SCOTTISH HOSPITALS INQUIRY

Hearings Commencing
20 September 2021

Day 10
Monday 4 October
Morning Session

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10:00

THE CHAIR: Good morning, everyone. I think we are ready to begin with the next witness, Mr Duncan?

MR DUNCAN: That's correct, my Lord. Denise Gallagher, who will be our next witness.

THE CHAIR: Thank you. (Pause). Good morning, Mrs Gallagher.

A Good morning.

THE CHAIR: As you are aware, you are about to be asked questions by Mr Duncan; I think you have had the opportunity to meet him, at least on screen or …?

A Yes, a couple of times.

THE CHAIR: We now have him in person. We will probably take a coffee break at about 11.30, but should you wish to take a break before that, just give me an indication and we will take a break. I think you are prepared to take the oath. Can I ask you, just where you are sitting, just to raise your right hand?

A Oh!

THE CHAIR: That is a very common situation. And repeat these words after me.

Mrs Denise Gallagher (Sworn)

Examined by Mr Duncan

THE CHAIR: Thank you, Mrs Gallagher. Mr Duncan?

MR DUNCAN: Thank you, my Lord. Good morning again, Mrs Gallagher. Can I just begin with some formal questions; and can I have you confirm that you are Denise Gallagher and that you live with your husband and your two children in North Lanarkshire?

A That's correct.

Q And without telling me where you work, could you tell us what line of work you are in?

A So I'm an advanced nurse practitioner, so I work with GPs, assessing patients, coming to clinical diagnoses and prescribing treatments and onward referral to specialist services.

Q And how long have you done that?

A So I have been an advanced nurse practitioner since 2018. Before then, I worked as a senior staff nurse in an accident and emergency department.

Q All told, how long have you been in nursing?

A I have been in nursing since 2002. That's when I qualified, really, so nearly 20 years.

Q Have you got any areas

of specialism that you have worked in over the years?

A I would probably say I have worked in emergency medicine for the bulk of my career, and now in my job I probably would say it's urgent care presentations, mostly dealing with children or older people and the spectrum in between.

Q What experience overall of that have you in dealing with, or having to be aware of, issues to do with control of infection?

A Every aspect of my job is about control of infection and even in emergency nursing, control of infections, because you could help spread it, to infectious diseases. So yeah, you have to be quite acutely aware of controlled standards.

Q Thank you. I think we know that you are here today to give evidence about the elder of your two children, your son, and he is presently 11 years old?

A He is, yes.

Q And I think we can see from your statement that when he was 8, he was diagnosed with leukaemia and received treatment at the Royal Hospital for Children and also the Queen Elizabeth University Hospital; and I think that was between May 2018 and March 2020?

A Yes.

Q You have provided the inquiry with a detailed statement and am I correct in understanding that you are content that that forms part of your evidence to the Scottish Hospitals Inquiry?

A Yes, I am.

Q You have also agreed to come along today and answer some more questions in relation to aspects of that; is that right?

A Yes, I am.

Q Now, am I also right in understanding that you have a copy of your statement beside you?

A Yes, I have.

Q Now, can I reassure you that you are not here to be tested on dates or anything of that nature, but if you do wish to have a look at your statement at any point, just do so and indicate to me that you wish to do so. Is that okay?

A Yes.

Q Let's begin the detail of your evidence, then, and can we start with some background. I wonder if you might tell us a bit about your son. We think it's important that we understand who those stories are about. So it would be helpful perhaps if you could give us a bit of information about that. I think he was in primary 3

when he was first diagnosed; is that right?

A Yes. He was in primary [redacted] and had increasing lethargy or tiredness and had complained of a sore leg.

Q Yes, I will come on to that maybe in a bit more detail. But what sort of wee boy is he?

A He was quite a chatty, sociable boy. He is on the autistic spectrum, so he is very fixated on his ideas and interests. But in general, he used to be quite a chatty boy. He would speak to everybody, thinking that they are his friends; and computer games was, and still is, his life.

Q Is he quite an academic wee boy?

A He is very academic. He loves school, absolutely adores it.

Q He loves?

A He loves school. That was one of the biggest things he missed.

Q Now, I want now to proceed, to just start to work our way through the history of your son's illness and his treatment. You have prepared a timeline for us. It is attached to your statement. I am not going to ask you to turn it up. But I am going to ask you this question: what was the timeline based on?

A So the timeline was based on probably, to do with the start of my job, my mobile phone, I had saved some dates on my phone just intermittently during times that was maybe of significant note or just keeping things up to date in memory.

Q And are we right in understanding from your statement that you also now have a copy of your son's medical records?

A Yes.

Q And did you rely upon those at all in completing the timeline?

A I only used that once to confirm about a sample; but the rest, I just have read through. I have not actually used that as a basis --

Q So it is a combination of your memory and what you had saved on your phone in the main?

A Yes.

Q Okay. Well, let's begin the story. I wonder if you could describe to us what it was initially that led you to think that your son might have something wrong with him and I wonder if you could then describe what happened after that?

A So it was my daughter's birthday, and my son was complaining of a sore leg. He had a sore leg, but he was bouncing about, that was fine. It resolved.

A couple of weeks later he started saying his leg was sore again, so this started on the Monday. By the Wednesday, he was not walking that great at all. He was complaining of a really, really sore leg, so he was getting weight-related or stronger doses of Calpol and Ibuprofen to manage that, and still going to school. I'd then taken him to my place that I worked at, or used to work at, at the time, and he was seen by a consultant who assessed him, had a feel of his leg and said that there was nothing wrong with his knee, although at the time I told him that he was tender on his distal femur, so the lower part of his long leg bone. And they said there was nothing wrong, so he went home. Then on the Friday, they -- [redacted] was literally non-weight bearing, so he wasn't walking at all. Couldn't walk. He was crying, severe pain. His leg was much more swollen. So I'd taken him back to my place of work, my ex-employment, where he was x-rayed and they found that he had a large sarcoma -- well, a large tumour on his distal femur at that time.

Q Just stopping there. What was suspected at that point?

A At that time, they suspected it was a bone tumour. They just said it was a tumour. They just didn't know.

Q And how did you feel on hearing that news?

A My world crashed down around me.

Q I think we know that there was then a referral to the [redacted]; is that right?

A Yes. [redacted] and [redacted] was assessed on the following Monday with an MRI scan and bone marrow biopsy and things, so very quickly thereafter.

Q Yes. And are we right in understanding that, I think it was round about 14 May that your son was admitted, or rather, mid-May that he was admitted to, or seen, at the Royal Hospital for Children for those investigations. He was then sent home to await the results; is that right?

A Yes. So because of the complexity of his bone marrow aspirate, there was too many cells, is what we were told; so they couldn't differentiate what kind of tumour or cancer it was. So they had to send away for lab analysis and further blood tests.

Q And so are the clinicians still thinking it might be bone cancer at this point, or are they now starting to think this might be something different?

A Mr Duncan, the orthopaedic consultant at that time, was thinking it is probably no longer a bone tumour. It was a bone tumour, but its essential or starting cells was not a bone -- so it wasn't a sarcoma that was related to a bone tumour. It was another type of cancer that he had.

Q Yes. I think we can see from the timeline that on 14 May, your son was admitted to have a central line fitted; is that right?

A Yes.

Q And that was actually before there was confirmation of the diagnosis?

A Yes.

Q So was that on the basis that, whatever the diagnosis was, there was going to be chemotherapy; is that right?

A Yes. They had mentioned the word "leukaemia", they had mentioned different types of things, but they still were preparing that he would have to have some form of chemotherapy, so they put a central line in place.

Q And do we also see that over this period, he was in and out of, I think, Ward 2B?

A Yes.

Q Was that for blood assessments?

A Yes, they were just routinely checking his bloods and just following up on him, just to make sure that he was still healthy or able to receive whatever they were going to decide.

Q And what eventually was the diagnosis?

A The eventual diagnosis was that [redacted] had chronic myeloid leukaemia with sarcoid -- a myeloid sarcoma and he was in blast crisis.

Q Yes. Now, I want to ask you a wee bit about that. In your statement, it is at paragraph 4 for those who wish the reference, you tell us a wee bit about the different stages of CML, if I can just call it that for convenience?

A Yes.

Q Do you want to tell us a bit about that just now and then maybe just give us an indication of what stage your son was at?

