SCOTTISH HOSPITALS INQUIRY

SCOTTISH HOSPITALS INQUIRY

Hearing Commencing
20 September 2021

Bundle 1 - Written Opening Statements Submitted to the Inquiry

SCOTTISH HOSPITALS INQUIRY

Table of Contents

THE SCOTTISH HOSPITALS INQUIRY

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

---

1. Introduction

1.1 My name is Steven Love QC and I appear along with my learned friend, Mr Gavin Thornley, on behalf of the 54 core participants who are represented before this Inquiry by Messrs Thompsons, Solicitors.

1.2 Those whom we represent are either patients, parental representatives of the patients or immediate family members of the 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. They formed the campaign group "Families for Healthy Hospitals" which greatly influenced and framed the Terms of Reference for this Inquiry

1.3 On behalf of those whom we represent we thank the Chair for affording us the opportunity to make this opening statement on behalf of them.

1.4 As will become clear, their children were admitted to hospital for treatment for serious illnesses such as leukaemia and other cancers and they reasonably expected that the best possible medical care and treatment would be provided for their children in a suitably safe and clean hospital environment. What they in fact faced was a catalogue of problems as a result of the hospital environment, the hospital water supply and the conduct of medical staff there.

1.5 The Queen Elizabeth University Hospital was supposed to be a state of the art or 'super' hospital with enough beds to hold in excess of 1,600 patients. It opened for patients in April 2015. The evidence from the parents and representatives which you

will hear lays bare the truth about their experiences of the circumstances surrounding the treatment of their loved ones at that hospital.

1.6 A significant number of children suffered infections during the course of their treatment at the hospital and, tragically, several of those children died as a result.

1.7 In recent times we have read detailed and lengthy statements taken by the Inquiry Team from those we represent and they paint a harrowing picture.

1.8 It seems from what is said on those statements that parents were frequently kept in the dark about the problems with the water supply and ventilation at the hospital. They were not informed about the cause of the infections suffered by their children, when it appears to be clear that the hospital knew that many of the infections were closely connected to the water supply and ventilation systems.

1.9 There was a lack of candour and a failure to obtain informed consent about the administration of drugs including the use of prophylactic antibiotics and their impact. 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. They were reassured by staff that it was acceptable to shower their child in the water and then let them brush their teeth in it.

1.10 There were significant numbers who suffered infection from 2017 onwards and of which the hospital must have been, or it seems was, aware.

1.11 The parents of the children affected want answers for what happened, what went wrong and why. Many of them have lost all faith in the hospital itself as a safe place to treat their children.

1.12 This Inquiry will, we hope, go towards:

(i) Establishing the truth of what happened and why

(ii) Bringing any past and ongoing wrongs to light

(iii) Learning lessons about the protection of patients and the families of patients who rely on the NHS for safe and appropriate treatment

(iv) Exploring the duty of candour owed to patients and their families

(v) 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

1.13 The core participants appreciate the extent to which the Chair has made it clear that the stories of parents and representatives should be heard at the outset of this Inquiry and they welcome the opportunity to be able to speak about what, for many of them, has been a hugely traumatic period in their lives and that of their children.

1.14 They have been invited to identify and describe any particular problems that they encountered and to talk about the emotional impact on them and their children. There are accounts of parents being left with long-standing emotional illnesses as a result of their experiences.

1.15 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 to be more stressful, traumatic and upsetting by the conduct and circumstances at the hospital itself. Parents could not believe that the hospital environment was, as far as they were concerned, making their already sick children more ill. For many of them whose child had leukaemia, the infections were worse than the cancer itself.

1.16 In this Opening Statement I would like to address:

(i) The purpose of this Public Inquiry and its Terms of Reference

(ii) The clients and their experiences

(iii) The physical and emotional effects on child patients and their families; and

(iv) Expectations and the future

2. The purpose of this Public Inquiry and its Terms of Reference

2.1 The Inquiry has been set up and its terms of reference have been fixed.

2.2 The Inquiries Act 2005 within which it will be conducted affords room for interpretation of what the Inquiry is meant to achieve, what kind of Inquiry it seeks to be. Useful Guidance can be obtained from a House of Commons Briefing Paper entitled Statutory Commissions of Inquiry: the Inquiries Act 2005 (30 January 2018, number SN06410). This suggests that a public inquiry, such as this, may serve a number of purposes. We think that these objectives merit some consideration as we start this opening part of the Inquiry.

2.3 It is recognised that there will be further substantive hearings in due course dealing with the remaining Terms of Reference and we reserve the right to make an opening statement, if advised, at the commencement of those hearings.

2.4 The relevant facts must be established.

2.5 We expect the Inquiry to ensure that the relevant facts are fully and fairly investigated without fear or favour. Those relevant facts will be exposed to public scrutiny.

2.6 Core elements of the evidence in this opening substantive hearing will come from patients and families. They will be asked to identify and describe any particular issues or problems they encountered during the course of treatment at or involvement with the hospital.

2.7 A purpose of a Public Inquiry such as this is to achieve accountability, blame and retribution.

2.8 Those whom we represent are aware that both individuals and organisations are responsible for what has happened to them. They wish to see truth and to see justice done for themselves and for their loved ones. They wish those individuals and organisations to be held accountable for what they have experienced and had to endure.

