctor knows best’ (or ‘management board knows best’) paternalism. There has been evidence to the effect that parents were made to feel stupid or overanxious

7. Conclusion

7.1 Those whom we represent are trusting that, despite the departure of both Counsel to the Inquiry, the Inquiry will remain absolutely committed to investigating, exploring and discovering the truth with the same rigour as they have shown to date.

7.2 We remain committed and look forward to working further with the Inquiry Team in this and subsequent substantive hearings. It is of the essence that full investigation and exploration is carried out based on transparency, respect, trust and honesty.