A So all we ever found out was that was three stages. You had the first stage which was the chronic phase, so the disease is in control. The second stage is the accelerated, so that's where things are starting to get a little bit more -- you know, the cells are becoming a little bit more erratic. And then you have the blast

crisis, where there is no healthy bone cells or blood cells being produced and that is the final stage of CML, which then acts like an aggressive form of acute myeloid leukaemia, which is a different type of leukaemia, but it is as deadly as that.

Q And can you recall what stage your son was at?

A He was at the blast crisis.

Q Now, I think we can see that he was admitted to the Schiehallion unit on 23 May and that treatment began, I think, two days after that, on the 25th. What was the treatment plan, as far as you can recall?

A So Shazi, his consultant, said that for [redacted], at the moment they would have to try and get him into remission; and that was the main ultimate aim, to get [redacted] back into remission and then probably he would have to get a bone marrow transplant.

Q And if we just take the two aspects of that, then. The getting him into remission bit, would that have been hitting him quite hard with chemotherapy?

A Yes, he got quite a toxic dose of chemotherapy.

Q And as far as transplant is concerned, was it definitely going to be bone marrow transplant or could it be stem cell?

A Stem cell and bone marrow, they are both the same treatment, but just different names. But yes, technically stem cell treatment, yes. He was to get a stem cell transplant.

Q Okay, thank you. Let's move then to think about his treatment, and what I want to do is just to take it in stages using the timeline; and the first section I want to look at is the period between May 2018 and early August 2018. If we begin this way and just have you confirm which ward your son was admitted to?

A [redacted] was admitted to -- he was admitted from 2B, which was day care, to 2A, the Schiehallion unit.

Q Yes. And are we right in understanding that he remained there until early August, when he was discharged home for a few days; is that right?

A Yes, that's correct.

Q And did he have chemotherapy over the whole of that period?

A He had chemotherapy at the end of May, start of June, and then had a prolonged period of neutropenia.

I think it was up to 40 odd days, where he was actually neutropenic.

Q Is that an unusually long period?

A Afterwards, yes. He had a prolonged neutropenia which I think they were not expecting, and we found that out at the end of his first cycle.

Q Yes. And I think you have already indicated that this was quite toxic chemotherapy; is that right?

A Yes.

Q How did he cope with that?

A He actually did amazingly. He had some inner strength that he just got on with it. He said at the start he was going to survive this and he was going to come home, and he did what he said what he was going to do. Yes, so he did take it in his stride. He just went and did what had to be done.

Q Was he quite unwell during it?

A Yes.

Q How long did the chemotherapy last in this initial phase, before he went on to being neutropenic?

A His initial chemotherapy was about eight days.

Q Okay. Now, I want to move on and just have you help us a bit with understanding what it was like to be in Ward 2A in those early weeks. The first thing I want to ask you about is his room. In which room did your son initially stay when he was on Ward 2A?

A So [redacted] was admitted to Room 1, which was behind the nurses' station.

Q And for those who want the reference on that, it is paragraph 13 in Mrs Gallagher's statement, and the paragraphs that follow. I think you indicate that there was a change to the room that he was in; is that right?

A Yes.

Q Why was that?

A I think they were just moving about for cleaning purposes and, well, at the time infections were, whatever. So they moved him over across the way to Room 15.

Q Was there a particular room that he eventually ended up in and became his main room?

A Yes, his main room on his first cycle was Room 20, so that room was a specialist room that was supposed to be designed to be as clean as you could possibly have it; so it had special air filters and double door entry for the control of infection.

Q What do you mean by a double door entry?

A So it had an entry door

as you went into like a small kind of fulcrum, as you would say, with a sink and a wardrobe where you could keep some things, and then that door would be shut, and then there would be a second door and it was to maintain air pressure so that the air was always flowing out of the room instead of in.

Q Do you recall whether there was any discussion with any of the doctors about putting him into that room?

A I don't know if there was any discussion, but [redacted] was actually not placed in that room immediately. [redacted] was neutropenic when he was in Room 15, which is not a specialist room, and eventually Professor Gibson was unhappy that he was still in the main ward and not being put in isolation, so he was out for at least two or three days being neutropenic in the main ward environment.

Q So did you say he was in Room 15 and he was going out and about in the ward as well; is that right?

A Yes, he was just straight across from the nurses' station with his door wide open, with no precautions, in the sense of ...

Q And I think Professor Gibson wasn't very happy about that?

A (Nods).

Q And so was it her

instruction that he was to go into Room 20; is that right?

A Yes. He had to go into strict isolation.

Q How long was he in Room 20 for, as far as you can recall?

A He was there for the remainder of his neutropenic stage, so he was in there for at least five weeks or so. It was quite a long time.

Q And can you recall whether he was in other rooms that were similar to Room 20?

A He was, during his second cycle. He was in different rooms on the other side of the ward.

Q And when was the second cycle?

A The second cycle would have been about the end of July, start of August.

Q So he had an initial cycle of, I think you said eight days, and then a break and then the second cycle began; is that right?

A Yes. They had to postpone his second cycle because his neutropenia was so long, but yes, he had a couple of days break and then put back into chemotherapy.

Q And sorry, and the rooms that he was in at that stage were rooms 23 and 24?

A Yes. So he was put into

Room 24 immediately when they started his chemotherapy, because his neutropenia was quite prolonged and then moved to 23, in between times to have room cleaning, and then put back into Room 24.

Q And in answering the way that you just did, are you suggesting that there was a link between being in Room 24 and the duration of his neutropenia?

A Yes, because he kept having fevers and temperatures and things.

Q What sort of room was Room 24?

A Room 24 was another specialist room that had two entries, so it had the extension door and then the inner door. But it had different -- all I knew is that it had different filtration. So the original room that he was in had its own ventilation system from an outside source. The inner room -- Rooms 23 and 24 had a different type of ventilation which wasn't as deemed cleaner. It was used for a different type of transplant but it had different ventilation systems, compared to 20.

Q That is what I was going to ask you about. I think you tell us something about that in your statement. I think it is at paragraph 45. You indicate there were different types

of rooms for different types of patient; is that right?

A Yes.

Q And are you indicating that, in fact, there was also different types of rooms for different types of transplant patients?

A Yes.

Q And what were the different types?

A So you had two different types. I will get it confused. So you have one where it is either a related donor, where it is their own cells they get back after treatment, or you have a non-related donor transplant, so they get stricter or more intense treatment to eradicate their immune system. And the rooms [redacted] was in, on the second time, were for the related donor, so not as intense treatment.

Q Okay. So Room 20 is for the unrelated ...?

A Yes.

Q Now, are you able to describe the layout of the rooms that he was in? And to be clear, you have helped us with the isolation rooms. You have helped us with the lobby area. I am just thinking now about the actual inner room or similarly Room 20, the bedroom and bathroom aspect of it. Can you help us a bit with that?

A Yes. So you go in from

the lobby area into your room, so normally it is a big room. You have your bed, there is a wardrobe and then you have got two double doors which is where the toilet area or the shower area is. They are often at the foot of the bed and, as I say, the doors are open and shut. It is easy. And then you have got your toilet, your shower and your sink and there is a sink in the room as well, off to the side.

Q Okay. Now, when your son was on the ward, who stayed with him?

A My husband and I, during his chemotherapy, would take turns around staying with him or staying over in Marion House. We didn't always stay overnight with him because once he was sleeping, he was sleeping. We needed time out, because it was intense isolation. So you are in a room on your own with him; near enough it would be 24/7, which is hard-going for him, because he is an 8-year old boy that wants to have his freedom.

Q So you would go and, from time to time, stay in Marion House?

A Yes.

Q And that is the house that's nearby and operated by the CLIC Sargent charity; is that right?

A Yes.

Q And I take it, whoever wasn't staying with your son would be back at home looking after your daughter; yes?

A Yes.

Q Now, I want to move on then, and have you think about, and tell us a bit about, the facilities on Ward 2A. What facilities were there on the ward for a boy who was the same age as your son? Was there a playroom on the ward?

A There was a playroom for younger children that liked to play with dollies or Lego and do arts and crafts. Those kind of things. Then there was a room for the teenagers as well that had computer games, pool table, jukebox, sofas, like a hangout space. [redacted], although with his treatment he wasn't able to leave his room, but there was nowhere. We used to try and encourage him to walk to the playroom, which he would do, and then he would go and get disappointed or upset because there was nothing that was appropriate for him to play with.

Q Was there a play team that came to the ward?