2.9 It is accepted that a fundamental purpose of this Inquiry is for the experiences of and consequences for those whom we represent to be heard and heeded. They need and deserve to be listened to.

3. The clients and their experiences

3.1 At the Procedural Hearing on 22nd June this year, Counsel to the Inquiry made it plain that he intended to begin the substantive hearings by hearing and recording the evidence of patients and their families. He did so indicating that, as a starting point, the focus would be on Term of Reference 8.

3.2 Term of Reference 8 requires this Inquiry: "To examine the physical, emotional and other effects of the issues identified on patients and their families (in particular in respect of environmental organisms linked to infections at the QEUH) and to determine whether communication with patients and their families supported and

respected their rights to be informed and to participate in respect of matters bearing on treatment."

3.3 It seems to us that it is entirely right and proper to the open the substantive hearings in this Inquiry with the evidence of patients and families as the starting point. It is crucial to those whom we represent that questions in connection with issues that are important to them as individuals are asked and answered.

3.4 Their stories and their perceptions of what happened to them and their loved ones is an appropriate starting point. This is entirely right and proper and will allow the Inquiry to ingather the evidence of patients and their families with a view making use of it in the Inquiry's further investigations.

3.5 The individuals whom we represent come from all walks of life, all social classes, all backgrounds and all age groups. Although their stories are different, they are united by some common themes that I will turn to in due course.

3.6 They required to seek medical care for their ill, vulnerable children when they needed it most.

3.7 They all put their trust and faith in the NHS. They trusted the doctors and nurses to whom they turned. They trusted their expertise and honesty. They trusted that their loved ones would receive the best care available in a safe environment.

3.8 It seems, from the statements that we have had the opportunity to review, that they were let down.

3.9 They have been left with their faith and trust in the NHS shattered as a result of poor communication, evasiveness and a lack of openness, candour and honesty.

3.10 They want answers. Why did they experience what they did? What could have been done to prevent those experiences? What can be done to ensure that nothing like it ever happens again?

3.11 Patients and their families ought to have been protected, involved and given informed choices. They ought to have been told the truth.

3.12 The Inquiry will hear that they were not.

3.13 The impact of what they experienced has to be understood and appreciated. This Inquiry needs to provide an opportunity for individuals' stories to be told. Those we represent plainly need that to happen for them to be able to move on.

4 The physical and emotional effect on child patients and their families

The Inquiry must pay attention to the following issues:

Problems with the water

4.3 Parents will be giving evidence to the Inquiry about the problems with the water supply at the hospital. They will tell the Inquiry about how they were told not to use the water from the sink taps in the children's rooms for drinking and how bottled water was supplied by the hospital. The children were hooked up to lines providing lifesaving treatment and medication for them. These lines became infected on numerous occasions. Children were put on antibiotics and in many cases the parents were not advised that their child was going to go on an antibiotic regime before it commenced.

4.4 Nursing staff were blamed for the infections.

4.5 Parents were blamed for bringing infections into the hospital.

4.6 The parents could see that they were not allowed to drink the water, but they were not told why not. They still showered their children in the same water, which their children and them were not allowed to drink. Filters were placed on the taps in the child's bedrooms and on the showers but, if the child was moved to another ward, the filters were sometimes not present. Parents and children watched as staff poured substances down the sink and the drain in the showers. Children became seriously ill from certain types of infections which the hospital knew or ought to have known were closely connected to the water supply in the hospital. It is a tragedy that some children died and that others were pushed close to that as a result of the infections they suffered. Many more children suffered severely as a result of the infections. That suffering was over and above the suffering caused by the very difficult medical treatments they were having for cancer and other serious illnesses.

4.7 Nursing staff and the doctors were aware of the infections and the link with the water supply, but there was almost total failure to explain the situation to parents. When this did happen it was through guarded conversations with nursing staff who were clearly in fear of risking their own positions. That sort of pressure on nursing staff can only have come from those in senior management at the hospital. Unless and until the hospital provides an explanation to this Inquiry, the parents have quite

understandably assumed that the hospital knew about the water supply problems for some time before the infections started and failed to do anything about it. This has undermined the faith of the parents in how the hospital cared for their child and them.

Ventilation

4.8 It is a common thread in the stories of the parents that the bedrooms were far too hot or sometimes far too cold.

4.9 The temperature controls did not work properly or at all in many cases. Fans were provided in the rooms by a charity which helped to some extent until one day they were all suddenly removed. The rooms occupied by child patients were hot and stuffy.

4.10 After the patients were moved to Ward 6A of the adult hospital, air filter machines appeared on the ward and then were placed into the bedrooms of the children. Mould had been found in the bathrooms. The doctors and microbiologists appeared to be concerned about the risk of infection and the potential for adverse effect on transplant patients. It seems that one parent was told that the filters were placed in the bedrooms with a view to trying to disperse the spores coming from the mould and thus reduce any contamination. This state of affairs for what is supposed to be a “super clean” environment shocked parents.

4.11 There was a strong smell of sewage on entering the hospital and in the bedrooms on the wards. The smell of excrement was not constant but would come in waves. It was nauseating for the both children and their parents. It was to the point that it could be tasted and not just smelt.

