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: 20 September 2021 to 5 November 2021

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1. Introduction

1.1 The 59 Core Participants represented before this Inquiry by Messrs Thompsons, Solicitors are patients and parents of the child patients who were, or are still being, treated on the children cancer ward and in the neo-natal unit at the Queen Elizabeth University Hospital in Glasgow.

1.2 Of the 59, the Inquiry heard oral evidence from 24. A further 3 had sections of their Statements read in to the evidence. Their evidence was in addition to or supplemented the lengthy and detailed witness statements provided by them, and others, to the Inquiry Team.

1.3 The stated purpose of the recent hearings was to enable the Inquiry to obtain evidence of patient and family perceptions. That stated purpose has been achieved.

1.1 In our Opening Statement we observed that a fundamental purpose of this opening section of the Inquiry was for the experiences of and consequences for those whom we represent to be ventilated and listened to. That has been done.

2. Observations on the Evidence

2.1 The evidence given about the conditions in the QEUH ('the hospital') and the additional suffering caused by infections was distressing and shocking in equal measure. This was all the more so given the sheer number of parents with similar stories, and the consistency of their individual accounts given in evidence covering a

prolonged period of time. Children died as a result of infections at the hospital. Children who are already seriously ill and in need of life saving cancer treatment should not be put at significant, additional and serious risk by the hospital environment. This should not happen in any hospital, all the more so a new, bespoke, so-proclaimed state of the art 'superhospital'.

2.2 It is clear from the evidence that the 'loss' of the Schiehallion Unit and its associated Umbrella, and all that involved in terms of the provision of world class clinical care in a suitable and supportive environment, had a significant, negative impact on the lives and treatment of patients and their families. That impact occurred in the darkest of times in their lives. Having a child treated in hospital is a stressful experience for any parent or family member at the best of times, and it should not be the case that it is made more stressful, more traumatic and more upsetting by the conduct and circumstances at the hospital itself. The comparison between the numerous positive accounts given of what had been available and provided under the Schiehallion Umbrella compared to what was made available to patients, parents and family members at the hospital after the Unit's closure and decant, was stark and upsetting.

2.3 Patients/parents told the Inquiry how they/their child developed infections while they were being treated at the hospital. Parents also told the Inquiry how, based on advice given by healthcare professionals involved in the treatment of their seriously ill children, they were ultimately more worried about the consequences of acquiring infections in the hospital than they were of the serious illnesses that had seen them admitted in the first place.

2.4 The full extent of the pain, distress and anxiety that these infections caused to both child patients, patients and families was clear in the evidence heard by the Inquiry. For the children that were affected, it is not known what the effect will be for them in the long term but, in the short term, there was ample evidence of the serious adverse impact on them as a result of what they, children, have been through.

2.5 The difficult situation that these children and their families found themselves in was seriously exacerbated by the fact that there was a fundamental lack of information provided by GGC. The feeling of many of the parents was that the doctors and the

nurses were constrained as to what they could tell them and their children about the problems that were thought to originate from the hospital environment.

2.6 There is, on the face of it, evidence that is highly suggestive of a serious cultural problem at the very top of GGC's management structure.

2.7 There is evidence of deceit, spin and cover up.

2.8 On the face of what patients and families saw, remedial actions were being taken repeatedly by the hospital in connection with the water supply, drains and ventilation. That work was carried out in plain sight of patients and their families, with no, or no proper explanation being provided to them about why it was that those remedial actions and procedures were being undertaken.

2.9 Evidence came from many witnesses about the lack of trust that they had in 'the hospital' and how that trust has been further eroded with the passage of time. The lack of trust issue was principally directed at GGC managers. Nevertheless, that also had the resultant effect of diminishing the trust and faith that patients and families so desperately required to place in the hands of their treating clinicians and nurses. That is a huge concern because it runs the risk of undermining the crucial bond of trust and confidence that should exist between a doctor or nurse and a patient or parent.

2.10 The lack or, in most cases, complete absence of any communication to parents was something that was entirely avoidable. It is frankly astonishing that an organisation as large and as experienced as GGC considered it appropriate to conduct itself in the manner described in evidence.