A Yes, there was a play team. Again, [redacted] enjoys science, he enjoys computers, so he is not your

typical 8-year-old boy. So, he used to always kind of quiz and ask about more advanced stuff, like space things, and there was very little that they could offer him, because they didn't have those kind of things in place for him. They did buy him a computer game to play on his Switch or his Xbox, so they did try, but there was very limited things that would interest or entertain him.

Q What about facilities for parents? What facilities for parents were there on the ward?

A There was a parents' kitchen, which was great. You had a place that you could put your food. So was quite funny. He always liked to eat just chicken. You just give them whatever they feel the need to. But it was a place that you could put cold drinks in. He loved milk, you could go and get milk. It was a place you could have a cup of tea or coffee, eat your meals or even just sit on the sofa and just look out of the window and just have time to yourself.

Q Did you ever speak with other parents when you were in the parents' room?

A Occasionally there would be somebody there. Again, it just depends on the time of day and night. But yes, I spoke to some parents and

some grandparents when I was there.

Q Did you find that helpful?

A Yeah.

Q Now, ignoring for the moment issues to do with the water supply, which I am going to ask you about towards the end of your evidence. What was your overall impression of Ward 2A?

A For me personally, I thought it was quite a dark, dull place when you walked in the corridor. It just seemed quite claustrophobic; although you did see the kids run about as normal, shouting and screaming and playing in the corridor. So yes, it was quite -- in that way. But I just felt it was quite a dark place that wasn't that nice in the corridors.

Q So are you indicating you have got conflicting views on it; would that be fair?

A Yes.

Q If we look at what you say in paragraph 53, just have a wee look at your statement.

A But yes, I did love it, because --

Q Yes. You began to love Ward 2A, because it became your home for so long. You know the staff, you know how the processes work and you know what you can get. Do you want to explain a wee bit more about

all of that?

A Yes, so it was comforting because it was one of those safe places that everybody looked after everybody. You bumped into somebody and you would ask how their kid was or you would ask how they are getting on; have they got neutrophils yet? So they understood the chat, they understood the -- is it a good day, is it a bad day? The nursing staff and the cleaning staff and the dinner lady, they just looked after our kids like they were their own. They just mothered them when we weren't there or comforted them or comforted us.

Q I'm going to come on in a minute to ask you a bit about the other side of the coin that you indicated, the dark environment. But before we get to that, I just wonder whether you can recall whether any of the staff ever said anything to you that might indicate that there were issues with the hospital environment. I'm thinking about when you were first admitted to the ward.

A So we were in Ward 2B, waiting for [redacted]'s bed to be ready. His bed was ready and the sister of day care was helping us through and she was like: just to let you know, the ward is under investigation for environmental issues. We don't know

what the issues are, but there is environmental issues. And that's how it was kind of put across; but that everything was in hand and we were -- it is what it is and it's getting looked at, and it was ...

Q What was your reaction on hearing that?

A I kind of chuckled a wee bit, because I thought: yes, it will probably be ventilation, because this place is sweltering.

Q Because it is?

A Sweltering, it was hot. When you walked into the actual 2A, it was really dark and there was no air, no flow of anything.

Q For those who want the statement references, it is paragraphs 73 to 74 for that aspect of Mrs Gallagher's evidence. Now, what you have just said really takes me to my next question which is: what was the temperature like on the ward? Was it sweltering everywhere?

A It was always hot, yes. It was always hot and humid and it was even worse because when we were in, as an inpatient, that was when it was one of the hottest summers. And yes, it was -- it could be hot. There was very little chance to try and cool the air. One of the auxiliaries said: one thing that you can do is open the toilet

door and the cooler air is in the toilet; and that would force the cool air from the toilet into the main room, which now looking back is -- the toilet is open and the toilet bowl is open with water and you are flushing.

Q You mentioned a moment ago something about it being dark. What do you mean by that?

A So when you went into the corridor, it was like a deep purple, everything was deep purple, all the walls. There was very little intense or bright lights. It just had purple stickers and things on the wall. It just seemed quite a dark place when you went into it.

Q And do you recall whether the lights were on or off?

A That was during the day. It was in the afternoon when [redacted] was put there.

Q And in addition to issues with the temperature, can you remember whether you noticed any issues at this point that might indicate something to do with the ventilation?

A Yes. When [redacted] was in Room 1, the ventilation shaft or the grid was hanging off down from the wall a wee bit and it had small little -- it looked like sampling ports or something, just dangling down from the actual air vent itself.

Q Did you raise that with anybody?

A No.

Q Now, the next thing I want to ask you about, again still thinking about these initial weeks on Ward 2A, is cleanliness. Did you have any concerns about the levels of cleanliness on the ward?

A Yes. They would clean -- again depending on different rooms, different isolations that the kids were in. So at the start, [redacted] was in a normal room, so they would clean once a day. But when he went into his strict isolation, they would come and clean in the morning; but it was the same cleaner that would clean the source isolation rooms. So the source isolation rooms, the ones with diarrhoea and vomiting, they would be cleaned first and then they would come and clean the strict isolation rooms, and then they would clean the general ward and I just didn't understand why that would be the case. I would have thought they would have tried to have at least a clean person and a dirty person clean the rooms.

Q Were you present when the rooms were cleaned?

A In the mornings, yes.

Q Yes. And were you

required to leave the room while the cleaning took place?

A No.

Q And can you describe to us how a room is cleaned?

A So the best explanation: they would do a top clean, so they would just dust the high level. They would then clean the toilet, the main room, and then the kind of cloak area.

Q And was the room mopped?

A The room was mopped, yes.

Q And I think you have indicated that your concern was that the order seemed to be that they started with the rooms where there was thought to be infection; is that right?

A Yes.

Q What size of team did the cleaning team compromise?

A So in the morning, there would be about maybe two in the morning, cleaning 24 rooms that had to be -- they had six rooms that were special strict isolation rooms. And then they had the source rooms which at one point it seemed like every child was on source isolation, so they all -- there was quite a high workload to clean all those rooms and do them thoroughly to the standard that they

should be cleaned.

Q So was this something that concerned you, then?

A Yes.

Q Did you discuss that with anybody?

A No, because I was too busy focusing on [redacted]. But again, you have to put your faith in the processes. I used to speak to the domestics about it and just say: you are going in all these rooms, what precautions are you actually taking? And they are like: well, we wipe our mops down and change the mopheads. And I was like: but you are still wearing the same shoes. I was obsessed about shoes when my son was in strict isolation.

Q I think you explain at one point in your statement that in the isolation room, your practice was to take your shoes off in the lobby area; is that right?

A Yes.

Q You would be in your stockinged soles in the bedroom area?

A Yes, or I would get slippers that was meant to be for inside the room.

Q The cleaning staff wouldn't take their shoes off. Is that what you're indicating?

A No member of staff would take their shoes off. They would

walk right through.

Q In your statement at one or two points, you indicate that you saw from time to time a more specialised form of cleaning involving vapour?

A Yes.

Q Do you want to tell us a bit about that?

A Yes. So one day, we were sitting in the room and these machines that looked like Daleks turned up. There were about six of them. We were told they were going to be steam vapouring all the rooms with bleach and that they were in a process of moving us all about, but this came from the cleaning staff. It wasn't from the medical or nursing staff.

Q So it was the cleaning staff that told you everything that you were told about that?

A Yes.

Q Did they say why it was being done?

A Just to do with the environmental issues or they were just doing stricter cleaning.

Q Right. And did you actually see what the vaporised cleaning actually consisted of? Did you see what it was they did?

A All we just knew is that they turn these machines into the

room. The room was sealed for a period of time. You couldn't see in the room or know what was going on. They were all sealed up with special tape and like a special bag type thing. You couldn't go in the room for at least 24 hours and then it had to be washed down and dried again.

Q Right. Thinking again just about these early weeks, how regularly did this happen?

A That happened at the kind of -- I'm trying to think. It would probably be at the tail-end of [redacted]'s first cycle, so yes, but they had to redo the rooms again because they didn't do a thorough cleaning because they wanted to do the drains. They didn't do the drains to start with. Then they had to go back and redo the rooms. So there was constant moving about of beds all the time.

Q Okay. Did you mean they had to redo the drains with these machines?

A Yes, or some liquid, because they started pouring bleach or something down all the drains at one point and they didn't treat the drains in these rooms before doing the steam vapour, so ...