4.12 The showers in the bathrooms attached to the bedrooms did not have proper ventilation.

Cleanliness

4.13 The bedrooms were only cleaned once a day by cleaners.

4.14 This was seen to be in contrast to the rooms being cleaned three or four times a day at the ‘old’ children’s hospital at Yorkhill. The rooms at the new hospital were cleaned quickly involving a quick mop and wipe. The same cleaning equipment was

used from room to room with no attempt to control the risk of infection transmission between the rooms. Parents frequently cleaned the rooms themselves.

4.15 Soiled nappies and bowls of vomit and stained bedding were left for long periods at a time in the rooms and the bathrooms.

4.16 There were no obvious attempts by the hospital staff to keep the rooms, including the staff/parent kitchen, spotlessly clean and disinfected.

4.17 The impression was that the bare minimum was carried out in terms of cleaning the rooms and the wards. The small number of cleaners and the reduced cleaning rota from the previous children's hospital must have resulted from a decision of someone in senior management at the hospital. It is hoped this Inquiry will provide some answers and explanations for the parents.

4.18 Parents frequently cleaned the rooms themselves, because they were so concerned about the state of the cleaning process they were witnessing on a day to day basis.

Drainage

4.19 The showers in the bathrooms of the bedrooms did not drain away properly and the floors became flooded frequently so that towels had to be used by the parents to try and dry the floor and stop waste water from spilling into the bedrooms.

4.20 Regularly there was a stench of sewage in the bedrooms.

4.21 One of the senior consultants advised the parents that there was a problem with the drains.

4.22 On one occasion sewage was seen coming up through the tiles in the area of the atrium of the hospital.

Communication

4.23 Individually the parents felt that they were kept in the dark about the reasons why their children were getting infections. There was a lack of understanding of what the parents and the children were going through. The level of communication from the doctors and nurses about what was happening with their individual child and how the issues with the hospital were adversely affecting was felt by the parents to be very

poor. Parents felt they were talked to in a condescending manner if they asked questions or queried what was happening.

4.24 The lack of transparency and openness about the problems with the water and ventilation in the hospital completely undermined the trust and confidence that the parents should have been able to have in the treatment, the medical staff and the hospital.

4.25 There was no proper explanation from the hospital staff about the reason for the sudden closure of ward 2A and 2B. This was against a backdrop of increasing numbers of infections amongst the children and worries over the water supply and the drainage. Again there was no proper explanation when air filter machines were installed in the ward the children were moved to.

4.26 Although some parents did receive a generic letter providing notification, some parents found out about the closure of ward 2A and B through the media and social media and not through the hospital - a total failure of communication with the parents of the children. There were instances of parents turning up for treatment with their child and finding the ward empty and full of workmen. As a result of the breakdown in communication from the hospital the parents relied on information from the media about what was happening at the hospital.

4.27 Children were given antibiotics as a preventative measure without any explanation to the parents as to why this was happening. When questioned about this there are examples of parents being told that it was for their cancer treatment or for an underlying problem, which has been shown to be false. This gives the impression of institutional lack of honesty.

4.28 There appears to have been no attempt by the management at the hospital to keep the parents informed about the ongoing problems, which clearly adversely affected their child.

4.29 When the media became aware of the severe problems at the hospital, parents were quizzed by staff to try and find out whether they had communicated with the press. This created a bad atmosphere when the focus should clearly have been on the medical treatment of the children. The parents felt intimidated by the manner in which they were treated.

4.30 It seems that Facebook pages were monitored for criticism. Parents frequently had to rely on the press to provide updates.

4.31 Confidential information about the treatment and death of one child appears to have been passed to the media by a member of staff at the hospital. The parents complained to the hospital, but there has been a failure to fully inform them about the outcome of that investigation and explain how and why it occurred. This type of breach of confidentiality and trust surely demands a level of interaction with the parents that the hospital has not even come close to.

4.32 There has been a failure to take responsibility for what has happened. This is illustrated by some of the statements highlighting examples where the parents and family members felt that they were being blamed for introducing infection onto the wards. Blame was also placed on the cleaners for the infections.

Facilities

4.33 Televisions in the bedrooms did not work properly. There was no consideration of the emotional impact of children being isolated in their bedrooms for days on end. There were insufficient play rooms and areas where the children could escape from their bedrooms. This became particularly acute after the move to ward 6.

4.34 There was no apparent consideration or effort to provide facilities for the different age groups of children which meant that the needs of certain age groups of children were largely ignored.

4.35 Following the move to ward 6 the facilities for the parents were very poor. There were no kitchen facilities for the parents who had to rely on staff for assistance. If their child needed a drink of milk, they had to ask staff and wait. Often the requested item wouldn't come or it would be the wrong item because staff were so busy. Parents couldn't leave the bedrooms in 6A because of infection control. The level of cleanliness was low. No thought seems to have been put into the welfare of the parents who were staying with their child 24/7.

Duty of candour

4.36 There have been cases identified of a lack of candour and honesty by doctors, including one of failing to inform parents that one of the principal causes of death of their child was infection acquired during treatment at the hospital. This has led to the impression of an attempt to hide or cover up the infection and the likely cause.

