SCOTTISH HOSPITALS INQUIRY

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14:02

THE CHAIR: Good afternoon, Professor Cuddihy. Mr Duncan.

MR DUNCAN: Thank you, my Lord. Professor Cuddihy, just a couple of further points about the Oversight Board and thinking about your work on it. At any point during the work being done by the Oversight Board, of which you were a part, was there actually ever any examination of the communication around the BBC Disclosure programme?

A Yes, sir.

Q Could you tell us a wee bit about that, please?

A Well, the Disclosure Scotland programme aired and, as we discussed previously, the lack of proactive engagement between the families and Greater Glasgow & Clyde, so I specifically requested of-- and within the 75 questions that were posed of the various individuals, but I also specifically requested certain things of the Oversight Board, and specifically I put in writing that this was about leadership. It was about leadership of the Oversight Board and holding to account those in Greater Glasgow & Clyde. It was about leadership of the Scottish government to ensure that, were those, or that body was placed into or escalated into Level 4, that they would respond accordingly to the advice, guidance and agreed protocols in relation to communication and engagement. And so, within that, I requested that they convene a meeting to specifically discuss the Disclosure Scotland programme; not the content, the communication and engagement, or the lack of it. As such, that was convened and it was convened online and there were many individuals in attendance.

Q Does that include individuals from GG&C?

A Yes. Electives from GG&C, the Chair of the various committees and the Communication and Engagement, members of Scottish government and all interested parties, and I-- as families represented of them. And at the very start of that meeting, if I recall, the person that actually chaired the event was Professor Craig White. Even before we got started, there was a request from one of the directors from Greater Glasgow & Clyde, Dr Margaret McGuire, who I believe is a decent person, and she says, “Before we start, can I say something?”, and she was given the floor, if you like. She says: “I want to say at the outset my profound apologies. I am truly sorry. I

am sorry for what has happened. We dropped the ball. It shouldn't have happened," and so forth. I believe her heartfelt apology. I do genuinely believe her. I've met her. She's that type of person. She would-- For me, this wasn't simply an individual failing. This was a corporate failing. This was a corporate failing to do that which was agreed. And I said to her at the time:

> "Saying sorry again doesn't wash. Saying sorry doesn't mean anything to me because it happened and it shouldn't have happened, and this is why we're here."

And so I asked-- And also important there was the Director of Communications from Greater Glasgow & Clyde. The Director of Communications was there, a lady called Sandra Bustillo. She said often that she and I would just never agree on matters, and I wouldn't because I didn't think she was reflecting what should've been effective communication. At the end of the day, she is the Director of Communication and Engagement. And so the meeting developed around who knew what and when and what did you do about it.

Q Who knew what and when in advance of the BBC programme?

A Yes. And, during that, it was apparent, whilst they were so sorry, that there was an awareness within GG&C roughly a week prior to the airing of the programme because BBC had contacted them. The BBC asked for comments, and then as it coincided with publication of the Independent Review, they were invited to give comment in relation to that. So there was an awareness. They would know and understand the impact that programme would have, perhaps not in its totality, but certainly the main components in relation to it, so much so that they compiled a response, a written response. As a Director of Communication, and you're interfaced with the media, you know how to ask questions of them. She's there to protect the reputation of the Health Board as well, so you wish to ensure that those questions that are being posed of you are relative to the subject matter, and indeed the comments that go forward, if not directly her own, are representative of the body, the Board.

And so I asked at the meeting, "Who all knew about the pre-prepared statement?" And it was online, so it was difficult to get the body language, but what was apparent was that many knew. And I asked, "Well, did you know? Did you know?" Because, you

see, part of being placed within Level 4 was that communications had to be cleared by Scottish government. Such was the concern about the ineffectiveness of communication, Scottish government officials would have to clear this.

Q Were there Scottish government representatives on the call as well?

A Yes.

Q Sorry, please continue.

A And so it tells you about the knowledge that was there. Still, no one thought to engage with the families.

Q And when you say, "the knowledge that was there", was it your impression that Scottish government representatives had been aware of the pre-prepared statement as well?

A They had an awareness, yes. And within that what they didn't know was that John Cuddihy had done his own due diligence and made contact with the BBC. I already knew what they had provided to the BBC in its totality. So once I clarified, I asked, "Is that prepared statement everything?" "Yes, it's everything." "Are you sure?" "Yes." I said, "What about this? You had given answers to a number of pre-prepared questions as well to the BBC," and you could tell.

And even then, at that point, even then in the lead-up to this, I went on the closed Facebook account, and I asked, "Can you give us, the families, a copy of your response, Greater Glasgow & Clyde, to BBC?" Silence. A second request: "Can you give us a copy, GG&C?" And the response came back, "Yes, you'll have it." A third request: "Can we have a copy?" Three requests – still nothing. And here we were within this environment again, still a willingness not to exchange information that they supplied a media outlet, specific questions that they had answered but not willing to share, that's a revelation. If I then say, "Well, that's what I have got," then agree, "Yes, that's correct."

Even worse than that, sir, was the fact that when I was complaining about this, when I was complaining about their lack of engagement, I was complaining about their reluctance to share. Greater Glasgow & Clyde at the time, if you will recall, there was a tragic event in Glasgow and it was an incident in the centre of Glasgow involving asylum seekers and someone was sadly killed, a knife attack. But such was the environment was armed police involved and what have you, and it was a major incident. Do you know that that was used within

the excuse not to communicate timeously with us? It was used as an excuse because those that would've been involved in communicating and engaging with us had to deal with the gold groups that would be involved in that. I'm very familiar with gold groups and silver groups, and I'm also very, very familiar with where we are in relation to this and our grouping, and so they were saying and doing anything and everything to justify their actions in relation to it.

And when I asked them at that meeting, "Did you have time to tell anyone about the Disclosure Scotland programme?" (Break in recording) response. I said, "Well, how could Jonathan Best send an email to the staff in relation to this?" So we had the foresight not only to have a preprepared statement to the BBC some seven days ahead of the Disclosure, consider those questions that were being posed and that were being discussed in the programme, but then to recognise the impact on the staff – and, as I've said, absolutely they should do that – still, even then, after all of that, never mind the proactivity, the reactive aspect, they still weren't prepared to share it. It was more about reputation again in relation to it. What it should tell them is if you are going to tell lies, you need a good memory. You need to be sure of your facts. And they would be wondering how I'm accessing this information. It's because people are providing it. Staff are providing it and they're telling us 'cause they see it's wrong. Many people are impacted here and not being told.

And I also said to them:

> "Each of you here agreed with the Communication & Engagement Sub Group. You agreed with the recommendations. You knew and understood our thirst for knowledge, and this was a programme that was going to focus on the hospital environment, but still you did nothing. You had it within your-- You have demonstrated through COVID you can be effective communicators, so it was a decision not to do it. A wilful act not to communicate."