2.11 This part of the Inquiry illustrated the existence of a host of problems experienced by patients and parents on a regular basis and over an extended period. These included: showers that, due to draining problems, flooded through toilets, into bedrooms and out into the main hospital corridor due; windows (or glass panels) that fell out and dropped from height; cladding issues; blinds that wouldn't close; televisions and Wi-Fi that didn't work; insufficient plug points for equipment required for the administration of medication; heating that didn't work properly or at all; ventilation that was ineffective; sewage leakage; a stench of sewage inside and outside the hospital; fungal growth; and an inadequate cleaning system. These are issues that any home owner would not tolerate if caused by the conduct of their own nominated

contractors carrying out work at their own homes. As many parents commented, it is hard to comprehend how an organisation such as GGC could allow such hopeless, obvious and inexcusable problems to exist in a state of the art superhospital at all, let alone for as long as they did.

2.12 There are numerous unanswered questions identified in the evidence of the Core Participants that still need to be addressed by the Inquiry and answered by GGC as well as the Scottish Ministers.

2.13 These include:

- When at the earliest was it known or ought it to have been known (if at all) and by whom that there was a serious issue with the safety of the water supply at the hospital? If it was or ought to have been known about, by what means? Professor John Cuddihy gave evidence about the existence of three water safety reports prepared on behalf of GGC by DMA Canyon Limited in 2015, 2017 and 2018. None of those reports were available to Core Participants before or when Professor Cuddihy gave his evidence – where are the reports?[1]
- When at the earliest was it known or ought it to have been known (if at all) and by whom that there was an issue with the ventilation system at the hospital and its suitability to cater for immunocompromised patients? If it was known or ought to have been known, by what means? It is observed that: (i) Professor Cuddihy gave evidence pointing to the existence of a report prepared for GGC by Innovated Design Solutions Ltd in October 2018[2] – that report was not available to Core Participants before and when Professor Cuddihy gave evidence – where is the report?; and (ii) Mr Alfie Rawson gave evidence that he understood that, in July 2015, a problem was identified with the ventilation system in the adult bone marrow ward (4B) resulting in the decant of patients away from that ward[3]

[1] Witness statement of Professor John Cuddihy at Paragraphs 99 and 100; Evidence, transcript (26th October 2021 (am)) at Page 8
[2] Witness statement of Professor John Cuddihy at Paragraph 98
[3] Witness statement of Alfie Rawson at Paragraph 57; Evidence, transcript at Page 40

- What heed was paid to the concerns raised regarding the use of 'flow straighteners' on taps following studies carried out in the aftermath of the death of four neonatal babies in Northern Ireland hospitals in 2011/2012?
- Where is the evidence of the results of the tests, monitoring and surveillance of air and water quality that ought to have been performed at QEUH?
- Has there been a deliberate attempt to try to cover up the problems that were known about the hospital environment (drainage, water and ventilation) prior to and after the hospital opened? There must be full transparency as to what GGC knew about the problems or potential problems with the hospital before it opened and during the period since.
- At any stage, did GGC feed ambiguous or even false information to junior staff or healthcare professionals to disseminate to patients and parents with a view to alleviating concerns that were growing at the hospital?
- How much did the Scottish Government know about the concerns that were being raised about the environment before the hospital was opened and how much did they know during the period 2015 to 2019? If they were advised of problems, what did they do to address them?
- Ward 2A (The Schiehallion Unit and all that goes with it) remains shut. Why? When will it open? Patients and parents continue to demand information about when it will be available. They have been demanding this information for a long time. They do not know why it remains closed. Why are they told a date for opening and then it is not kept? Professor Michael Stevens advised one of the Core Participants that the ward was due to open later in the summer of 2021. It didn't. The patients and families have been asking this question for several years and it is something that they continue to be concerned about.
- There remains a requirement for patients and families to attend the hospital for treatment. Why has the hospital failed to address this lack of clarity even now when the Inquiry has heard the evidence of the parents and patients affected by the Schiehallion Ward's closure?
- It is understood that many of the child patients in Ward 6A are currently in isolation.

- What happens if, after this Inquiry, a child relapses and has to go back to the hospital for further treatment? Will they be treated worse? Will the child receive substandard care? How can this fear held by parents be allayed?