4.37 Underlying much of the treatment of children and parents at the hospital is a failure to properly advise the parents about the treatment of their child and the reasons for that. This goes to the heart of the relationship between doctor and patient. It highlights the lack of respect for the rights of the patient and their parents to be properly informed and for consent to treatment, including administration of drugs to child patients, to be informed and properly obtained.

4.38 The Inquiry ought to give consideration to the issues of patient autonomy and the risks posed by a 'doctor knows best' paternalism. Many of those whom we represent were made to feel stupid or overanxious.

Complaints

4.36 The statements indicate that there have been numerous issues about complaints made by parents that have on many occasions been ignored or overlooked by the hospital. Given the severity of the situation, particularly over the period in 2018 and 2019, the parents did not feel that their complaints were being listened to. That is a fundamemtal part of the process and the failure of the hospital to properly address the complaints of the parents is something that needs to be answered during the course of this Inquiry.

The statements of the parents cover a number of other issues that includes the following:

Refusal or delay to provide medical records.

Staffing levels for both nursing and cleaning staff appearing to be inadequate for nursing care and cleaning.

Provision of medication, which includes examples of over or under dosing of patients as a result of staff being too busy with room moves which has led to painful consequences for the child patient.

Physical construction issues, such as mould in bathrooms, windows falling out at the from of the hospital and part of the roof falling off.

Internal bedrooms facing onto the atrium being noisy at night and too bright seriously impairing sleep of the child and parents with them in the rooms

Funding applications for treatment being ignored and contradictory advice.

5 Expectations and the Future

5.1 As stated above, it is appreciated that further substantive hearings will be held in due course focussing on the terms of reference and issues such as the construction of the hospital and its associated amenities.

5.2 This Inquiry must focus on past events with an eye to the future.

5.3 It should be recognised that decision making must be understood from a patient's perspective.

5.4 Those whom we represent have fears for the future. What happens if after this Inquiry their child relapses and has to go back? Will they be treated worse? Will their child receive substandard care? How can this fear be allayed?

5.5 There must be transparency as to whether senior members of the NHS Board were feeding ambiguous or even false information to junior staff to disseminate to patients and parents with a view to alleviating concerns that were growing. Was there a deliberate cover up?

5.6 There must be investigation into the response of the NHS Board and Scottish Government to the concerns that were raised about the operation of the hospital.

5.7 Public confidence requires to be rebuilt or restored and that can only be achieved if matters are fully, properly and openly investigated.

5.8 The public requires to be reassured that lessons can, have been and will be learned.

5.9 There requires to be a specific apology in due course for what went wrong and the consequences.

5.10 Healthcare professionals need to be reassured. They should be encouraged to feel able to voice concerns without fear of repercussion.

6 Conclusion

6.1 The 54 individuals who have asked us to represent them have engaged with this Inquiry process with confidence that it can, and the hope that it will, deliver on its terms of reference and meet their objectives. If the Inquiry is not about them, and people like them from all over Scotland, who is it about and who is it intended to benefit?

6.2 Parents who have provided statements 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. They have found that the statement takers and witness engagement team have been supportive and kind, have given the families the time and space they need to discuss the most traumatic events in their lives and have ensured that statements have been all-encompassing. For that we are very thankful to the Inquiry Team and the empathy and understanding shown by them in the course of their investigation.

6.3 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, transparency, respect, trust and honesty.

We are grateful for the opportunity to make this opening statement.

WRITTEN SUBMISSIONS FOR MOLLY AND JOHN CUDDIHY

TO THE SCOTTISH HOSPITAL INQUIRY

SEPTEMBER 2021

INTRODUCTION

On 24th January 2018 Molly Cuddihy was diagnosed with Metastic Ewings Sarcoma of the rib at the age of 15 years old. At the time of diagnosis the tumour had spread to Molly's lungs and to one of her vertebrae. Shortly after diagnosis, on 27th January 2018, Molly commenced a course of highly immunosuppressive chemotherapy which was delivered to her as an inpatient in Ward 2A of the Queen Elizabeth University Hospital/Royal Hospital for Children (hereinafter QEUH/RHC). Wards 2A and 2B of QEUH/RHC are known as the 'Schiehallion Unit'. QEUH and RHC are operated by NHS Greater Glasgow and Clyde. Molly attended as an inpatient to receive chemotherapy throughout February, March, April and May 2018. On or about 13th April 2018 Molly attended ward 2B for platelets and a blood transfusion. Molly had a raised temperature, a C-Reactive Protein Test of 201 and severe throat pain. Molly experienced septic shock and required fluid resuscitation a number of times. She rigored. On 14th April 2018 she was transferred to Ward 2A room 6. Testing did not reveal the source of infection. Molly was discharged on 20th April 2018. In early May 2018, Molly was admitted to Ward 2A, room 17, with fever but cultures were negative and she received a course of antibiotics. Following discharge home, Molly's fever reoccurred and she was readmitted on 9th May 2018. Cultures were again negative. A thrombus was identified in one of the large veins at the top of Molly's chest associated with her central line (CVL). This was treated with an anticlotting drug and on 16th May 2018 further blood cultures were taken before Molly was discharged home on 17th May 2018. On 30th May 2018 Molly became very unwell and on 31st May 2018 she was admitted, as an emergency patient, to Ward 2A with febrile neutropenia requiring multiple fluid bolus and IV antibiotics. Molly started to rigor. A saline bolus was administered via her central line with a second and third saline bolus subsequently