And so, whilst Margaret McGuire apologised because she recognised they dropped the ball, quite frankly, they never even had the ball in their hands 'cause they had no intention to play it. No intention to play it. And I remember saying to the Chair of the

Board, Jane Grant, and others, "If you cannot withstand scrutiny internally, you will never withstand it externally." And that's the level of engagement. It would only become apparent if you pushed and you pushed. I shouldn't be doing that. I should be at home with my sick daughter.

Thinking of this, I had no right to be sitting there and holding them to account about a communication strategy in relation to a TV programme that was exposing and exploiting the vulnerability of my daughter, and I have to go and sit with a number of people to challenge them. That's just wrong. On so many levels, that is wrong, and they knew it and that's why they proffered an apology at the start of the meeting. An apology meant nothing because they did it and they knew they were doing it, and they would also, I suspect, "An apology'll be okay." Wrong.

Q Thank you. Now, just to pick up on a few points from that: so there's a meeting of the Communication & Engagement Sub Group to specifically look at the communication piece around the BBC programme, is that right?

A Yes.

Q And are you indicating that the invitees, whether it's GG&C or the Scottish government, are being asked to disclose whatever it was by way of documentation or information about that communication, is that correct?

A Absolutely.

Q And when, a moment ago, you indicated that you had asked them on the call, "Is that it?", and you got the answer, "That's it," and you then gestured thus, are you indicating that you were in a position to produce an additional document that had not been disclosed, is that right?

A The additional documents were those pre-prepared questions and associated answers.

Q And you say pre-prepared questions. What were the provenance of those preprepared questions? Which organisation prepared those?

A BBC.

Q And that had gone to the Scottish government, to GG&C or to both?

A GG&C, as I understand it.

Q Yes, and it had been answered?

A Yes.

Q And returned to the BBC, as you understood it?

A Yes.

Q And when you disclosed the existence of that component of the communication with the BBC, which had, as you said, been the whole point of the meeting, can you remember whether anyone among the GG&C representatives acknowledged their prior awareness of that document?

A Eventually, it was acknowledged, yes.

Q Was there any awareness of acknowledgement among SG representatives?

A (No audible reply)

Q And when you indicated a moment ago that when the (inaudible) question that I think was before the subcommittee on that occasion was around why there hadn't been any communication with patients and families, are you indicating that one of the explanations that was offered at one stage was to do with engagement in the serious incident that had arisen in relation to the attack on an asylum seeker, is that right?

A Reactively. Proactively, no explanation, but reactively as to their delay in response in producing the written narrative.

Q I see. So the explanation for not producing everything in advance of your meeting was this incident, is that right?

A Yes.

Q And did you indicate that that was said to be something to do with a requirement to be part of a gold group meeting or initiative in relation to that incident, is that right?

A Yes.

Q And a gold group is something that's set up when there is a serious incident or serious investigation that has an impact on the wider community, is that right?

A Crisis management, yes.

Q My understanding of gold groups is that they're something that emanates from within the police, is that right?

A It's a multi-agency response.

Q And of the agencies that were on the call with you, were they both saying that they'd been involved in that process or was it GG&C that were saying that?

A GG&C.

Q Yes. Now, just one further matter in relation to the Oversight Board, and something that you indicate in your statement, Professor Cuddihy: if you look at paragraph 282 of your statement-- Have you got that in front of you?

A Yes.

Q You've dealt with quite a

bit of this already, but one of the things you mention in the first sentence or so is that:

> "NHSGGC consistently failed to develop any tangible evidence of change or even any evidence of attempts to implement identified recommendations."

Which identified recommendations do you have in mind?

A Communication & Engagement Sub Group.

Q What about the recommendations that had been made by the Independent Review? While you were involved with the Oversight Board, were you ever provided with any evidence as to whether those recommendations had been addressed?

A It was an ongoing process and I would say that I don't think all of the recommendations were addressed, no.

Q Now, let's move to a further matter that I think was discussed extensively, or it was discussed during the Oversight Board process, and it goes back to the very start of your evidence yesterday. It's the reports by DMA Canyon. You've explained that you came to know at some stage that GG&C had advice from that firm highlighting concerns with their water supply three years before Molly contracted her infection, is that right?

A Yes.

Q And you also say in your statement that that first report, and perhaps other reports, were said to have been "lost", is that right?

A (No audible reply)

Q And is it your understanding that that was an issue that was considered by the Oversight Board? Is that right?

A Yes.

Q What is your understanding of what "lost" means in this context?

A In this context, it says that the reports are not available for whatever reason to the decision makers in Greater Glasgow & Clyde.

Q Who said or which organisation said that the reports had been lost?

A It was from GG&C.

Q And, from your understanding of things, what did they mean by "the reports had been lost"?

A That someone somewhere was responsible and, for whatever reason, had lost the 2015 report and it was not accessible to

anyone in order for them to consider the material contained in it but, more importantly, the recommendations that were derived from it.

Q You said yesterday that your understanding of things is that those reports were commissioned by and were directed to, initially at least, the Estates department, is that right?

A That's correct.

Q Do you know what, if anything, happened to the 2015 report after that?

A My understanding, sir, is that the report itself was delivered to Greater Glasgow & Clyde both electronically and verbally to Estates, and specifically to Mr Ian Powrie and other named individuals in the report. And following that, I understand, separate to the report itself, that the knowledge from the report was within GG&C, so much so that there had been discussions as to the review by DMA Canyon, to the findings by DMA Canyon and the recommendations that were made in, specifically, a series of emails from June 2015 between Microbiology and Estates. The significant point here for me is that, despite the document itself being unavailable for whatever reason, there is corporate knowledge and that corporate knowledge is present within those who had read the report.

And, indeed, the request is to access this report that no one has seen. The request is to determine the findings of the report because those individuals requesting it were the microbiologists that sat on the Water Safety Group, who had a role and responsibility in relation to this. But also of the recommendations: "How will the recommendations be carried out? Who will carry them out? What does it mean? How should we respond? What is it that we're responding to? What are the threats that we're facing, if any?" And those emails had started between the microbiologists and Estates. But as emails grow, sir, and you look at who the emails have been sent to and who they are copied to, you then start to see that the email chain started to grow. The initial response was to have a meeting with Ian Powrie and the microbiologists who would articulate those three specific requests all about the report, the findings and the recommendations.

It was then apparent that the requesting microbiologists, despite this, were still not able to see this report or, indeed, get that information. And so the email chain would continue and it would involve the Deputy

Director, an individual called Mary Anne Kane, and her response: “Why are you emailing me? This information has already been imparted to the Water Safety Group.” To let you understand, sir, and through my enquiries at the time, there are three separate and distinct Water Safety Groups. There is the South, the North and others. If you like, they are geographically focused, and the South Water Safety Group had responsibility for the new hospital and, as it had been, the Southern General Hospital, and hence the reason why this was the drive for information because they had responsibility and they wished to know information that would enable them to make informed decisions about the safety and wellbeing of the broader patient group simply about legionella in water. They hadn't seen anything, and so it was apparent between the mutual exchange of emails that this corporate knowledge at least to the existence of the report extended to some 10 people between Estates and Microbiology.