Q Okay. So as far as you can recall, the first time that you saw the vapour being used was towards

the end of your son's treatment in August, would that be, or July?

A Yes, July/August, yes.

Q At some point, did you get a letter explaining to you something about this?

A Yes, I think there probably would have been a letter left in the room, usually left sitting on top of the bin.

Q Do you want to have a look at paragraph 93 of your statement? That might help you a bit. And in fact, 92 and 93 might be the ones to look at.

A Yes. (Pause). Yes, we weren't allowed to use the sinks for pouring anything down.

Q Yes. And what you said a moment ago about a letter or a leaflet, is this what you are referring to?

A Yes. It was just left on the bin in the room.

Q Yes. And doing the best you can, roughly, what did it say?

A It just said that they had found something in the drains and that pouring foodstuffs down was encouraging the growth and we should be giving it to nursing staff to be discarded.

Q Is your recollection, then, that the concern was not about

blocking the drains? The concern was about bacteria?

A Yes.

Q Okay, thank you. I want to move on a little bit, still just staying within these early weeks, and I want to just think about the treatment that your son received. Am I right in understanding that he experienced a number of temperature spikes when he was having his treatment?

A Yes.

Q Do you know whether that's something that can be a normal part of therapy?

A From what I -- as I say, I have no experience in oncology, but from what I experienced or what I was told, that you could have neutropenic fevers just as the body is trying to reset and develop neutrophils. Yes, it can be common.

Q I think you described that at paragraph 13. I think you talk about the neutrophils fighting back or coming back; is that right?

A Yes.

Q Do you recall a particular temperature spike on 7 July 2018?

A I do.

Q Yes?

A Yes.

Q Apart from the temperature spike, why is that a

memorable date?

A It was my husband's birthday, but also it was probably one of the worst days that I have ever seen .

Q Yes. Now, in your statement, and for those who wish the reference, it is paragraphs 15 to 17 and we might look at those paragraphs in a minute, Mrs Gallagher. But just thinking about what you have just said about it being one of the worst days. I wonder if you could just walk us through your recollection of 7 July?

A So yes, [redacted] was just wanting to go to the toilet. So he got up and walked to the toilet and came back, and he just was quite agitated and shivery and I was like, “Is everything okay, [redacted]?” And he was like: “I just don't feel very well.” He just started to shiver and rigor. So I pressed the button. The nurse came in and checked his temperature and he was borderline pyrexic or high temp, but he was starting to just get more unwell and just a kind of red rash developing on his body. And so the nurse came back and checked his temperature and it had risen even more so, so he had a proper fever. At that time there was a protocol that they had to -- any neutropenic, because he was neutropenic at that time, they had

to get antibiotics, blood cultures, and set him on fluids, just to support him through that period of time. At that time there was another child on the ward that I know was having a fit, so the medical staff couldn't attend to [redacted] directly, so it was a senior nurse and a staff nurse that attended [redacted] and then they got the advanced nurse practitioner to come and see him and check him over to see what they could do and what was actually happening to him at that time.

Q Let's just go over that in more detail. You described him having something that you pronounced "rigor"?

A Rigor.

Q We have had differing pronunciations of that word over the past two weeks or so. Some have pronounced it "rigor" and some have pronounced it "rigor". Is that the correct pronunciation?

A I think so. I have never been corrected on that term, so ...

Q I'll proceed on the basis that, as a nurse practitioner, perhaps you might be correct about that. What is rigor?

A Rigor is basically where the body's temperature was so high to the point that -- it is easier for you to describe it as: the body is turning the

thermostat up. So the body recognises there is an infection, so in order to kill the infection, it needs to increase the temperature to kill off that bacteria, virus or whatever. Sometimes when they have an overwhelming infection or sepsis, they can have this rigor and that's just basically the body starting to make the muscles twitch and shiver to increase the body temperature further to kill off the bacteria.

Q That was going to be my next question, which was to ask you: how does rigor present?

A So usually it would be, somebody is like -- just they are cold, sweaty or clammy or they start to shiver and that is just the body trying to increase its temperature.

Q And when your son was experiencing this, was he distressed?

A Yes.

Q Physically distressed?

A He was, yes, because he was panicking, thinking: what was happening to him?

Q Yes. And how were you feeling, as you were observing all of this?

A Again, probably with my nursing background, coming in thinking something is not quite right, something is quite seriously going on here and we need to get it sorted and

he's got his central line, and I know he's got no neutrophils, so there's obviously something bad happening if he is rigoring, because there's very little reserve in the tank in terms of his immune system, and at that point he was on four different antibiotics.

Q Yes.

A So he was on pretty much everything that they could throw at him.

Q Just before we move to that, I think you described in your first answer on this a moment ago, you said that he had pyrexia or he was near to having pyrexia. Is that the way you put it?

A Yes.

Q What is pyrexia?

A So pyrexia is a high temperature, anything above 37.8 and above.

Q Moving on then to what you just said. He was already on four antibiotics; is that right? Those were preventative antibiotics?

A No, that was still actually treating the fevers that he'd had previously, before that.

Q So was that part of the protocol?

A Yes.

Q And are you indicating, then, that -- sorry. At what point was

he put on to those four antibiotics?

A So they would have been staged approaches, because he was probably having -- he was having fevers because again it was his neutrophils trying to rise up beforehand. So every time he had a fever or they would review him, they would put either an antibiotic on or change it to something else or to add another thing. So yes, he'd probably got to the point that he's had so many fevers that he's probably been put on at least three or four different antibiotics to try and combat that.

Q And you are describing, not the minutes before this particular event; are you describing the days and weeks before?

A Yes, as I say, because again it is quite common to develop a neutropenic fever.

Q So in fact, just going back to the start of this bit of your evidence when you said there had been a number of different temperature spikes. You are speaking about that period, he is on these four antibiotics as far as you can recall; is that right?

A Yes.

Q And during this event, was there a discussion about putting him on further antibiotics?

A Yes. So the doctor came and says: oh, we'll give him a different antibiotic, we are going to give him another antibiotic and I went: no, you are not. You can't give him anymore. He is on all these different antibiotics. He is on Meropenem, he is on Gentamicin, he is on Vancomycin which are pretty toxic antibiotics. He was also on Caspofungin, which was an anti-fungal. I said: so if you are telling me that you are on four different antibiotics and he's got a neutropenic -- he's got a fever and you want to give him a further antibiotic, it is not going to make a difference and I think they should stop using the line.

Q Could you give us the names of those four antibiotics again, for those who are noting?

A The first one was Gentamicin. Then there was Vancomycin.

Q Vancomycin?

A Vancomycin. And then there was Meropenem. And then there was Caspofungin.

Q Sorry, the last one?

A Caspofungin.

Q Right. And why were you concerned about the suggestion that he be put on a fifth?

A Well, I would have thought, with that combination of

antibiotics, that would be surely controlling his fever or his infection. And if they are giving him that and he is still having a fever, then I think there is something else going on that needs to be further investigated or there is a source somewhere, and I knew [redacted]'s body like the back of my hand. There was nowhere else that there could have been a source of infection, other than the line.

Q So you are already beginning to suspect there might be a line issue at this point?

A A line or something else kind of going on.

Q Yes. In addition to rigoring and the presentation around that, were there any other signs that there was something not right at this point?

A His skin. His skin.

Q How did his skin look?

A He was starting to develop this kind of red rash across his body and his limbs and his torso. It just didn't look like your average kind of -- like you know chickenpox or anything. It just looked like either a reaction or some kind of -- it was quite a red rash.

Q How quickly did that come on?

A Very quickly.

Q Seconds, minutes, hours?

A Probably minutes. It was very subtle to start with, and then over the coming days, or even the next day, it was more apparent.

Q Yes. And you talk about the next day. Was he still exhibiting a temperature by this stage?

A No. Things had settled down when they stopped using his line.

Q What do you mean, they stopped using the line?

A So there was a discussion at that time, because the doctor was coming in adamant that he was to get another antibiotic or something for his line. I said: you are not giving him anymore. Rest the line. Give him a chance, and let him recover and see what is happening. He was unhappy, but the advanced nurse practitioner who was on that day, indeed, thought that stopping using the line and giving it a 24-hour break would give us a chance to see what was happening. And the next day the professor reviewed [redacted] and he was much better and improved.

Q Professor Gibson?

A Yes.

Q And when you say "rest the line", are you meaning rest the line

as regards all antibiotics?

A Everything, stopped everything.