administered. A new intra venous canula (IVC) was inserted into Molly's left hand. Blood cultures that had been obtained from Molly's CVL on or about 16th May 2018 were identified as mycobacterium chelonae. Mycobacterium chelonae is a hospital acquired infection. On 1st June Molly's CVL was removed. Triple IV therapy involving imipenem, amikacin and clarithromycin were administered for 3 weeks, following which clarithromycin was discontinued because of concerns that prolonged use could cause changes to electrical activity in the heart, with a risk of abnormal heart rhythm. Despite the treatment ceasing, Molly developed an abnormal heart rhythm. A new CVL was inserted on 13th June 2018 to support Molly's ongoing treatment and chemotherapy. On or about 15th June 2018, Molly received her first cycle of VAI chemotherapy. Following cessation of intravenous antibiotics on 22nd June 2016, Molly was advised that she required a further five months of oral antibiotics. Molly was discharged on 29th June 2018. Molly continued to take oral antibiotics and undergo cancer treatment during day care attendances and inpatient admissions. From 26th September 2018, Molly was no longer admitted to ward 2A, as both wards 2A and 2B had been closed as a result of the incidence of hospital acquired infection amongst patients. Molly was scheduled to undergo surgery to remove her originally infected rib and two final sessions of chemotherapy in October 2018. Molly was admitted to Ward 3A at the QUEH/RHC on 18th October 2018. Her temperature was taken on admission and was normal. She was shaking that evening and was given a sedative. Contrary to Schiehallion patient protocol, which should be implemented for child patients regardless of where they are being cared for, Molly's temperature was not monitored overnight. At the final pre-surgical checks the next morning Molly's temperature was taken and shown to be 40 degrees. The anaesthetist advised that Molly's surgery could not procced. Molly was started on antibiotics, namely gentamycin, tobramycin, tigacycline, and ciprofloxacin. After a period of time, she was prescribed oral azithromycin and clofazimine. In addition, due to ongoing issues with water, other antibiotics were given, namely co-trimoxazole prescribed as a prophylaxis. Molly remained in hospital for the following two months. Her chemotherapy and surgery had to be delayed. Mycobacterium chelonae was again isolated from cultures take on 19th October 2018. A new central line was inserted

on 31st October 2018. This second central line had to be removed and replaced. Removal and insertion of the first, second and third central lines resulted in Molly being subjected to four additional surgical procedures. Molly was very ill and remained as an inpatient on Ward 6A, receiving antibiotics until her discharge on 21st December 2018. Molly's surgery to remove her rib finally took place in January 2019. The delay in Molly's surgery and the disruption to her cancer treatment caused great distress to Molly and her parents Maria and John Cuddihy and her brother Daragh Cuddihy.

Samples taken in Ward 2A on 14th April 2019 identified the presence of Mycobacterium chelonae at four sites on the ward. These were rooms 6 and 17 which Molly had occupied, also in room 16 and an undisclosed fourth location. Further water samples taken on 20th June 2019 reported finding Mycobacterium chelonae at the QEUH, however, the location was recorded as "QEUH/kids" and did not identify which wards or rooms were affected. On 4th July 2019, John Brown CBE, Chairman of the Board of NHS GGC wrote to John Cuddihy, Molly's father, expressing regret and apologising on behalf of the Board, that Molly had contracted Mycobacterium chelonae while she was an inpatient in the Royal Hospital for Children.

Molly Cuddihy

As a result of acquiring Mycobacterium chelonae Molly suffered severe pain, discomfort and distress. Rather than seeing the QEUH/RHC as a place of safety, where she benefitted from the care and expertise of Dr Sastry, her treating doctor and the medical/nursing staff in the Schehallion Unit, it now became a place of potential danger where access to necessary life-saving treatment was compromised. Following her contraction of Mycobacterium chelonae, the doctors, responsible for Molly's care were placed in an impossible position of deciding whether to resume her chemotherapy, which would result in the reduction of her immune system, at a time when bacteria, threatening the life of such a vulnerable patient, remained within the ward environment.

Conversely, a decision not to resume chemotherapy increased the risk of her cancer spreading.

Following Molly contracting Mycobacterium chelonae she endured extended hospitalisation attributable to the infection; prolonged antibiotic therapy; the necessity to twice remove her Central Venous Lines (CVL); inclusion on the PICU Watch List, deterioration in her kidney function, abnormal heart rhythm, high frequency hearing loss and the need to modify the planned delivery of her cancer treatment. This caused anxiety, stress, pain and suffering to Molly and the rest of her family. Molly's unplanned and prolonged hospital admissions, as a result of her contracting Mycobacterium chelonae, disrupted her education, family life and social life.

Molly's unplanned and prolonged hospital admissions created considerable additional anxiety for both Molly and her family. It necessitated Molly's mother, Maria, being resident in the hospital during admissions. Molly continues to live with the ongoing anxiety that her health will be further affected by Mycobacterium chelonae. The distress and anxiety that Molly has experienced due to her contacting Mycobacterium chelonae has necessitated her receiving psychological support.