Q And, just to be clear, Professor Cuddihy, that email chain or series of email exchanges that indicates that broader knowledge, when do you say that dates from?

A June 2015. There is an interesting lead-in to that narrative.

The interesting lead-in is in May 2015 when Microbiology seek to confirm the protocols for water sampling and who that responsibility rests with, and the answer within the narrative was clearly given as Estates and, thereafter, the email exchange develops. So, knowing that Estates are responsible, this is where the focus of the communication is.

Q Reading the Oversight Board report – which we’ve, no doubt, all had an opportunity to do – do you agree that the impression appears to be that, on this question of the report being lost, the report made it from DMA Canyon to Estates but, for whatever reason, it never left there into Microbiology, in particular, is that right?

A Correct.

Q But what you're indicating is there's a wee bit more to the story than that, is that right?

A Absolutely.

Q There was at least awareness of it out with the Estates, is that what you're saying?

A Undoubtedly.

Q Now, that’s it being lost. Let's look at the other end of that story. In the Oversight Board report, the Oversight Board report that the 2015 DMA Canyon report eventually

"surfaced". What do you understand that to refer to?

A It surfaced in that the knowledge from the report was now available at that point for others to access. Previously, it had not.

Q Now, we can all read the report for ourselves, but I think what they indicate is that the report :

> "'Surfaced' [they put inverted commas around that word] as part of the review of historical documentation that we provided to HPS and HFS for their reviews of water system and infection issues in March 2018."

Does that accord with your recollection of what the Board understood the position to be?

A Page 192 of that report, that's exactly what it says. March 2018 is when it surfaced.

Q We can, as I've said, all read the final report for ourselves, but are we right to understand that it indicates that there was no evidence, or rather that no evidence had been seen by the Board, which demonstrates that the DMA report was actioned prior to 2018? Is that right?

A Prior to March 2018, yes.

Q And do we also see that they indicate that in March 2018,

GG&C conducted an internal investigation as to why the 2015 report had not been actioned until then, is that right?

A Correct.

Q Have you yourself ever seen any report that sets out the results of that investigation?

A No.

Q Do you know whether such a report was made available to the Oversight Board?

A Not to my knowledge.

Q The Oversight Board's final report also indicates that it was July 2018 when an action plan to complete the recommendations of 2015 were said by GG&C to have been completed, is that correct?

A (No audible reply)

Q Have you seen that action plan?

A As far as I'm aware, the action plan is still not complete.

Q Do we understand, in fact, from the Oversight Board report that it was September 2019 that GG&C said that the work arising from the DMA Canyon reports was completed? Is that right?

A Yes.

Q Have you yourself seen evidence or reporting that substantiates that?

A No.

Q Do you know whether evidence or reporting that substantiates that was provided to the Oversight Board?

A No. Not in relation to the 2015 report, no.

Q Are you saying it wasn't?

A I'm not aware of it.

Q And just finally on the Oversight Board, maybe just to clear up something that arises from a rather ambiguous question I asked before lunch: am I correct in understanding from what you said that the Oversight Board has no powers to compel or had no powers to compel the production of documents?

A As far as I understand it, no powers to compel.

Q Thank you. Now, we move on towards your final reflections, but there's one further matter I want to ask you about in your statement. You've mentioned already today, in fact, and it's the Paediatric Trigger Tool. For those who want the references, it's paragraph 305 that it begins in Professor Cuddihy's statement. Now, I do appreciate that in your statement you indicate that that's a matter that you intend to provide further evidence in relation to. But, just to assist all of us, I wonder if you could start by telling us what it is.

A Again, this should have been seen as a positive out of the sadness. We had two eminent individuals in the wider team in the form of Dr Patricia O'Connor and Professor Peter Davey, who would, alongside the Independent Case Note Review, examine the 84 cases. Their intention in examining those cases was to ascertain what learning they could extract that would further inform those practitioners involved in paediatric care and paediatric treatment. Essentially, they would consider a number of variables from the history of all of these young children, and the outcome would be that they suggest that there's opportunities for earlier intervention within their paediatric treatment plan in areas like, when they start to show a certain response, indicators of effect would be seen in a patient and it would allow the interventions to come in at an earlier stage.

So an example I would give you is the interventionist in PICU, right on the bell (?). By reviewing all of this material to prevent that, you could prevent these wee souls from going to PICU. Quite a remarkable piece of work. Even to consider it, that they're thinking about this is a remarkable

piece of work that we should be shouting from the rooftops. And if Scotland are so intent on being the leaders in patient care, in particular paediatric patient care, what a wonderful thing to tap into the knowledge, and perhaps we can prevent some future wee boy or wee girl going into Paediatric Intensive Care. What a wonderful piece of work that this would be. But, of course, further work would have to come in relation to it, but this was the intention and they would make recommendations in relation to this because we have to learn from the experience. Whilst that's painful for us, because our children can't be seen as guinea pigs, but that's how we improve. That's how we become better. We review, we reflect. "We want to save 9 out of 10 children." We want to save 10 out of 10. So anything that can be done in relation to this, what a wonderful thing, and that's what the paediatric treatment tool would be.

Q And if we just think about your conclusions overall about that piece of work, what is the concern that you have?

A Well, first and foremost, that report, having been commissioned and endorsed by the then Cabinet Secretary for Health, Jeanne Freeman,

and the then Chief Nursing Officer, as a viable piece of work to engage as part of all of this, it was to be published in March 2021 on the same day of the Case Note Review and of the Independent Case Note Review, the Oversight Board Overview Report and the Independent Case Note Review. It would be published alongside that. And the reason why it should be published alongside it was not only to inform, but there was a support mechanism in place.

Professor Mike Stevens and his team and various others had accessed psychological support, medical support, social support for those who would read these documents, because in reading them there would be impact when reflecting on the 84, whilst anonymised, you can put not only names, you can put faces to the narrative. So, people would require support. That's why that's when it should have been published. But it wasn't. It wasn't published, and actually, not until final days of the Independent Case Note Review was there a meeting convened consider the learning from the Independent Case Note Review, which Dr O'Connor was there and asked, "Who has seen my report?" No one had seen it.

"Why has no one seen my

report? Why is this possible?" And resulting from that was Professor Mike Stevens, the Chair of the Independent Case Note Review sent a letter to the current Cabinet Secretary for Health: "Why has this not been published?" To the current Chief Nursing Officer:

"Why has this not been published?" Nothing.