Q Yes. And are you indicating to us that over that 24-hour period, or by the next day at least, the temperature had stabilised?

A The temperature had reduced and he was much better.

Q Yes. But he still had the skin rash?

A Yes, he had the head to toe red rash over his body.

Q Now, do you recall what discussions there were at this stage about what it was that was causing this?

A Yes. So there was concerns, because the rash was quite red and florid, so it was bright red, that it could be measles; at which point I was beyond livid because he'd only been in isolation, and I have had measles. Everybody we know has not had measles. So I didn't see that as being a valid reason for the red rash, but there was concern because he was in that strict isolation room where the air pressure blows out into the corridor, that they had to move him out of the room, so they literally just packed him up and put him into an open access ward room.

Q I think you deal with this

at paragraph 18. I think as you have just indicated, you are indicating to us that the room he was in at this point was one in which, as it were, the air is pushed out to protect from infection coming in. And at the point where there's now a suspicion of measles, there is obviously a concern for other patients; is that right?

A Yes.

Q So he's moved rooms at that stage. And what sort of room was he moved to then?

A Just a normal ward room.

Q A simple single room?

A (Nods). Yes.

Q Now, I think you said that your son was beyond livid, or was it you?

A It was me. I was beyond livid, because I was like: how did he even manage to get measles? Everybody, you would have thought in that kind of ward environment, everybody should be tested or immunised against all childhood diseases and not ...

Q I mean, how long had it been since your son had been at home?

A He hadn't been home for at least four weeks, and there was no contact with his sister either.

Q This is the 8 July, so it

was at least four weeks prior?

A Yes. The only contact that he had was between me and his dad.

Q So you were pretty concerned to hear that there might be measles on the ward. Is that where --

A Yes, because I was like: where did it come from?

Q Are we right in understanding, Mrs Gallagher, that eventually this presentation stabilised and the skin rash disappeared; is that right?

A Eventually, yes.

Q And I think we can see, just turning back towards the timeline, I think we can see that your son was discharged home for a few days at the start of August 2018. Had he finished, I think, what would be his second cycle by this stage?

A No.

Q No.

A It would have been ... no, he hadn't, no.

Q No. So he was discharged home mid cycle; is that right?

A No, he was discharged home at the end of his first cycle.

Q I see.

A As I say, it was quite prolonged. I think he was in for 40 odd

days before his neutrophils returned.

Q I see. So a cycle comprises the eight days of actual treatment at the start and then the 40 days of being neutropenic?

A Yes, so basically the cycle would be the start of his treatment, so the start of chemotherapy, right through to the end when he gets the return of neutrophils. So yeah, his was very prolonged.

Q Right. At the point, if you can recall, at the point where he got to go home for a few days, how was he doing?

A He was doing good, yes. He was going home. He was eating what he wanted to eat. He was happy.

Q How were you doing?

A Yes, happy I had him home, because home doesn't feel home without your kids beside you, especially when you have been separated for so long.

Q At this point in time, as far as you can recall at least, was there a projected date for his transplant?

A Yes, so when we were told about [redacted]'s leukaemia, we were advised that the transplant date had been set for September. There was no fixed date, but September was his transplant date, because they

obviously had found a donor that was 10 out of 10, fantastic match, the best that we could get for him.

Q Now, one other thing I wanted to ask you about, before we move on through the timeline, is preventative antibiotics. And again, just thinking about these early weeks of care. Do you recall whether your son was on any preventative antibiotics?

A Yes. They started him on Ambisome at the start, to cover -- they put it as fungal infections, because that's how it was put to us at the time. They didn't have much time to get [redacted] on to chemotherapy. They started him on Ambisome which he had an anaphylactic reaction, so they changed that to the Caspofungin and he was on that throughout the first cycle of his treatment. It wasn't until we were discharged or going to be discharged after the first cycle that Dr Chaudhry had indicated that he doesn't need to be on Posaconazole or Caspofungin, because he's not going to be in hospital. He is out of the environment.

Q That is what I was going to ask you about. You indicate at paragraph 70 of your statement, you indicate a discussion with Dr Chaudhry about the use of preventative

medication. And can you just have a look at that? I think you indicate at the beginning, Dr Chaudhry had indicated that he would need to go on to Posaconazole, Caspofungin and I think you also indicate that he was on Ciprofloxacin; is that right?

A Yes.

Q And just have a look at the rest of what you have said in paragraph 70, and then I will ask you a couple of questions. What I want to know is, at the start of your son's treatment, what you were told about the use of preventative medication of this nature?

A At the start, we were told he just needed to have antibiotic cover for infections. That was the kind of general gist of it. Maybe hospital-acquired or just in general, skin infections, anything like that.

Q When, as far as you can recall, did you have the discussion with Dr Chaudhry that you referred to there?

A So the discussion about the Posaconazole was when he was getting discharged after his first cycle of chemotherapy, because she was going through his Kardex and she was like: oh he'll not need the -- well, Caspofungin he wouldn't get because it is IV only, but she went: oh, you'll not

need the Posaconazole because he is not here. He'll be safer at home.

Q Where were you when you had that conversation?

A That was in Ward 2A.

Q In his room?

A In his room, when she was going through his Kardex.

Q And you specifically recall a mention of Posaconazole; is that right?

A (Nods).

Q What was it she said about that?

A He is not here and he is going home. He is safer.

Q And do you recall what, if anything, she said about being here, i.e., being in the hospital meant that Posaconazole might be required?

A It was just more to do with the environment or infections.

Q And really in essence, what you have said in your statement, that's what you recall?

A (Nods). Yes.

Q Yes. Okay, let's move on a little bit, Mrs Gallagher, to look at the period of August to September 2018. Now, I think we know that your son was readmitted and began a new cycle of chemo; would that be right?

A Yes.

Q And do you recall

whether he was in isolation again over this period?

A They put him straight into isolation.

Q Do you remember which room?

A Room 24.

Q And for those who want the statement references, we are round about paragraphs 20 and 21. And again, I was going to ask you about cleaning. Can you remember whether you saw the Dalek cleaning, if I can call it that, again during this period?

A Not that I can think of.

Q Who stayed on the ward with your son over this period?

A At that time it was a bit between -- it was more shared care between my husband and I at that time, because my daughter was going to start primary school.

Q Yes. So did your mum stay with your son?

A Yes, she stayed sometimes with him, yes.

Q To allow you and your husband to be with your daughter when she had her first day at school?

A Yes.

Q I think we know from your statement that, over this period of time, your son underwent a few

surgical procedures. I am going to ask you a bit about them in a minute. Just thinking about what led up to that and thinking about -- I think in your timeline, you describe it as being late August. I think, in fact, your son might have got to go home again for a few days; is that right?

A He did, yes. He finished his cycle and we got him home for a couple of days.

Q That is helpful. So you went back at the beginning of August, and how long would the cycle last?

A That one was slightly shorter, but yes, I think it would have still been about the four or five-week mark, so he was discharged late August, early September time.

Q Okay. And I think you indicate in your statement that you became aware of him complaining about something?

A Yes, he was complaining of a sore stomach.

Q And was that initially at home that ...?

A No, he was complaining of that during his second cycle of chemo. They wondered if it was maybe more chemotherapy-related or more related to the chemotherapy and the recovery phase; and he was again spiking temperatures. And I thought

he maybe had appendicitis of some sort. The professor, one time he had a fever, had assessed him and felt that he had to get growth hormone to stimulate his neutrophils again because he was unwell and that was when they thought he had appendicitis or appendix problems.

Q If we just take this in stages then. Sorry, forgive me. I think was it you who initially suspected that it might be appendicitis?

A Yes.

Q And did you examine him and think that might be what it was?

A Yes.

Q And Professor Gibson thought the same?

A Yes.

Q And the decision, based on that, was to do what?

A So they asked the surgeons to come and see him and to assess him, and he had pain as classic for appendicitis. They ultrasounded him, but they couldn't find anything, but the agreement -- or we were preparing [redacted] to go for a transplant, so any signs or any source of infection, we would have to deal with that and get his appendix out if there was any question. He was to get an appendectomy.

Q Is that what happened?

A Yes, after me arguing with the surgeons yes.

Q Sorry?

A I had to argue with the surgeons and the professor.

Q In relation to what?

A They felt that he didn't need an appendectomy, but from when it was put to myself and the professor and us taking a risk about [redacted] going into transplant when he has no immune system, if it was a source of infection, it needed to come out.