2.14 The evidence given by Core Participants confirmed and elaborated on some key areas and important issues for them:

- Patients and parents perceived that they were frequently kept in the dark about the problems with the water supply and ventilation at the hospital.
- Patients and parents were not informed about the cause of the infections suffered by them/their children, when it appears to be clear that the hospital knew (or ought to have known) that many of the infections were (or may have been) closely connected to the water supply, ventilation and drainage systems and an ongoing problem with vermin.
- There was a failure to obtain informed consent about the administration of drugs including the use of prophylactic antibiotics and their impact.
- Children suffered numerous line infections that caused additional surgery, suffering and delays in essential treatment.
- Patients and parents were told they had to use bottled water rather than the water from the taps, yet their children were still being showered in the same water that they were not being allowed to drink.
- Those who gave evidence feel that GGC must have known about the number of infections and perceive that there has been a failure to properly address the problems.
- When GGC ultimately closed ward 2A, the hospital did not appear to the parents to have a properly thought-through plan about how they would care for the child patients' medical and psychological needs as well as the needs of the parents and carers.
- The parents of the children affected have wanted and still want answers for what happened, what went wrong and why. They deserve answers.
- Many of them have lost all faith in the hospital itself as a safe place to treat their children.

2.15 While the Timeline[4] provided along with the Closing Statement by Counsel to the Inquiry runs to November 2020, the fact that problems are ongoing must not be lost sight of. As at the date of this Statement, it is understood that many patients are still inpatients in isolation on Ward 6A.

2.16 There is a fear that, despite the evidence that the Inquiry has heard to date, GGC and the Scottish Ministers have not listened and that things will remain the same.

3. The Closing Statement by Counsel to the Inquiry

3.1 The Closing Statement by Counsel to the Inquiry provides a detailed, accurate and thematic account of the evidence heard to date. It is comforting for those we represent to hear that all witnesses, including those whose evidence was given in closed sessions or was redacted, or those who simply provided statements, can rest assured that their evidence has been and will be carefully considered. It is understood and accepted that the content of the Statement is not to be treated as proposed findings in fact but, rather, a summary of witness 'perceptions'.

3.2 The Statement identifies and explores the importance of a number of key factors or themes:

(i) The dramatic and life-changing course of the cancer journey[5] and the importance of the Schiehallion Unit/Umbrella and all it offered to patients and families alike as they embarked upon that journey.

(ii) Infection – the most immediate risk to an immunocompromised patient – the evidence in connection with this theme was jaw-dropping, particularly when considered against the backdrop of a brand new hospital that was proclaimed to be 'state of the art'. The account given of the evidence and the observations made by Counsel to the Inquiry in analysis at Theme 10 of their Closing Statement is accepted as accurate. That account (see: Page 66 and following at Paragraphs 192 to 198 and Appendix 3 commencing at Page 116) and additional observations are adopted wholesale and includes the following:

[4] Appendix 2 commencing at Page 106 of the Closing Statement by Counsel to the Inquiry
[5] Page 16 at Paragraph 25 and following

"But two things should be noticed about (the witnesses') perceptions. ***The first is the sheer volume of evidence on this subject provided by witnesses. Appendix 3 to this submission lists families from the present group of witnesses who raised a concern about the impact of an infection or infections upon their child. A perceived link (or the possibility of a link) between an infection and the hospital environment was raised in the case of some 25 patients…It is further to be recalled that this cohort may simply be a subset of a wider body of evidence…The second point to be made is as follows. No medical evidence was led in relation to any of the infection incidents referred to in evidence****"*[6]

(iii) Trust – whether speaking of trust in clinical care, or in the processes and procedures of that care in the hospital environment, or in those responsible for providing and managing that environment – *"trust is a – and perhaps the – necessary ingredient if patients and families are to take the first step of the journey and keep going…"*[7]. Trust was eroded and, insofar as trust in GGC is concerned, has ended up grossly diminished.

(iv) Communication about hospital related issues (including water, drainage and ventilation) – it is observed in the Statement that: "*Not a single witness identified a good example of communication by managers in relation to the perceived issues with the hospital building or infection risk. This contrasted with communication from doctors and nurses about clinical care. This was mostly considered to have been exemplary. But for many patients and families, communication about the building was communication about clinical care. Universally, it was considered to have been lacking. Responsibility for that was said to lie with (GGC) management.*"[8] Who else would or ought the responsibility for communication start and finish with? Is their merit in the perceptions of patients and families that communication with them was not the priority of GGC managers? Is it appropriate for the media to have been the first port of call of GGC managers? Did GGC managers react to press