And so, I sent communication to these individuals also, but specifically to the new board, the new governance group that had taken over from the Oversight Board, which is now to be called Advice Assurance and Review Group ("AARG"). Quite appropriate – AARG. And this Advice, Assurance and Review Group, I sent to them, to the office of the Chief Nursing Officer. And the response I had was just to basically push away at the start. And then, "How, Mr Cuddihy, can we work together to ensure that we land this report appropriately?"

How on earth can you be asking these questions? What about corporate governance? What about the seamless transition corporate knowledge? A decision had already been made by the then Cabinet Secretary for Health, and if that decision is to be rescinded, you should have it documented. The Chief Nursing Officer was already involved in it. We now have a new Chief Nursing Officer. Is that what we do? Is there no concurrence in decision-making around paediatric care?

And they then asked, "How could we do this and support families?" I said, "But the support was already in place. We had arranged it." Says, "Well, it needs to really go in front of the new Advice, Assurance and Review Group to consider how they will deal with this" to the absolute disgust of the authors of the report and everyone else at that meeting. So much so, sir, that I continue to keep communication, and they told me that it would be presented at a meeting in August of 2021.

From August 2021, nothing until last Friday, there was a chap at my door, recorded delivery from the Chief Nursing Officer. If I would like a copy of the report, or should I say Molly, wish a copy of the paediatric treatment tool, redacted report, please respond to this email. And at the back, a copy of the support network that is in place.

Now, sir, I am in no doubt that timing was very, very convenient. Very convenient. That on Friday, prior to me coming to give evidence, it's delivered and requiring of a signature at my home. Why was it not published? We've had to challenge;

the authors have had to challenge. And now, they will give a redacted version of the report. Another example for me of the corporate failing communication and engagement.

Q Who has ownership of this document? Which organisation, as you understand it, has ownership of it?

A Well, it would have been through the Oversight Board, I would imagine. But the Oversight Board is no longer in existence. And I'm told to go to the Advice, Assurance and Review Group.

Q In terms of, you've identified the authors, but is this a process, in terms of the organisation that was responsible for taking forward the report, was it the Oversight Board? Was it GG&C? Was it the Scottish Government? Who was it?

A It would've been the Oversight Board at that point, yeah.

Q And are we to understand that this is essentially a review of the 84 cases – and by the 84 cases, you mean the 84 cases referred to in the Independent Case Note Review?

A Absolutely.

Q Is it a review of essentially what went wrong?

A No, it's about where they

can learn. It's about how they can extract the data to see other, earlier interventions that we could make. And so, if these indicators repeat themselves, it would allow us then, within this tool to predict far more effectively than there had been. It would allow further earlier intervention in the treatment of paediatric patients.

Q So, when you're indicating, as it were, a reluctance or reticence about publishing this, from which organisation do you see that emanating?

A Well, certainly not from those within the Independent Case Note Review, because they were asking for it. Certainly not from those authors, because they were asking for it to be published. The Chair of that meeting was Professor Marion Bain, and questions were asked. So, I would take it, as we have developed and moved, whoever Professor Marion Bain operates for, that's where the answer is, sir. 'Cause the Oversight Board is no longer at play, neither is the other. So, it will be there to determine ownership, and I would then say disclosure.

Q You had mentioned Professor Marion Bain in your statement in this section, which begins at paragraph 305. You understand her

to be connected to GG&C?

A I'm really unsure if she is in GG&C or the Scottish Government. I don't know. The role was interfaced with both. I don't know.

Q Thank you. Let's move on, then, to consider, then, reflections. I'm going to have you give us your reflections on two things. Second one, one you emphasised to me yesterday: impact. First one, communication.

A consistent theme (break in recording) the evidence that we have heard here from patients and from families has been that the reporting of issues to do with the hospital mainly came from the media or from other parents on the ward or from clinical staff on the ward. Would that be your experience also?

A Yes.

Q Regards communication, let's go back to the very start of your evidence, where I spoke about the various components of communication and one of them being the content. Let's talk about the content of communication. I think it's pretty clear from your evidence that as far as clinical communication, i.e. from clinicians and nursing staff, what you got was detailed, truthful, with no hidden bad news, would that be fair?

A Yes.

Q In the case of communication from management, what would the position be?

A Little.

Q Something less than how I've just described the clinical communication, would that be fair?

A Absolutely.

Q And the question of whether-- In due course, we'll come to the obligations around communication, but on the question of communicating bad news, bad, bad news, or even uncertain (break in recording). The question of communicating those things, is it your evidence that clinical staff absolutely got that had to be communicated?

A Yes. And times, if it wasn't, there would be justification and rationale for not providing it.

Q Yeah. I mean, that's an interesting observation, because there is one instance where you and Molly (break in recording) a different view about an absence of communication at a particular point. And Molly, in her evidence said essentially what you've just said, that although she disagrees with the decision that was taken, she understands that the person who took it had her interests at the forefront of his/her thinking at that point, is that right?

A (No audible reply)

Q On the question of whether bad news and uncertainty had to be communicated, did management understand that?

A Well, in my opinion, sir, no.

Q Secondly, there is the other component of communication: the identity of the messenger. Keeping with what you've just said at the very outset of this part, when it came to issues to do with the hospital, it appears that the impression of you and others is that it fell to the clinical staff sometimes to communicate what was going on, is that correct?

A Yes.

Q I mean, we've looked at paragraph 137 of your statement, where you speak about that. Maybe just exploring that a little, in your view, is it possible that there may have been some reasoning behind devolving the communication piece to clinical staff? If that's what was going on.

A Undoubtedly, I would consider there was reasoning for it. Otherwise, it wouldn't have happened. But I would consider that the reasoning there was that they were a significant touchpoint between the hospital and patients. So, one would consider at times that, yes, that may be the most

appropriate.

But what we were talking about was not patient treatment, patient care to the nursing staff, the medical staff. What we were talking about was the environment, we're talking about is water drainage, air conditioning. Certainly whilst Dr Sastry and the nurses and everyone else are very gifted, and have a far, far higher intellect than I, I am not aware of any of them have the knowledge in relation to water, air conditioning or drainage. And if they are focused on such matters, then they are not focused on the matters of critical clinical care. So, the reasoning for it, sir, I don't consider to be in any shape or form supported by any critical thinking.

Q Without going back to it, I think, at paragraph 137, you say it's possible that what was going on here, in terms of clinical staff being the conduit for information about the environment, it's possible what was going on here was a desire to alert rather than alarm. I think what you're indicating is that doesn't really stand up to any scrutiny because those aren't the people who really know about the issue, is that it?

A Yeah. And indeed, I actually spoke (break in recording) that when we reviewed the communication

and engagement, and did encourage them again, if this happens, to make sure you have someone from Estates going around with you. 'Cause even some of the individuals, the managers, would not have the knowledge to answer.

Q Putting to one side for a minute the question of whether, on the assumption that such reasoning was going on about a communication strategy, putting to one side the question of whether that stands up to scrutiny or not. Do you consider that it was possible that, at least sometimes, what you and others saw as poor communication from management was itself a product of trying to do the right thing by patients, at least in the manner in which communication was conducted?