Q Yes. For those of us who don't have a medical background of any kind, what then -- what was the risk that you were concerned about with the appendix?

A So when [redacted] goes into bone marrow transplant, they literally obliterate his immune system, so he has nothing. So there's no white blood cells to fight an infection. He can't make his own blood cells at all. He is dependent on blood transfusions and things. So if someone gets to that, you can't even give them a growth hormone to stimulate them to make their own blood cells, so essentially there is nothing you can do if he develops an infection. You can give him antibiotics and hope that he can recover from that, but there is nothing you can do.

Q And an inflamed appendix would be something that could contain --

A It would be fatal.

Q So ultimately the decision was that there should be an appendectomy; is that right?

A Yes.

Q Where was that done?

A That was done in the Royal Hospital for Children, Glasgow.

Q Can you remember which ward?

A He was originally in 2A, but because he had a surgical complaint, rather than a cancer complaint, they moved him to ward 3A.

Q And that would be?

A The general surgical ward.

Q And that would be general anaesthetic?

A General anaesthetic, yes.

Q And how was that done? Is there an injection first and then ...?

A Yes, they used his central line to induce him.

Q Now, do you recall any discussions with any of the doctors involved in that procedure immediately after the procedure?

A Yes.

Q Tell us a bit about that.

A So the surgical team came to review [redacted] after the surgery and told me that his appendix looked "lily white", was his words, and there was nothing wrong with it.

Q In your statement, you indicate at paragraph 28, and just have a wee look at it. (Pause).

A Yes.

Q You indicate that you had a discussion with one of the doctors and he said something about a gram-negative infection?

A Yes. So again, [redacted] had returned to the ward. The surgeons had been, and a doctor, Dr Pinto, who is the oncologist consultant came and spoke to me to say that, in fact, [redacted]'s blood culture grew a gram-negative infection and that was all he had to say. Again; a gram-negative infection could be from the gut, which would explain if it was appendicitis. But the surgeon just told me that the appendix was lily white.

Q Yes. So the doctor who told you about the gram-negative infection was not somebody who was involved in the actual surgical procedure; is that right?

A Yes, it was the oncologist.

Q Yes. So this was a separate investigation. Where had

they taken the blood cultures from?

A His central line.

Q And that had come back showing a gram-negative infection?

A It did, yes.

Q And did the doctor who reported that to you indicate whether that might have any link to the suspected appendicitis?

A Yes. A gram-negative infection can come from the gut so again, if they thought he had appendicitis, then you would maybe expect that finding.

Q But you also indicated that you did have a conversation with one of the surgeons who had been involved in the procedure; is that right?

A (Nods).

Q And what was it that they indicated about your son's appendix?

A They did tell me that it was "lily white"; that it looked like there was no infection.

Q Yes. Now, you mention that at paragraph 29 of your statement and you also indicate a discussion with one of the advanced nurse practitioners. Do you want to tell us a bit about that?

A Yes. This was later on in the day, it would probably be more towards after dinner time. The ANP came in to say that: “Oh, [redacted] has got

steno". And I was like: "Okay, he's got a steno infection." I'd never heard of it. So I was like: "Right, okay." And then, as I say, it wasn't until we kind of thought about it and Googled it and read about it, and I just heard the term "stenotrophomonas".

Q Yes. So as far as you can recall, when the nurse practitioner gave you this information, she referred to it as "steno", rather than stenotrophomonas?

A (Nods).

Q And did she say anything about what the likely source of it was?

A (Witness shakes head).

Q You are not sure? You can't recall?

A I can't actually remember. I was just kind of more like: okay, he's got this line infection. I knew it was a line infection, but I just didn't know where it came from or ...

Q I am sorry, it was my fault. It was a bad question. As you have already indicated, the cultures had been isolated in his line; is that right?

A They had isolated that in his blood, so it could have been from his line or it could have come from his body. But the likely source would be the line, after reading about it and things.

Q And just so we understand. At this point in time, did he still have his line in?

A Yes.

Q It is obvious from your statement that there were further discussions about this. Can you just pause at this point. On hearing that the appendix is lily white, and on hearing that your son has got something called steno, which you assumed would have something to do with his line, I think; is that right?

A (Nods).

Q What was your reaction on hearing all of that?

A I was upset, because we'd forced [redacted] to go through a procedure that he might not have needed to have, to get the appendectomy, and he was suffering great pain from that. And they had sent him to theatre, knowing that he had a gram-negative infection, used the line to give him his anaesthetics, operated on him, sent him back up to the ward with the line still in situ. It remained in situ for at least two days before they could remove it again.

Q And when was it that you started looking into, or investigating, what steno was?

A The night I was told he had it.

Q And what did you do?

A I read about it, Googled it. I asked to speak to [redacted]'s consultant, Dr Chaudhry, who I met anyway and I just asked: where did the infection come from? And she was like: I can't answer that, but I said: I would like to speak to someone about it, because I'm not happy. And she arranged a meeting with -- I assumed it would have been maybe infection control or the charge nurse because normally when you do a complaint in the NHS, you deal with the responsible for care in the first instance. And I was under the impression that's who I would have had a meeting with. And a meeting was set up, because I know Shazi was going on holiday; and there was a meeting set up between Jamie Redfern, the deputy manager of the hospital, and Teresa Inkster, the head of infection control or microbiologist.

Q Okay. Well, I will come to that in a minute, and we will just take this in stages again, if I might. In your statement, you indicate that around about this time, you had another conversation with a nurse. Do you remember that one?

A Yes.

Q Can you tell us a bit about that?

A So the nurse came in to

do his observations and I was like: "Oh, have you heard [redacted] has got steno?" And she went: "What, [redacted] has got it?" And I was like: "Yeah." She went: "Oh." And then she was kind of saying that there was more kids unwell on the ward than what we know.

Q Okay. So just stopping there. For those who want the reference to this, it's paragraphs 61 and 62. What, if anything, did you read into her reaction on you telling her this news?

A That she was shocked.

Q Shocked, in what way; concerned?

A I think, yes, she was upset that it looked like he'd got this line infection. She was quite concerned. And I'd asked if it had been in relation to the rooms that he'd been in, because obviously you can see from my statements that there were some people coming in uniforms and looking at the drains and doing all the cleaning things. And she was like: "You are closer than what you know."

Q Can you just walk us through that in a bit more detail. So you had the exchange about steno?

A (Nods).

Q And you indicated a moment ago that she said something about other children having it; is that

right?

A She said there was other kids, yeah, that have got infections as well.

Q Right. And what was it that you then asked about a connection with the rooms?

A So the rooms that [redacted] was in, and I know of a little boy -- or a boy that was in one of the rooms that had subsequently passed away, but I knew he had longstanding other issues as well. But when [redacted] was in that room, there was people in burgundy uniforms coming in to look at the sinks, taking pictures and obviously the toing and froing between 24 and 23, there was a lot of movement between those rooms for "cleaning", as they would say. And I was just kind of, in my suspicious minding, thinking: “Is there something else going on here?”

Q And which of those two rooms can you recall that you had a concern about?

A Room 23.

Q So it's the fact that there was a child that unfortunately had died in one of the rooms, and also that there had been these people coming in, in uniforms, doing some sort of work; is that right?

A Yes.

Q So you asked her if there was a connection and what did she say?

A I'm closer than you can know.

Q Is that all she said?

A She just said: I'm probably -- she just said that I was closer in my judgment or my concerns than to what she could assert(?) to; and that there could have been a link. That's all she kind of said.

Q How was she during this conversation?

A She was quite upset.

Q Did she give you any indication as to whether there were other discussions going on about this issue?

A She just knows that there was kids sick, and nobody was listening to the nursing staff. They had been under intense scrutiny, had been investigated by infection control about their practices, because of the high levels of infection in the ward, and she felt that nobody was listening. You know, it wasn't the nurses' fault. It wasn't the medical staff's fault. It was: “Is it the building?”, you know, things that are outwith their control.

Q Thank you. Now, if we move on a bit from there. Maybe before we do so; I wonder, just so we can identify the particular passage in

your statement that relates to what you have just said. I wonder, Mr Costello, if we could maybe just have a look at that passage. It is paragraph 62, page 21 of bundle 5. (Pause). Can you just confirm that paragraph 62 is the passage which outlines your evidence in relation to the conversation you have just told us about; is that right?

A Yes.