John Cuddihy

In an effort to find out what had occurred and to seek assurances that his daughter would be safe within the ward, Professor John Cuddihy sought information from QEUH/RHC and NHS Greater Glasgow and Clyde. He hoped to receive some sort of explanation as to why his daughter had contracted Mycobacterium chelonae whilst in an acute childrens' ward which accommodated extremely vulnerable, immune compromised patients. His various investigations, the detail of which may be more relevant to future chapters of evidence, produced nothing to allay his fears and on the contrary, his discussions left him concluding that there was a lack of command, a lack of control, no effective communication to patients and families, an absence of a

duty of candour, no apparent dialogue between medical staff and infection control and a total lack of understanding of the fact that there continued to be an ongoing issue with the water supply. This further added to the distress, stress and anxiety suffered by John and Maria Cuddihy.

It became apparent to Professor Cuddihy that the processes and procedures that should have been adopted once an infection has been identified had not been followed. He observed every day "organisational chaos" within the ward where Molly was receiving treatment with a total break-down of faith, trust and honesty, lack of coordination and absence of leadership. He observed new patients being treated within other wards, outpatients advised not to visit ward 2A; "deep clean" followed by "deep clean", signage on water fountains and advice not to drink water from the taps, already fitted with filters. In all the circumstances his perception was that no-one had a "grip" of the crisis.

Such was his concern with the failure in corporate governance that he was left contemplating whether he should seek to remove Molly from the ward, however, the outstanding medical care at the hands of the clinical team under the leadership of Dr Sastry resulted in him deferring this decision.

CONCLUSION

When Molly was diagnosed with Metastic Ewings Sarcoma on 24th January 2018 at the age of 15 years old, Molly, Daragh, Maria and John Cuddihy were extremely worried and fearful of what the future held. They all knew a "battle" lay ahead. Molly became increasingly aware of the ravages of chemotherapy on her body. Despite this, she continued to conscientiously engage with her academic studies, with the aim to study medicine and she adapted to a life that involved hospital admissions to the Schehallion Unit, to receive potentially life-saving treatment. Then, in addition to this already very challenging set of circumstances, Molly contracted Mycobacterium chelonae, a hospital acquired infection that had catastrophic effects on her health and her ability to access life-saving cancer

treatment. The challenges that followed, resulted in concern for Molly's survival on a number of occasions, extremely painful and debilitating side effects of treatment and an emotional impact on the whole family that is beyond words. For Molly's parents this generated a strong sense of helplessness and immeasurable distress and worry. They were unable to protect their child from the adverse health consequences of the infection she had acquired. At the same time, as potentially life-saving cancer treatment was required, they had to admit their daughter into a hospital environment where they knew that ongoing failures in corporate governance and ineffective infection control measures had exposed and may continue to expose the lives of young, seriously ill, immune compromised patients, including Molly, to significant risk. A position that no parent ever wishes to find themselves in.

Clare Connelly, Advocate

4th September 2021

SCOTTISH HOSPITALS INQUIRY

OPENING STATEMENT ON BEHALF OF GREATER GLASGOW HEALTH BOARD (KNOWN AS NHS GREATER GLASGOW AND CLYDE)

FOR THE HEARING COMMENCING ON 20 SEPTEMBER

1. On 03 July 2015 the Queen Elizabeth University Hospital, ("QEUH") and the Royal Hospital for Children, ("RHC") in Glasgow were officially opened by Her Majesty the Queen, a historic date which represented the realisation of the cornerstone of NHS Greater Glasgow and Clyde's, ("NHSGGC") Acute Services Strategy, initially formulated in 2002. That strategy had at its heart the delivery of the highest standards of healthcare provision to the community it served, within "state of the art" hospital accommodation designed to ensure the safety and wellbeing of all patients whilst receiving medical treatment.

2. In these circumstances, it has been a matter of the utmost concern to NHSGGC that, since both the QEUH and RHC opened to the admission of patients in 2015, certain issues have come to light which may have adversely impacted on the specific needs of some patients, including the young and very vulnerable.

3. NHSGGC has the greatest sympathy for the suffering and anguish that has so obviously been experienced by patients and families alike and, against this background, welcomed the announcement made by the then Health Secretary in September 2019 that there would be a Public Inquiry into the issues which have arisen. NHSGGC is determined to ensure that the issues which have required to be addressed in both hospitals do not arise in any other future NHS infrastructure project, and it will provide all the assistance that it can to the Inquiry to enable it to fulfil its vitally important remit.

4. The safety and welfare of its patients always has been, and remains of paramount concern to NHSGGC, and it is committed to seeking to improve the service which it provides to patients and their families wherever possible. If this Inquiry should find, in due course, that there may be any lessons to be learned on the part of NHSGGC in relation to any of the Inquiry's Terms of Reference, both the Inquiry and the public should be in no doubt that comprehensive steps will be taken by NHSGGC to address those matters robustly and promptly.