A Undoubtedly, there would be an aspect of that, sir. I'm in no doubt in relation to the intentions of certain individuals, but even the timing of it was reactive. It was not proactive. And even when it was to be proactive, it was not considered about the audiences they were speaking to. So, proactive to someone in the ward, but not proactive to someone who was an outpatient.

So, for me, knowing who'd actually sat, sketched out a

communications strategy, who is it that we need to speak to? What is it that we need to communicate? Why is it that we need to communicate? And how will we communicate? Will we do so in a letter? Will we do so in a discussion forum? Will we do so on social media? On Facebook? Some or all of these things? I would expect to see such a communications strategy, and I asked for it, sir, repeatedly. "Can I see your communications strategy? Internal and external." And indeed, when I had a meeting with him at the outset, they accepted that their communication was poor and, "We will look to do better."

Q The hypothesis I'm putting to you just now, if I understand you correctly, might sometimes deal with question of what the motive was, i.e. whether it was a good motive or not a good motive. But in your view, it doesn't address the deficiencies around the communication piece, is that right?

A Absolutely. But it also doesn't address, not only that, it doesn't address the "what". And as we have discussed here, what it is that they were communicating was fundamentally at odds with what it is that they knew. What they were communicating was fundamentally at

odds with what they knew.

Q We'll come back to that, Professor Cuddihy.

And just, again, dealing with hypotheses, and thinking about a slightly different hypothesis, I wonder if anyone among management might have been entitled to think, “We were promised state of the art hospital,” and instead they might possible think, “We have, in fact, been dealt a terrible set of cards by the contractors and the subcontractors and the building professionals who provided advice.” Is that a hypothesis that you accept as being at least tenable?

A Absolutely.

Q And I wonder then, if at least sometimes-- Again, another hypothesis, sometimes might it have been the case that management might just not have known what to say?

A There's a couple of things within that.

First of all, have they, management, been held accountable of that which they are not responsible? It was the contractors’ fault, and not theirs. Okay. And in some ways, when Jane Grant made a public statement, one of the few where she was on, she said that she had inherited issues from the previous leadership. She inherited issues from the previous leadership, and I can understand that.

So, my question then, at the time, “Jane Grant, okay. This didn't happen on your watch, if that's what you're saying. Whom is responsible? What leaders did you inherit these issues from? What were those issues? When did you become aware of them? What did you, Jane Grant, do about them?” And also, within that, sir, it is not the responsibility of the construction company, regardless of their liability in any of this, but it's not their responsibility to carry out a legionella risk assessment. That is the responsibility of Greater Glasgow and Clyde. It is not their responsibility to address the recommendations come from that report, in that the water bypassed the filtration system.

There was valves closed, there was contaminated water flowing into that system for years, potentially colonising it. That's not a contractor-- If the causation is a contractual issue, deal with that, but you're responsible, Chief Executive. Your responsibility, Board, is the maintenance and the upkeep of that facility. And if you have an expert report that has been laid before you that tells you what is wrong, it is your responsibility to address it. That's not what happened ‘cause they

did nothing. They lost the report. That's not a contractor's problem. That's a Health Board problem. And they didn't just lose the 2015 expert report. The 2017 report, which is a statutory requirement, which further informs the Chief Executive, said, "Listen. See, over the last two years these same risks apply, but now they're even greater risks. You've done nothing about it." That's not a contractor's problem. That's a Greater Glasgow and Clyde Health Board problem.

And the individual that took receipt of that report, Tommy Romeo in 2017, had received email communications telling him there was bacteria on the ward in 2017 in Ward 2A, but we do nothing. Greater Glasgow and Clyde, I would imagine, in the Risk Register has water as a risk because you have a statutory requirement to ensure you have external scrutiny of Legionella and risks. 2015, 2017, they did nothing.

And it's my understanding, never even had it on the Risk Register. And further, sir, what's not a contractual problem is if your staff are trained or not.

In a 2018 report, "Authorised person not been trained", but there is a further major comment within that

report, sir, and that is that DMA Canyon reflected on the draft scheme of the water management and reflected that they had certain issues. And within the report they opine that they'd need answers to their comments, and they directed that to a lady called Phyllis Urquhart. And the importance is Phyllis Urquhart is the Compliance Manager for Estates. That is not a contractor's problem, sir. That's a Greater Glasgow and Clyde Health Board problem. To ensure that the risks are identified, responded to, communicated and managed with appropriately trained staff. That's Jane Grant's responsibility. And if she inherited that problem, what did she do about it? Because when the report surfaces in March of 2018, she still did nothing because the INT is sitting, and they never disclosed it for a further three months. And also, the corporate knowledge is in the heads of those individuals who are aware of the reports, the same individuals who are members of the INT, as Jennifer Armstrong was at pains to point out about the collaborative nature when she sent me the letter 2018.

So, the corporate knowledge, sir, is in the INT. And is GG&C's responsibility. And Jane Grant's vicarious responsibility are the actions

indeed of those individuals which operate on her behalf, and those individuals that are responsible for the care and the duty of care of our patients.

Q So, just to take my, essentially, two hypotheses and take the second one first. On the question of whether the problems with the hospital might be part of why the deficiency that you and others report on communication, you see that as providing no defence whatsoever to those deficiencies, is that right?

A Absolutely none.

Q And on the other hypothesis that I put, that even though the deficiencies about communication pertain in particular to the question of going through clinical staff, the proposition I put to you, and maybe also the fact of pills being sugared and the message being softened, "Everything's okay. The water's wholesome." On the hypothesis I put to you that maybe sometimes – you see it wrongheaded as all of that was – but maybe sometimes what drove that was a desire to protect the patients in some sense? I think what I take from you is that word "sometimes" has to be emphasised because, at the very least, there are instances which you identify which simply do not permit of a benign explanation, is that what it comes to?

A The decision to close the ward, sir, in September of 2018, if they wished to sugar-coat the pill, the many pills, bitter pills that we have been asked to swallow, you could have done so by saying:

> "You know what, not only are we closing this ward, we're going to rip out air conditioning system. We're going to replace the water system. We're going to ensure that those bathrooms and everything within it have the right fabric and materials that are water resistant. We're doing all of this. However, and whoever is responsible, that's for us to deal with in our legal argument with these companies. For you, our patients, because we have a patient-centred approach, please take a confidence that what we are doing is we are doing full respect to you 'cause we're protecting you. And we're going to prevent any other child from contracting anything here. This is what we're going to

do."

You don't say, sir, "We're going to take advantage of the ward closure and upgrade the air conditioning system." You don't say that.

Q Your position is that the decision to frame what was going on in that way, you see as being impossible to reconcile with the notion that what they were trying to do was, in some sense, protect patients and reassure them. Is that your position?