Q And you say: "I also asked her the question about [my son] being in Room 23, in Ward 2A, previously because there had been a young boy in the ward roughly at the same time, who had sadly passed away. He had been in Room 23 and had mostly resided there. I asked the staff nurse if [my son's] infection had something to do with that room as it was never really used and there always seemed to be senior staff and management around the room." Is that what you recall; is that right?

A Yes.

Q "I also asked if this room was a hot spot for steno. She replied, 'You don't know how close you are' and she got quite upset and distressed. She said, 'Nobody's listening, there's more kids becoming unwell on the ward and nobody's really paying attention'." How clear a recollection have you got of that conversation?

A Very clear.

Q "She said that the nurses were the ones that had been cross-examined and interrogated and told it was their fault when it had been something outwith their control." Thank you. We can put that to one side, Mr Costello. Thank you very much. Now, a moment ago, you indicated that there had also, around about this stage, been a discussion with Dr Chaudhry and if it helps you to just relocate where that is, it is paragraph 63 of your statement, I think you deal with this. Can you recall where you were when you had the conversation with Dr Chaudhry?

A I was actually in the ward at the time, because [redacted] was still an inpatient.

Q Yes. And can you tell us a bit about that conversation?

A So the conversation with Shazi was just regarding: where did [redacted] get stenotrophomonas? Because I know he had only ever been from home and to the ward. He hadn't been anywhere else. I don't play with his lines. And I just didn't understand: why did he get this? Because I know he had been home for a couple of days. Why did it -- why now? And we kind of came to the conclusion, maybe

because he was off these different antibiotics, that the line had then started to become more colonised, no longer under control, the infection.

Q When you say "We came to that"?

A Shazi and I assumed, because obviously he had stopped all the antibiotics, the line was rested and left, there was nothing going through or treating anything that was going on, so the line must have been just growing more and more bacteria and infection.

Q What did she say that she would do about this matter?

A She would contact someone in regards to my complaint.

Q And would that be somebody in infection control?

A I assumed it would have maybe been an infection control nurse or manager. You know, I just thought it would be somebody from infection control.

Q Were you told after that that there would be a meeting?

A Yes, there was going to be a meeting and she was going on holiday, so she couldn't attend, and I just assumed that it would just be a meeting between myself and whoever was coming from infection control.

Q Okay. Now, we will

come to that in a minute, but I think we can see from the timeline that there was further surgery on 11 September to remove your son's central line; is that right?

A That's correct.

Q But was he still having antibiotics at this point?

A He was having antibiotics to cover the line infection.

Q Yes. And did that continue after the line was removed?

A They were able to get -- as long as they were able to get IV access on him, yes. But after a time, they failed, there was no -- his veins had all shut down and he was suffering greatly, getting cannulas put in.

Q Yes. I will come to that in a minute. But after the line was removed, I think you indicate there was a concern that there would be something called breakoff of bacteria into the bloodstream; is that right?

A Yes.

Q And was that why there was required to be further antibiotics; is that right?

A Yes, to treat anything.

Q And as you indicated there, only insofar as they could do so intravenously; is that right?

A Yes.

Q For those who want the

statement reference, we are now at paragraph 32; and I am going to ask you a bit about how it was they administered the antibiotics intravenously after the line was removed. Do you want to tell us a bit about that, Mrs Gallagher?

A Yes. So [redacted], he had to get two injections, one in the morning and one in the evening. So he had a cannula put in and he was allowed to -- we negotiated that he would come home and have a day pass, but more often or not the cannula was dislodged or removed, so he would have to have another cannula put in, and at some points it would have to go into his feet, which was kind of a boundary for [redacted] that just made him too distraught. So it got to the point that we just asked the doctors: "Is there any way we can move to oral medication to allow [redacted] not to undergo several attempts at IV access?" We did attempt to keep him in the hospital to see if that would save the lines but that didn't make any difference. The cannulas were --

Q Are you able to describe to us the process of your son being given a cannula?

A So in terms of -- if [redacted] knew there was a cannula coming, because they get wise to it in the end, you would have to physically hold him down and restrain him, to the point of him screaming that it is worse than death, it's the worst pain he's ever had and to let him go. Sometimes he would happily let you sit and try, or you could put an am-top(?) on, but essentially it was always traumatic, especially when they failed and they would go to his feet and that would just be -- he was just even more distraught and upset.

Q And how many attempts, on each occasion, how many attempts would it take to get a cannula attached?

A The doctors would keep going until they got a line. But eventually, after a couple of times, I would be like, "That's enough. You need to stop. It's too traumatic for him and for us to watch."

Q And eventually there was an agreement that you would proceed by way of oral antibiotics; is that right?

A Yes, on the proviso that if he got unwell, that he would be straight back into the hospital.

Q Yes. And I'm just wondering whether this was the occasion on which there was a discussion about the Posaconazole not being required?

A No, that was after.

Q Now, I think we can see

from the timeline that your son moved on to day care after this, is that right, for a spell?

A Yes. When the line came out, yes, he was able to just get regular check-ups for day care.

Q And what was the plan at this stage?

A So the plan for [redacted] was to allow him to recover from his appendectomy and then they delayed his transplant to allow that recovery. He needed six weeks for his wound to heal.

Q So that is a delay of six weeks?

A (Nods).

Q Now, your timeline indicates that you have a particular recollection of a day patient visit on 20 September; I think your father may have accompanied you that day?

A Yes.

Q Do you want to tell us a bit about what happened then and I will maybe ask you about the detail once you've done that?

A So yes, we were attending the day care. It was just a checkup on [redacted] and maybe the plan going forward because we were still awaiting a transplant date because everything had been pushed back. So we were sitting in the waiting area and

the manager, Jamie Redfern, and Teresa Inkster had turned up wanting to speak to us, or to me.

Q And for those who want the references, this is paragraph 65 in Mrs Gallagher's statement. And you then had a meeting with them; is that right?

A Yes, that was my second meeting with them, yes.

Q Second meeting. So there had been a previous meeting?

A Yes, there was.

Q When was that roughly?

A That was at the start of September, roughly about the 6th or the 8th, or something like that.

Q Okay. And what was that meeting about, the first meeting?

A The first meeting was them -- asking: where is the stenotrophomonas, where did the infection come from?

Q Was that first meeting the one that happened in response to the discussion with Dr Chaudhry?

A Yes.

Q And at the first meeting, can you recall what was said?

A So at the first meeting, Professor Gibson sat in as well and I had asked about the stenotrophomonas infection and Teresa Inkster had immediately

apologised and said that she apologises for [redacted] having the infection; it was likely from the hospital. And I was like, “Okay, I will have to accept that.” I said I was unhappy, but from everything that I have read about the infection, once it colonises a place, it's colonised and it's in, and this is the second or third occurrence of something happening in the ward. What were they going to do about it?

Q What did she say to that?

A Nothing.

Q Did she dispute what you said?

A No.

Q Where were you when this meeting took place?

A That was in the parents’ room in Ward 2A.

Q And your recollection is that Dr Inkster said that the infection had come from the hospital?

A Yes.

Q What did Professor Gibson say?

A She was just there, you know, listening to the meeting.

Q Do you have a recollection of her saying anything, though?

A No. She just said that she was kind of there, just to kind of listen in, in the meeting and the chat between myself, and the complaint, because Shazi couldn't be there.

Q And what about Mr Redfern? What did he say?

A He didn't say anything.

Q So the meeting on 20 September, how did that come about?

A I think that was actually probably a follow-up to a phone call that my husband made.

Q And can you recall what the phone call had been about?

A So I can't remember the dates, but we were at home with [redacted], planning to go for a transplant and it was in the news about: the Schiehallion had shut and moved, or the Schiehallion was shut, is what we were told on the news; and we were in great shock. My husband phoned the ward, phoned the hospital. Nobody was talking to us. We managed to get hold of day care and the sister had spoken to him about, you know, they've just heard and there was no further information but that we would be informed of what the plan -- or we would be informed of something. And that's how it was kind of left.

Q Okay. And was the meeting, therefore, solely about that question, about the closure of the ward?

A I would have assumed

so, yes, yes; after we had the chat, it was.

Q In particular, was there any discussion at that meeting about the infection?

A They said, as a result of what was happening or what they had found in the ward, that they had to make a plan and they needed to know that the plan could be in place before they could move the ward over to Ward 6A and that [redacted] had a bed here in Glasgow.

Q So can I take you please to your statement and can you have a look at paragraphs 68 and 69? (Pause). Have you had a chance to read what's there?