5. It is recognised, of course, that the purpose of the evidential hearing to commence on 20 September 2021 is a limited but, nevertheless, vital one; namely to enable patients and their families to share with the Inquiry their respective experiences, and perceptions of how the issues being investigated by the Inquiry impacted upon each of them. NHSGGC will listen carefully and sympathetically to the evidence to be led and will, in its submission at the conclusion of the Inquiry, provide comment, where appropriate, in order to endeavour to assist the Inquiry in its consideration of that evidence. At this juncture, however, on behalf of NHSGGC I would merely wish to conclude this brief statement by providing reassurance to all patients and families who have experienced distress, anguish and suffering that, wherever possible, NHSGGC will continue to provide support to all

those whose lives have been impacted by the issues to be explored in this Inquiry and that, as previously indicated, NHSGGC will assist the Inquiry to the fullest extent it can.

Peter Gray QC
06 September 2021

SCOTTISH HOSPITALS INQUIRY

OPENING STATEMENT ON BEHALF OF LOTHIAN HEALTH BOARD (KNOWN AS NHS LOTHIAN)

FOR THE HEARING COMMENCING ON 20 SEPTEMBER

1. INTRODUCTION

1.1. This Opening Statement is produced on behalf of NHS Lothian with reference to Direction 3 issued by the Scottish Hospitals Inquiry.

1.2. At the time of writing, NHS Lothian has not seen the evidence that will be before the Inquiry during the hearing commencing on 20 September 2021. It is understood that the purpose of the hearing is to allow patients to give evidence about their experiences and that the Inquiry will not be seeking a direct response to that evidence from NHS Lothian.

1.3. NHS Lothian will not try to anticipate and address in advance the evidence that individual patients may give. Any inconvenience or distress that may have been caused to patients and their families is very regrettable. NHS Lothian will listen carefully to patients' evidence and will take the opportunity to learn from it. However, unless requested to do so by the Inquiry, it is not anticipated that NHS Lothian will seek to comment on the specific evidence that is placed before the Inquiry.

1.4. In these circumstances, the purpose of this Opening Statement is twofold. Firstly, it provides a brief narrative of the events that occurred at or around the time the Royal Hospital for Children and Young People (the "**RHCYP**") and the Department of Clinical Neurosciences (the "**DCN**"; an adult service) were due to open. Secondly, it provides some detail on the steps taken by NHSL to ensure that patient care was not compromised.

2. DELAYS TO THE COMPLETION OF THE NEW HOSPITAL

2.1. NHS Lothian wishes to reiterate its sincere apology to all those who were inconvenienced, concerned or disappointed by the delayed opening of the new facility.

2.2. The "**new hospital**" (the RHCYP and the DCN) was due to open at Little France from Tuesday, 9 July 2019. Testing carried out in late June 2019 by IOM, a specialist ventilation consultancy commissioned by NHS Lothian, identified that there were only four (instead of 10) air changes per hour in some of the bedrooms in Paediatric Critical Care.

2.3. NHS Lothian's executive team was first made aware of this ventilation issue on the evening of Monday, 1 July. Meetings and discussions took place, both internally and externally with Scottish Government and its agencies over the course of the next two days to assess the implications of this discovery.

2.4. NHS Lothian recognised that the Emergency Department, Critical Care and Paediatric Inpatient Services would need to remain for the time being at the Royal Hospital for Sick Children at Sciennes Road (the "**RHSC (Sciennes)**").

2.5. During 4 July, Scottish Government made the decision that the new hospital would not open on 9 July and that no services would move, from either RHSC (Sciennes) or the DCN at the

Western General Hospital. The Scottish Government took the lead in communicating this decision on the day, both internally and externally.

2.6. It is important to note that, as part of the originally scheduled move on 9 July, the Emergency Department (Minor Injuries and A&E) at the RHSC (Sciennes) was to close its doors. This is significant because it is only these urgent care services that are unscheduled with patients attending unannounced. All other services are accessed by way of planned appointments. This means that the location where patients should present themselves is contained in their appointment letters.

2.7. When the decision to delay the opening of the new hospital was taken, it was important that this distinction between emergency services and scheduled appointments was addressed in communications both with patients and with the public in general. Accordingly, direct communication was required with patients (or their families) who had scheduled appointments in order to give them details of their new appointment location (and time, if applicable). By contrast, in relation to the general public, the priority for communications was to raise awareness that, in an emergency, they should continue go to the RHSC (Sciennes) to access Minor Injuries or A&E services.

2.8. So far as the DCN is concerned, all access is scheduled or by means of clinical referral. DCN patients were not due to begin attending the new hospital until the week commencing 15 July and the number of patients scheduled to attend that week was lower than normal due to planned consultant annual leave.

3. STEPS TAKEN BY NHS LOTHIAN IN RESPONSE TO DELAY

3.1. Following the decision of 4 July not to open the new hospital, NHS Lothian took the following steps to mitigate the impact of the decision.

(i) Identifying the affected patients

3.2. NHS Lothian immediately undertook to identify all RHCYP and DCN patients who had outpatient appointments or scheduled procedures booked. For Children's Services, patients could be scheduled up to eight months in advance. In the DCN, patients could be scheduled up to three to four months ahead. All of these patients were the focus of direct patient communication.

(ii) Contacting the affected patients

3.3. The RHCYP had just over 5,000 outpatient appointments and 330 theatre procedures scheduled throughout July, August and September 2019. The process of contacting patients prioritised those with the most imminent appointments. Patients were contacted by phone and this process continued, following date order. It was explained to those contacted that they should not attend their appointment or procedure at the new hospital but instead attend the existing facilities, i.e. the RHSC (Sciennes) and the DCN at the Western General Hospital (the "**DCN (WGH)**"). All Children Service's patients with appointments in July were contacted by phone within two to three weeks. All DCN patients were contacted by phone within two to three weeks.