[6] Page 67 et seq, Paragraphs 192 to 195
[7] Page 17 at Paragraph 28
[8] Page 8 at Paragraph (xviii)

coverage in a protectionary fashion rather than communicating candidly and transparently with the patients and families under their care? The Statement also provides: "*The combined effect of a lack of information and clinical staff being left to field questions appeared to put a strain on relationships between parents and staff. Parents were frustrated by the lack of information and staff were "burnt out". One witness perceived that some parents were being provided with more information than others; information was only provided to those who pushed for it and she simply did not have the energy. More than one witness recalled nurses encouraging parents to go to the press to try to get answers. Some witnesses queried why they had to fight for information relating to the hospital environment when the fight they should have been focussed on was against cancer?...The overall tenor of the evidence was that communication failures at the very least contributed to a fracturing of trust between patients and families on the one hand and "the hospital" on the other. When asked how they felt about the hospital now, the response from witnesses was universally negative. Many expressed dread at the thought of returning. That dread was not directed at the care provided by clinical and nursing staff but at the perceived risks posed by the hospital environment to patients. That in itself indicates that the concerns of patients and families persist and that communication from GGC, or elsewhere, has not allayed or managed those concerns.*"[9] We agree. It is our position that there is no evidence to suggest that that culture has changed despite the nature and quantity of the evidence heard by this Inquiry.

(v) Lack of candour – this theme overlaps with the themes of communication and trust. We accept as accurate and adopt what is said at Paragraphs 240 to 251 of the Closing Statement by Counsel to the Inquiry. A clear explanation for the way in which GGC told patients the story of the hospital is called for. Were patients and families misled in relation to concerns they had about and problems associated with key systems including drainage, water supply and ventilation? Based on what they knew, did GGC managers

[9] Page 87 at Paragraphs 254 and 255

fail to provide patients and their families with a candid and accurate account of the issues with the hospital building and the risk of infection posed to them in consequence? Those whom we represent are entitled to an answer to that question.

(vi) The vast majority of witnesses did not criticise the frontline clinicians and nursing staff responsible for their care or that of their children. Indeed, Core Particpants were at pains to point out before they concluded their evidence that the issues they had (particularly involving communication, trust and candour) were with GGC managers. We accept as accurate and adopt all that Inquiry Counsel observes at Paragraphs 253 to 255 of their Statement.

4. The Glasgow Questions

4.1 In the Closing Statement by Counsel to the Inquiry, three 'Glasgow Questions' are posed. Each is addressed in turn:

1. **Do Core Participants accept that in the above summary, and in what follows, this closing statement accurately sets out the accounts given by witnesses (and if not can they identify where)?**

   Ans: Yes. Those whom we represent accept that the summary and what follows in the Closing Statement by Counsel to the Inquiry accurately sets out the accounts given by witnesses.

2. **At this stage, are Core Participants able to identify any areas of the narrative provided by the patient and family evidence that is capable of agreement?**

   Ans: This seems to us to be a matter for other Core Participants to address and, in particular, GGC and the Scottish Ministers.

3. **On the particular question of infection risk, are Core Participants able to say whether they consider that there is evidence that either establishes or indicates links between infections and the built hospital environment?**

Ans: This requires a detailed examination of each patient's medical records and some input from medical experts in order to show that there was/is an evidentially proven causal link between the infections and the hospital environment. Given that this part of the Inquiry was about hearing the perceptions and experiences of patients and their families, this type of evidence is simply not yet available. It is a matter for the Inquiry to investigate and seek expert evidence that either establishes or indicates a link between the infections suffered and the problems with the water supply, ventilation system, drainage and vermin. Some of the children's infections were investigated as part of the Review carried out by Professor Stevens. However, many parents found the process and findings unhelpful, unclear and in one case deeply distressing.

The Closing Statement by Counsel to the Inquiry includes the following: "*The Inquiry has been provided with a substantial body of evidence said to indicate the possibility of links between serious patient infections and the built hospital environment. Some of that evidence proceeds on the basis of suspicion: links between infection are suspected or assumed to exist because of circumstantial evidence thought to support those links. That circumstantial evidence includes the various issues with key building systems already discussed; and it includes perceived increases in the incidence of line infections. (xiii) But not all the evidence of possible links between infection and hospital environment can be said to be based only on suspicion or assumption. Several witnesses say that they were told either by clinical staff or via reports provided by the Case Note Review ("CNR") that the possibility (at least) of a link had been established.*"[10]

[10] Page 7 at Paragraph (xii)

The careful and entirely appropriate use of the words ‘possibility’, ‘suspicion’, ‘suspected’, ‘assumed’, ‘circumstantial evidence’ and ‘perceived’ only goes to highlight the unacceptable and persisting lack of information provided to patients and families.

The circumstantial evidence points very strongly towards there being a link between infections developed by patients and the hospital environment.