A Absolutely. And if they really wished to protect us, sir, they would have considered that the air conditioning in Ward 6A was not fit for purpose, but they were putting us there. They were putting my daughter in there and all the other children, but the water wasn't fit for purpose because they had the DMA Canyon reports telling them, they had the Intertek report telling them, they had the Innovate Design Solutions reports telling them. Yet, the put us in Ward 6A. How is that giving us a sugar-coated pill? That's giving us a pill laced with other badness (?). We're going out of the frying pan and into the fire, and even that fire that we're going to is so red hot that we then have to be displaced to a third place. How can that possibly be a communications strategy that is defensible? It's

impossible.

Q Well, let's just look at that a little further because currently we're speaking about issues to do with communication in a somewhat abstract way, in the sense that we're not currently looking at the obligations that sat with GG&C in relation to communication with patients and families. I think it's clear from your statement that is something that you've looked at, and I'll mention three sources of obligation, the third of which I'm going to ask you some questions about.

In your statement, you mention first of these: the UN Convention on the Rights of the Child, and Articles 12 and 13 in particular, is that right? Second one, that I think comes across from what you and Molly have said. Molly said on Monday it is just wrong to see communication to do with the hospital is sitting outside process of communicating on clinical matters with the patient, is that right?

A (No audible reply)

Q Yeah. So, on the question of gaining patient consent (break in recording) procedures, you also have spoken about documents that had to be signed in advance of procedures. I take your position to be, and Molly's position to be, that

information to do with risk arising from the hospital environment, should have been part of that too, is that that your position?

A Yes.

Q Yes. Now, let's move onto the third source of obligations, which is duty of candour. When did you become interested in the concept of the duty of candour?

A Only because of this experience, sir. And it was being bandied about like a badge, like a shield. The word “confidential”, the phrase “duty of candour”, elements of which I understood. But really, what was it? What did it mean? What was the responsibility? And so, in order to go in and have discussion and to challenge or provide opportunity, need to try and understand that a bit better.

Q Yeah. And just to help everybody on this, there is quite a significant section of your statement that sets out your thoughts on it, beginning at paragraph 316. I'm not going to take you through this in detail, Professor Cuddihy, but just to give everybody the reference.

I think we can see from what you say that you came to co-author a paper on this topic, and I think it was published in the Journal of Medical Ethics, is that right? Who was your co-author?

A Dr Inkster.

Q Just a fairly high, in general, level, if you permit it, what is the duty of candour?

A It’s requirement of individuals who form relative to harm. There’s six criteria within harm. To advise patient groups of where harm has been caused. Causation is not a factor within this, and, if you like,

Dr Sastry would fulfil his duty of candour when he told us about the harm caused to Molly. He did so, he didn't understand the causation in relation to this.

Q So, is the creation of risk itself enough to engage the duty of candour, is that what you're saying?

A That’s right.

Q Sorry, I interrupted.

A So, that criteria is quite clear. And for me, the outset, in relation to duty of candour, there was a lack of understanding of that and a lack of application. And it's part of supposing it's interwoven with section 12 and 13 in the provision of information, in order for you to make an informed decision. And it's on the part of those clinicians, whoever he or she may be, and an obligation, they must impart this information to you regardless of the causation. Explain it

to you. And there is a part within it, you have to extend an apology, even if it's not you that is responsible, but you extend an apology and advise in relation to those six criteria of harm how this came about. Identifying also within it what you will do about it.

Q And, just trying to take in summary form what you've set out in meticulous detail in your statement, just trying to understand your conclusions, am I right in understanding that you go as far as saying that an understanding of duty of candour was, in your view, among GG&C routinely absent?

A Yes.

Q I think, do we also see, Professor Cuddihy, that you actually go even further than that at points? And that you actually say, in your view, the only explanation for deficiencies in communication on some occasions is duplicity?

A Absolutely and unequivocally.

Q Why do you say that?

A Even in the absolute absence of causation, they knew and understood, even in the balance of probability, causation. They knew, better than I or any other individual, the impact of harm 'cause they warned us on the very day set foot within their

hospital. They understood better than I and anybody else, should we be exposed to an environment that posed a threat to our daughter, even when she was at her most vulnerable, this is all the things that you need to do to protect her. In many ways, they're all looking ahead to the holistic duty of candour, 'cause they're warning us about harm that could be caused if this occurs. And so, you take all of that advice, and you protect.

Then the knowledge that they had from the various expert independent reports from their own staff, taking their Hippocratic oath, their duty of care, telling them there is an increased risk to immunocompromised patients and, as a consequence, harm – yet do nothing, yet "we do not disclose our corporate duty of candour". Instead, some may consider that they will sugar-coat the pill. Well, even if they wanted to, they're not entitled to under those circumstances. They have a duty, a statutory requirement, to make it known. And even when one reflects on section 12 and section 13 in relation to the UN, and indeed if we consider the World Health Organisation, it is our right, our right to access information that will impact on the health, the safety, and wellbeing of our children. What we choose to do

with it is a matter for us, but we have a right to that information. Even to think we had a right to go to another hospital elsewhere, the world offers no boundaries when it's the health of your child. And yes, I know that they have a corporate responsibility to the wider community, to the wider patient group. They cover a huge area; we are only 454 families. So, we – when it comes to it – are a small number. So, if we put that out there that our water is contaminated, what is it that we're saying to the wider patient group? But, actually, that water, if it's contaminated, is affecting the rest of the hospital, so it then goes broader than the paediatric care.

They have a duty of care to the greater, wider patient population and to be honest, to be open, and transparent, elements of duty of candour, and they've chosen not to do so. It's a wilful act, sir, to deprive of information. To deprive of information. When it's exposed that there are documents there that will support our hypothesis, we lose them: we lose the 2015 report; we lose the 2017 report; we lose the 2018 report. When we asked for maintenance records, they are not available because, "We have lost them". I am sorry, sir, that is not acceptable for a public sector

organisation that have a duty of care for a patient population. "We have lost it." Can you imagine: "I've lost your medical record, Molly"; "I'm sorry, I have lost the list of medication, Molly"; "I'm sorry, we've lost the record of how we treated you, Molly. We'll just have to make it up as we go along." Or even worse: "We're not going to tell you, Molly, that we've lost it – just going to give you a sugar-coated pill and hope for the best." Well, that's the hypothesis, sort of, that's what we should be accepting of. And I'm sorry, I cannot, in any shape or form, consider the actions of Greater Glasgow and Clyde Health Board, of Jane Grant, Jennifer Armstrong, Jonathan Best, of all of those named individuals, were acting in the best interests of my daughter or those other children. They were acting in the best interests of themselves, because the question is: "What did you do about it? When did you know? How did you prevent this from happening?" It was easy to say, "I lost it", that it was a big, bad contractor that did it and ran away. No, not with the life of my daughter. No way.