(iii) Issuing revised appointment letters

3.4. Revised appointment letters were also issued notifying patients of the new location of their appointments. It was NHS Lothian's strategy to retain the original date and time of appointment with only the location changed. In the vast majority of cases, this was achieved.

(iv) Patient reminders

3.5. The practice of calling patients and their families to remind them of their appointments was also initiated. These calls ensured that patients and families were aware of the need to attend the existing facilities as opposed to the new hospital.

(v) Telephone helpline

3.6. A telephone helpline for patients and their families was set up to address any concerns that patients/families may have had in relation to the delayed opening of the new hospital. The helpline went live on 5 July 2019 and formally closed on 5 January 2020. It was staffed seven days a week: Monday to Friday from 8am to 10pm; and Saturday and Sunday (including Christmas Day 2019 and New Year's Day 2020) from 9am to 5pm. There were a total number of 139 calls to the helpline during these six months. Thereafter, a helpline was operated by Children's Services staff. Calls were minimal and the helpline gradually ceased to be used.

(vi) Staff attendance at the new hospital

3.7. Staff were based at the new hospital to identify any patients who attended the site incorrectly and to direct them to the existing facilities. Patient transport was reserved and on standby for this purpose should it have been required.

3.8. Services at the existing facilities were flexible to accommodate any patients who mistakenly attended the wrong location to ensure they were able to access the care they required.

(vii) Advertising

3.9. As soon as the decision on 4 July 2019 had been taken, work began immediately to inform the public that they should continue to attend the Emergency Department at the RHSC (Sciennes). The paid advertising campaign that had been running to promote the opening of the new hospital and, in particular, the move of A&E services to the new RHCYP was cancelled. The NHS Lothian website and corporate media accounts announced that the move to the new hospital had been delayed. The radio campaign that had been running to promote the opening of the new hospital was switched to advertise the delay.

(viii) Media

3.10. NHS Lothian has a standard protocol for sign-off on all proactive media releases and reactive media statements. On 4 July 2019, an additional step was added to this protocol for all media communications relating to the new hospital. This required that all media releases and statements, once cleared by NHS Lothian, be submitted to the Scottish Government for clearance by the Cabinet Secretary. Access was via the Scottish Government's health communications team who would pass the proposed release or statement up the line to policy colleagues and then on for final clearance by the Cabinet Secretary herself. This procedure was initially extended for two weeks, but then on the Scottish Government's direction it was continued indefinitely for all matters relating to Children's Services and DCN. It ceased once the new hospital was occupied on 23 March 2021.

(ix) Results

3.11. As a result of mitigation measures adopted by NHS Lothian, out of over 5,000 children's scheduled care appointments, fewer than twenty patients attended the wrong hospital site over a period of months. However, these patients were signposted to the correct hospital, offered transport if required, and were seen by the relevant clinician.

3.12. Approximately eight to 12 DCN patients attended the wrong site. All of these patients had been informed of the change and many had previously confirmed they were to attend the

DCN (WGH), but on the day attended at the new facility. Contract taxi transfers were arranged for those who did not have their own transport.

4. CONTINUED OCCUPATION OF EXISTING FACILITIES AFTER JULY 2019

4.1. Following the decision not to move to the new hospital in July 2019, an action plan of improvement works was initiated to upgrade the existing facilities at the RHSC (Sciennes) and the DCN (WGH). The action plan also extended to generally improving the environment for patients, their families and staff. This work commenced in September 2019.

4.2. In October 2019 Health Improvement Scotland carried out an unannounced inspection of the RHSC (Sciennes) and the DCN (WGH) between 22 and 24 October 2019. A very positive report was published in January 2020.

5. CONCLUSION

5.1. It is obviously regrettable that the issues with the new hospital were identified at such a late stage in the project and so close to the planned opening date. NHS Lothian is keen to assist the Inquiry in trying to determine why that was the case and what lessons can be learned to prevent that happening in any future public infrastructure projects.

5.2. It is also acknowledged that the timing of the decision not to open the new hospital will have caused inconvenience and concern to some patients. However, NHS Lothian believes that the actions taken following discovery of the problems ensured that the quality of patient care and safety was not put at risk and any inconvenience to patients was minimised.

Jonathan Barne QC
Alasdair Burnet QC
06 September 2021

SCOTTISH HOSPITAL PUBLIC INQUIRY

Opening Statement

on behalf of

NHS National Services Scotland

National Services Scotland (NSS) would like to place on record our deep sympathy for the patients and families affected by the issues before the Inquiry. We will listen closely to their evidence and are committed to supporting the Inquiry in any way that we can. We hope that the Inquiry will be able to give those affected – and the wider public – a full understanding of what happened. NSS is ready to help implement the findings of the final report and any interim reports. We will work with partners to ensure that lessons learned are acted upon in support of national infection prevention and control and the continuous improvement of Scotland's health estate.

SCOTTISH HOSPITALS INQUIRY

Hearing Commencing

20 September 2021

Bundle 1 - Written Opening Statements Submitted to the Inquiry