The findings of the Case Note Review Overview Report dated March 2021 (‘the CNR Overview Report’) were critical of GGC in respect of: failure to provide access to data; the time taken to produce data about microbiological surveillance of the hospital environment and the extent of building, repair and maintenance work that took place in relevant clinical areas during the period of review; GGC’s failure to establish an electronic database of microbiological typing results (a key strategy in the ability to link bacteria identified in one person or place with that from another person or place) with the result that the Overview Board had no ability to easily relate potentially linked bacterial isolates, and this despite over five years of experience in investigating outbreaks of Gram-negative environmental (‘GNE’) bacteraemia and concerns about the hospital environment; the result was that the Overview Board concluded that it was, in consequence, unable to interpret the true extent of relatedness between patient and environmental isolates, even with the provision of some data using state of the art Whole Genome Sequencing methodology.

The CNR Overview Report determined, among other things, that: 84 children and young people between them experienced 118 episodes of infection which fulfilled the criteria set for inclusion in the review (not all cases fulfilled the criteria); the great majority had a diagnosis of cancer or leukaemia but a small minority had other forms of serious blood disease or another condition requiring the expertise of a haematologist or oncologist; while eight episodes were unrelated to the hospital environment, and in one case they were unable to

determine the relationship, of the rest, 76 (70%) could possibly relate to the hospital environment and 33 (30%) probably did; they were unable to identify evidence that unequivocally provided a definite relationship between any infection episode and the environment and there were complex reasons for this which are discussed in more detail in the body of the report; in the absence of a definitive link to the environment, they nevertheless felt the possibility of a link remained strong; they grouped episodes they had defined as 'Strong Possible', 'Probable' & 'Strong Probable' into a single group which they felt might reasonably be considered to be 'Most Likely' linked to the environment – this constituted 37 (34%) of all episodes and included an excess of one particular bacterium (Stenotrophomonas); there was also an increased likelihood that the infections constituting the 'Most Likely' group had occurred in 2018 and this may well have been related to the particular excess of Stenotrophomonas bacteraemias in that year.

The individual Case Note Reviews relating to the infections acquired by the children of Kimberley Darroch, Witness 1 and Denise Gallagher found that those infections were probably related to the hospital environment.

The individual Report from the Independent Expert Panel relating to Milly Main's infection dated 15th April 2021 states, among other things, that: "*Based on the information available to us we considered that this infection (Stenotrophomonas) was Probably related to the hospital environment. Factors in our decision included the clustering in time and space with another case (which occurred 10 days earlier in the same ward). The fact that Milly had been continuously in inpatient Ward 2A for 7 weeks prior to this infection, also suggests hospital environmental acquisition…*". There was, however, insufficient data to identify a specific source. The Independent Expert Panel concluded that, on balance, the Stenetrophomonas infection acquired by Milly must have made a contribution to her deterioration. The causes of death recorded on Milly's Death Certificate dated September 2017 included "*Multi*

System Organ Failure Possibly Due to Line Sepsis Due to Stenotrophomonas Maltophilia".

As Counsel to the Inquiry observes, many witnesses reported a high incidence of vermin (pigeons) on the QEUH campus and a high level of pigeon droppings. The link, if any, between the vermin reported and the water treatment plant is presently unknown.[11]

Further detailed inquiry and investigation, including expert medical opinion, is merited. The Inquiry should seek independent expert medical opinion on the nature and impact of the treatments and procedures typically used in treating cancer but should also, in the absence of any candid and detailed disclosure of evidence by the hospital, obtain independent expert medical opinion from medical experts with expertise in the areas of microbiology, infectious diseases and epidemiology about the likelihood of there being a link between the infections developed by patients and the hospital environment.

Within the medical records provided by the hospital to patients/families (not produced in evidence to the Inquiry), there are minimal laboratory results and it is hard to form a timeline of events from a patient's records. This has allowed families to come to the conclusion that there is information that is being deliberately withheld from them about the infections suffered by them/their children/loved ones.

This is, we are advised, an ongoing problem. For example one Core Participant whom we represent discovered, after reading her son's medical records, that he had contracted Aspergillus. She recently went to an appointment at the QEUH and was approached by a Consultant who spoke to her about the evidence she had given to this Inquiry. The Consultant advised that what she had said in her evidence was 'wrong' and that it states in her son's medical records that he had

[11] Page 34 at Paragraph 84

a ‘false positive’ result for Aspergillus. This is not something that she had previously been told, whether verbally or in writing. Most importantly, it is not recorded in the medical records for her son that she received from the hospital. It has caused significant upset and begs an explanation.