Q Thank you, Professor Cuddihy. I want to now move to the second aspect of the reflections that I wanted to ask you about, and you've

just touched on the most important one: impacts upon the one thing that brings you here today, Molly. What are the avoidable impacts on Molly from the story of the hospital?

A First of all, if it wasn't for the hospital and the collective, if it wasn't for that Schiehallion unit, brainchild of Professor Brenda Gibson who attracts world-class people, if it wasn't for that, we wouldn't have Molly. Wouldn't have her. Many people should say, "Well, you should be happy with that." And I think about this because we have a duty to respect, to think about other families, and to reassure them the environment they'd gone into is a safe environment. That's not my job, and there's a guilt in that, me sitting here and saying the things I am saying. I take no pleasure in this, and I wish to God I never had to say any of this. I wish to God I didn't have to say it because I know the damage that it can do for others. I know the impact that it can have in people when fear is in you, you're scared to go to the very place that offers you the life treatment for your son or daughter.

But, sir, if we don't scrutinise, if we don't hold to account those who are responsible for the impact-- I can't change the cancer, it's not a lifestyle choice. If it was, we would say, "Don't smoke. Don't drink. Eat this, don't eat that. It's a prevention strategy." These wee souls don't have that. They're born with it – DNA. So, they give them a chance. We entrust them into an environment that's going to protect them and prevent them, that they will be the equivalent of Dr Sastry in ensuring that the medicine for the building is applied in the dosage required, that the early intervention is applied to ensure that we do not expose and exploit. They're simply asked to ensure that the air conditioning system is not depositing dirty air into a clean environment. We asked them to ensure the water that's coming in is going through a filtration system. Why on earth did we put a filtration system, but we don't use it. We asked them to simply maintain the system, but in two years we've got dirty sponges in the cold-water tanks. We asked them simply to protect our children. We asked them to give the medical profession a world-class facility that allows them to care for our children.

Sir, they have engaged in a series of wilful acts so reckless as to show an utter disregard for the consequences – the consequences in my daughter as being miserable. Miserable. She

contracted bacterial infection, the treatment of which has left her irreparable liver damage, 54 percent function in her kidneys, damage to her spleen, her bowel, body absorption – not because of the cancer, because of bacteria. Because of the bacteria.

They, sir, responsible in their wilful acts not only to impact on the physical safety and wellbeing of my daughter and all of those other wee vulnerable kids, impacts on their vision for the future, and removed the very support mechanisms that helped them mentally, psychologically, emotionally. Who better to know this is the very people in a hospital that they preside over? And if not themselves having the skill to do it, they have an abundance of people that could help them – but they dismissed them, they dismissed the microbiologists, they dismissed the experts; and this is indicative of a closed leadership. They do not share information so no one can challenge them. And it's that wee group's thinking-- And of course they're right and everyone else is wrong. They lack humility. They've deprived my daughter of a quality of life, an already eroded quality of life because of her terrible cancer, terrible cancer – and they have eroded further her quality of life.

And even in times when she's needed me most, I have not been there because I'm away fighting with people. Every meeting I had, every letter you're writing, every report you're reading consumes you because you're doing it, you think, for the right reasons, for your daughter and these other kids. And time is so valuable. On margins, I'm not enjoying a life with my daughter, I'm sitting here talking to you; I'm at an independent review, a communication and engagement subgroup; I'm at an oversight board. Even when you say all that together, they've placed them into special measures, the impact that they have had on us as a family unit – how do you quantify that? How do you quantify the fact that your wee girl was taken to an edge of a cliff so often? And it's not the cancer that's taking her to the cliff, they are actually driving her to the cliff. How can they live with themselves?

I started off this, sir, believing, does any one of these individuals get up in the morning and decide either to do something or not to do something that would harm a child, and I would refuse to believe that. I would refuse to believe anybody (break in recording). Just take a look at the wee kids, who could hurt them? Who could

hurt these kids? By their actions and, more, their inaction, they were wilful. They were wilful and they should know the impact that they have had on those wee lives. It is shameful, absolutely shameful, and we need to expose it. And whatever (inaudible), we might be able to help somebody along the way and it will be worth it – even for one – worth it because, regardless of what happens and regardless where it happened, we need to know and understand why: "Why? Why would you allow that water to bypass filters? Why would you not do anything to protect our children?" The impact is immeasurable, sir, and it continues.

I'd mentioned previously, Molly's story is traumatic enough. What we have had to do here, and all the fathers and all the mothers, and all the kids, we have to sit and watch-- it's like watching a video that's being rerun from different angles. We know the start of the story, and we know the end of the story, and all we're just seeing is the different perspectives of the trauma that these kids are going through because of a building, because of decisions made and not made, and you know the outcome is still there. Where the movie could have been influenced is at the start. They could have done something at

the start of this movie, would have better protected. It wouldn't have prevented all of the bacteria, of course it wouldn't, of course it wouldn't. But do you know what? It would have better protected, and nobody would be sitting here today to say, "You exposed these children to increase risk from water, an increased risk from drainage, an increased risk from air conditioning." We had to shut the wards for three years, three years! And COVID has had an impact, that tells you the extent of the damage in that hospital, in that ward. The legacy of that impact will be far reaching, sir. I don't know what tomorrow will bring for Molly or these other kids, and whatever the outcomes here will be will not change that. Can't influence change, and that's worse in some ways the impact we've been through.

Q Thank you, Professor Cuddihy.

Now, on the question of influencing change. You sat, watched Molly's contribution towards that on Monday for four-and-a-half hours or whatever it was, sitting where you are just now. How did you feel watching your wee girl do that?

A I didn't want her in here. Terrified what it'll do to Molly, coming in here. We're so far away from her, I

mean, as well to be out of the country. Just wanted to come in (inaudible).

Q How was she? How was she after her evidence on Monday?

A She went back in the car; she just slept. She's been in her bed since. I don't know how it'll impact Molly. In her head she feels (inaudible) very determined individual. She's my wee girl. Girl should never have been here. She shouldn't have been put in this position to expose our own vulnerability-- For me to expose-- look at the state of me. I've exposed my own vulnerability, and this is the impact of it: a visual demonstration of impact. Here it is. Molly's been through enough. We shouldn't have to put people through this. It's wrong, it's cruel, it's inhumane. We are where we are because you want to make a difference. She'll get through it with the love and kindness of the people who have continued to support her, and I'm sure that they will continue to do that.

Q Thank you. Now, I want finally to go back the story of the hospital, and I want to go to your concluding remarks in your statement. And I wonder if we could have those up on the screen, please. If we could go to paragraph 370. Now, on this occasion, Professor Cuddihy, I'm going to get you to do the reading. Do you want a break or do you want to----

A No.

Q -- bash on?

A Not at all.

Q Paragraph 370 of-- I'm sorry, do you not have the page number? My Lord, I wonder if we could just have a quick five-minute break.

(Short Break)

THE CHAIR: Mr Duncan?