If those whom we represent are going to be challenged by personnel at QEUH about the evidence they gave before this Inquiry and on the basis of the content of medical records that have not been seen/produced, then that is, of course, entirely unacceptable.

If infections are not accurately recorded in a set of medical records, it creates a false picture about what was going on overall.

It is liable to further undermine trust.

Further inquiry is merited.

5. The Edinburgh Questions

5.1 In the Closing Statement by Counsel to the Inquiry, two ‘Edinburgh Questions’ are posed. They are addressed in turn:

1. **Do Core Participants accept that in the executive summary, and in what follows, this closing statement accurately sets out the accounts given by witnesses (and if not can they identify where)?**

Ans: Yes. Those whom we represent accept that the summary and what follows in the Closing Statement by Counsel to the Inquiry accurately sets out the accounts given by witnesses.

2. **At this stage, are Core Participants able to identify any areas of the narrative provided by the patient and family evidence that is capable of agreement?**

   Ans: This seems to us to be a matter for other Core Particpants to address and, in particular, GGC and the Scottish Ministers.

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 It remains the hope of those whom we represent that this Inquiry will go towards:

(i) Learning lessons about the protection of patients and the families of patients who rely on the NHS for safe and appropriate treatment. Why did they experience what they did? What could have been done to prevent those experiences? What can be 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. Recent Developments

7.1 On 26th November 2021, GGC released a statement on their closed Facebook group page in the following terms:

> "*We are sure that you will be aware of recent claims in Parliament and negative stories in the media, and we know that this is bound to be distressing and worrying for you, as it is for our staff.*
>
> *However, despite the inflammatory claims that have been made, we would like to reassure you that our priority is the safety, care and wellbeing of our young patients and their families.*
>
> *All our wards offer a safe clinical environment, where your child continues to receive the very best of care from highly skilled, experienced and dedicated staff.*
>
> *As you would expect, our focus is on providing your child with the best possible care and we are constantly reviewing our care, treatment, processes and procedures with a view to continually improving the environment in which our young patients are cared for.*
>
> *You can have confidence that we will never waver from that commitment to your child.*
>
> *We will keep you updated if this issue develops further but, as ever, if you have any questions, about your child's care or any other issues which might concern you, please do not hesitate to contact us.*"

7.2 This is taken, perhaps wrongly, to include reference to recent media coverage and questions in the Scottish Parliament relating to the circumstances surrounding the death in December 2020 of Mr Andrew Slorance, the then head of the Scottish Government's Response and Communication Unit.

7.3 His widow, Mrs Louise Slorance, appears to have raised concerns about an Aspergillus infection contracted by her late husband while he was being treated at the QEUH. This Inquiry has not, as yet, heard evidence surrounding the circumstances of Mr Slorance's treatment and death and it may yet do so. At First Minister's Question Time on 25th November 2021, the First Minister confirmed, among other things that: serious concerns had been raised by Mrs Slorance; those concerns required full and

proper investigation; the Government had taken further action; she had written to Mrs Slorance confirming the initial actions that were being taken, including an independent review of Mr Slorance's (medical) case notes; and Healthcare Improvement Scotland had been asked by the health secretary to carry out a wider review regarding the more general concerns about Aspergillus infections at the QUEH.

7.4 GGC's Facebook statement has caused anger and upset to those whom we represent and others who have recently indicated a desire to seek Core Participant status in this Inquiry.

7.5 The content of GGC's Facebook statement is inconsistent with and runs contrary to the evidence heard by this Inquiry. It demonstrates, not for the first time, a lack of appreciation of or consideration for the distress and anxiety that release of such a statement might cause. Those who gave evidence to this Inquiry did so to the effect that they have been pressing GGC for answers and information in connection with many issues, in some cases for years, without receiving any let alone a satisfactory response.

7.6 They find the GGC statement insensitive, objectionable and justification for their fear that, despite the evidence that the Inquiry has heard to date, GGC have not listened and that things remain and will remain the same.

8. Conclusion

8.1 Those whom we represent are trusting that the Inquiry's investigations will demonstrate that it was/is not simply 'perceptions' that they had/have.

8.2 Parents who have provided statements and/or evidence to the Inquiry have found the whole process to be reassuring. It has been a clear demonstration of the Inquiry's commitment to exploring and discovering the truth.

8.3 We are committed and look forward to working further with the Inquiry Team in this and subsequent substantive hearings, knowing that those we represent will, perhaps for the first time, see full investigation based on transparency, respect, trust and honesty.