MR DUNCAN: Thank you, my Lord. Professor Cuddihy, if we can now move towards the conclusion of your evidence, and I'm going to ask you to provide us with some concluding remarks, and I'm going to begin with the remarks that you've included in your statement. And I might just have you read what you've set out at paragraph 370 to begin with, please.

A

"In all the circumstances, I believe that there has been a corporate failing with regards to ensuring that the environment in which my daughter was treated, was safe. There appears to me to have been sufficient

information available from 2015 that resulted in those responsible for infection, prevention and control, raising concerns that the environment presented increased risk to vulnerable cancer patients, such as my daughter Molly. I am also in no doubt that the leadership of NHSGGC, whether through dysfunctional and corrupt practices, failed to respond to, manage and communicate to those at risk. Despite numerous opportunities to engage proactively, they failed to do so and have actively suppressed information from those who could make informed decisions with regards to the outbreaks of infection."

Q Thank you. Now, Ms Verrecchia, could you maybe take us, please, to page 157, and we'll have Professor Cuddihy read paragraph 373.

A

"My daughter contracted a bacterial infection whilst under the care of NHSGGC. I appreciated that she would be susceptible to such risks and did everything in my power to protect her. When I consider the actions or inaction on the part of NHSGGC, I am in no doubt that they could have done more, much more to protect my daughter from such environmental risks. They were aware of the risks, as identified in the 2015 DMA Canyon report, the 2017 DMA Canyon Report and the 2018 DMA Canyon report. They were aware of the increased risks from water, ventilation and drainage as they had been advised as such by their own microbiologists but failed to listen and take the appropriate action. They have systematically, tried to frustrate and supress each and every investigation and engaged in wilful acts so reckless as to show an utter disregard for the consequences. They have presided over a crisis which has become a scandal that has led to the exposure and exploitation of those whose

lives have already been so dreadfully impacted through no fault of their own."

Q And if you go on and read paragraph 374, please, Professor Cuddihy.

A

"My daughter and those other children, our families and indeed staff, have witnessed a developing series of events that individually have impacted on our lives, physically, socially, psychologically and emotionally. Collectively, the failings of NHSGGC have reduced further the quality of life that my daughter has. They have further eroded her chances of survival when small margins mean so much and often the difference between life and death. The failings have led to further illness, which in itself, further complicates the delivery of cancer treatment. Even if my thoughts or conclusions are emotionally influenced resulting in my judgement being impaired, one cannot ignore the fact that my daughter----

Q Go onto the next page, please, Ms Verrecchia, so we can have Professor Cuddihy continue. "The fact that my daughter…" Have you got that? It should be at the top now.

A

"… judgement being impaired, one cannot ignore the fact that my daughter contracted a hospital acquired infection and in doing so, impacted her quality of life and chances of survival. One cannot ignore the comments from those doctors, microbiologists and other NHS staff who have disclosed their perception of the failings, raised and documented since 2015. One cannot ignore the fact that the bespoke ward 2A/2B, designed to cater for my daughter's treatment for cancer, has been closed for nearly three years, that the ward she was decanted to was closed twice, that review after review have been conducted, parliamentary questions have been posed and public inquiries have commenced. One cannot

ignore an independent expert panel who conclude that 30% of the 84 cases they reviewed were probably linked to the environment whilst 70% were possibly linked. One cannot ignore that they concluded that two deaths occurred, at least in part, where the environment was a contributing factor."

Q Thank you. Now, if we go on, please, to page 159, and I'll have you read paragraph 378, please.

A

"However, Molly is also threatened by the NHSGGC, organisational environment, or rather those who influence and direct that environment. They have had numerous opportunities to change and influence the environment. For whatever reason they continue to fail in their duty to protect and in my opinion, change will only be realised once those involved are removed as they have demonstrated that they have neither the operational or professional competence to discharge their statutory

obligation relative to the provision of healthcare."

Q And if you go on finally, please, and read paragraph 379 on the same page.

A

"If you ask me, what do I think about Greater Glasgow and Clyde, clinically, I think I've made it very clear in that anything I say here does not in any way relate to those involved in clinical care. In terms of the corporate entity, they, as a group, have engaged in a series of wilful acts so reckless as to show an utter disregard for the consequences. That's what I think about them. I started in this believing that no-one would get up in the morning and do something that would hurt a child or, indeed, fail to do something that would increase the risks to that child. I am in no doubt that there are those who have devolved responsibility, who have abdicated their statutory responsibility and they have engaged in a dysfunctional organisation and knowingly suppressed

documents that has ultimately increased the risks to my daughter, exposing her to a hospital acquired infection that has and continues to threaten her life."

Q Thank you. We can put that to one side, Ms Verrecchia. Professor Cuddihy, I have come almost to the very end of my questions and my last question is this, and I will then give you the opportunity to say anything further that you would like to say: what would you like to see emerge from the Scottish Hospitals Inquiry?

A Recommendations that will lead to tangible change so that no other child or other family can experience what we have all experienced and endured, and that the staff, wonderful staff, the men and women, can have an environment that allows them to focus on the primary clinical care of their patients, and not to have to operate in an environment where skills are tested as a consequence of the failing, human feeling, of those that control, operate GG&C.

Q Thank you. Before you conclude your evidence, is there anything further that you would like to say?

A I suppose, simply, what I would like to say is thank you for giving us a voice. It feels as though we've been shouting in the darkness so long. We've been fearful for so long, not only of the cancer, of the environment, and indeed from ourselves – can't do anything right from doing wrong. So, all I would like to do is to thank you for compassion that you have shown, the empathy that you have displayed in your communication and engagement; in no way to compromise any integrity, but simply to enable us to speak freely. And for myself moreover to articulate what I have found, and to enable us to present this information simply allows informed decision making to be made. Nothing else. And absolutely to scrutinise every single bit of what I have said, and I would love so dearly for you to prove me wrong on so many things – I would love it so dearly.

So, I can see only positives that come on from this public inquiry. I can see only an opportunity of tangible change, and I can see certain families and other wee patients that have a terrible enough life to go through and do so in the full trust and confidence in a facility that's there to cater for all of their needs, so thank you.

Q Thank you, Professor Cuddihy. My Lord, as indicated, those are all the questions for Professor Cuddihy.

THE CHAIR: Professor Cuddihy, for providing your witness statement and providing your oral testimony today and yesterday, thank you very much. It may be, as I understand it, you will be coming back to give further evidence at a later stage, but these are decisions yet to be made. But for the moment, thank you very much, and that's the end of your evidence for the time being. Thank you.

A Thank you.

(The witness withdrew)

THE CHAIR: What I perhaps should do, before I finally conclude it, is to indicate we're not sitting tomorrow but we will be sitting again at 10 o'clock on Friday. Am I correct?

MR DUNCAN: That's correct.

THE CHAIR: Right, I apologise for losing sight of that, but until Friday.

16:10

(End of Afternoon Session)