A Yes.

Q Can you confirm to us: is what you have set out there what happened at the first meeting?

A Yes.

MR DUNCAN: Thank you. My Lord, I'm looking at the time. I am about to move on to a new chapter.

THE CHAIR: If this is a convenient moment, we will take our break just before half past. As I say, we will take a coffee break for 20 minutes, so if I could ask you to be back at about ten to 12. Thank you very much, Mrs Gallagher. Perhaps Mrs Gallagher would be allowed to go.

11:30

(Short break)

11:53

THE CHAIR: Hello again, Mrs Gallagher. I think we are ready to resume. Thank you, Mr Duncan.

MR DUNCAN: Thank you, my Lord. Moving on a little further, then, in the timeline, Mrs Gallagher. I think we can see from your statement, it is paragraph 35 for those who wish the reference, that I think around the end of September, your son had something called a PET scan. What is that?

A So they use a form of radiation to basically show any fast-growing or rapid-growing spots in the body. So [redacted] had that scan at the end of the treatment, just to see how his -- it was basically essentially to check how his sarcoma on his leg was doing.

Q What did it show?

A On that scan, it showed he had a hot spot on his distil tibia.

Q What's a hot spot?

A So a hot spot is basically a rapid area of growth.

Q Can you recall whether there was any explanation for that from any of the doctors?

A There was no explanation. They had to -- the first concern was: was it a relapse or a recurrence of the disease?

Q And was that investigated?

A Yes, he was given a bone biopsy.

Q A bone biopsy. How is a bone biopsy undertaken?

A So [redacted] was put to sleep and they would then get a needle or a kind of drill or a screw where they drill into the bone and take a small segment out to test it.

Q Okay. And that came back and disclosed that there was no recurrence; is that right?

A Yes.

Q So what, at that point then, was the explanation for the hot spot?

A So as a result of [redacted]'s original tumour, he had developed a -- they'd basically broken his femur bone and so he was put in a long leg cast and they wondered, because his cast was then taken off during treatment and things, I did wonder if it was to do with his weight-bearing, because he was walking very strangely and more walking on the inner aspect of his foot. Was it more trauma related to that, than actually being anything sinister? And that is what they concluded that it might have been.

Q Was there any thought that it might be anything to do with the infection?

A Not initially to my knowledge, no.

Q Okay. Did this incident have any effect on the date when his transplant was going to be?

A Yes, they put another two-week postponement, or for at least three weeks.

Q Yes. Okay. I want to move on to a different topic now, and that is the closure of Ward 2A. We know that wards 2A and 2B in the Royal Hospital for Children closed in September 2018; and I think my first question would be: when did you first hear about that?

A It was on the media, the news.

Q Where were you when you heard?

A At home.

Q And you heard it on the news? And what was it you heard, that it was moving or that it was shutting?

A It was closing.

Q How did you feel about that?

A Distraught. We were planning for [redacted] to come for a bone marrow transplant. That was the completion of his treatment. He needed it, in order to save his life. And

we were under the impression that that was what was going to happen; he was to get his bone marrow transplant very quickly in Glasgow, and then get that completed. But when they told us it was closed, Glasgow is the only place in Scotland that does that treatment, and we were then looking at: "Where do we go? What do we do? Do we have to go to Newcastle, Manchester? Where do we get the funds and then try and split the household up?" We were just going through all the options to get through and to get this done, because it needed to be done.

Q What investigations did you make about alternative solutions?

A Well, we didn't, because we didn't know what was the -- we just knew that the nearest centre is either Newcastle or Manchester.

Q Did you try to contact anyone on the ward?

A My husband phoned the ward. There was no answer. He phoned day care and it was engaged. He tried to phone Jamie Redfern, there was no answer. There was just no communication, until the sister from day care contacted us to say: "It's in hand and it will be dealt with", kind of thing. And that's all they said.

Q And was there any

further explanation?

A No.

Q In your statement, at paragraph 110, you indicate some further comments by Mr Redfern on this issue. Tell us a wee bit more about that?

A So obviously I went into day care as an appointment for [redacted], and Jamie Redfern and Teresa Inkster was there waiting for me.

Q Just pausing there, is this the meeting of 20 September?

A Yes.

Q Sorry, on you go.

A They were waiting for me and I was told that they wanted to speak to me. So my dad was with me and they spoke to us, and Jamie Redfern had apologised about the lack of communication, but I had to understand that they had to make these plans in place first and make sure that the plans would work before informing people of what was happening.

Q Okay. And at that point, did he or anybody else indicate what the plans were, as far as you were concerned?

A Yes. So Jamie Redfern had said that the plan was going to be that Schiehallion or Ward 2A was going to move over to 6B or 6A of the

adult hospital; and that [redacted] has a bed for his bone marrow transplant and it will be in 4B which was the adult bone marrow unit. They were allocating some rooms in there. And he had his bed. That is what they assured me.

Q In fact, if we move on a bit in time, we can see, it is paragraph 36 for those who wish the reference, we can see that I think your son was admitted to Ward 4B on 29 October in the adult hospital and that was to start conditioning for his transplant; is that right?

A Yes.

Q And the transplant itself, I think, was on 8 November?

A Yes. His actual date of cells were the 8th.

Q Going back to one of my questions from right at the very start. What sort of transplant was it?

A He had an unrelated donor, so it was a person that had donated their stem cells for [redacted].

Q And I think he stayed on Ward 4B after that for a spell; and then, what, was discharged to Marion House; is that right?

A Yes.

Q What happened when he got to Marion House?

A He literally got home, or to Marion House, put his pyjamas on

and he looked quite red and flushed and it looked like he was about to take a fever, and we went back again.

Q To where?

A We ended up having to go to day care, because they had already used his bed in 4B.

Q Day care at 6A?

A Yes.

Q Was he admitted?

A He was admitted, yes, because he had a fever.

Q To the inpatient part of 6A?

A No. There was no beds; so they opened up one of the day care beds or one of the day care side rooms and that's where [redacted] went.

Q That is very helpful, thank you. Can we have a look at paragraph 37 of your statement, Mrs Gallagher. We don't need it up on the screen, Mr Costello. I was going to ask you to just help me a wee bit with what you have said there, but I think you have already given us the answer. You say that he got put into a day care room because they had no ward rooms left. It was a side room, but it was part of the day care unit. They had just extended it and put an air filter in his room. It is really just that last bit about them extending it and putting in an air filter. What do you mean by

that?

A So the difference between 6A and day care is that there is a double door. So what they just did is opened the double door so that room could be part of the ward. So that was all they did and that was just the way that they absorbed the extra room into the ward.

Q Okay. We have come to understand 6A being one whole ward with day care at the extreme end, the distal part, and with the inpatient care being before that. Are you saying that he was put into the area at the end, one of the rooms there?

A Yes. So it's like two corridors through 6A. So day care basically takes the far tip, then they have a couple of side -- just a couple of rooms, treatment rooms on this side here, and then the further along you come, there is a side room that they have never -- I don't know if they have ever used it, but it was used for day care to give chemotherapy and things, so they just opened the door and that was where --

Q They used one of those?

A It was one of those rooms that was attached to the ward, yes.

Q Thank you. And at this point, what was the suspicion on the

part of the clinicians as to what it was that was giving rise to this presentation?

A Because he had a fever, they always would assume infection first. The professor reviewed him the next day and they thought it was graft versus host. That is [redacted]'s body reacting to the blood cells because they were all developing into ...

Q But your son was eventually discharged to day care again; is that right?

A Yes.

Q Now, just pausing there and just thinking a wee bit about what you have said about 6A**.** Did you have any issue with the way that 6A was laid out with where day care was, relative to inpatient care?

A Yes. So again, there is one entrance to 6A, which is at the lifts. So you have to come past all the rooms with your kid who has had any kind of infection, and then walk round to day care. So there's quite a high level of footfall past the doors; and it again comes back to my obsession with shoes, walking through the buildings and bringing anything up.

Q Now, we can see, just going further forward in time, we can see that there was a readmission in December 2018, January 2019. And

can you recall what that was for?

A [redacted] had developed a fever again at home, and we brought him in just to get him checked over, and he was still spiking temperatures. He was on antibiotics and they were finding that his cultures were coming back positive for a staphylococcus epidermidis infection. So every time they sampled him, it was coming back with this infection and eventually they decided to take a peripheral sample, so one off his line and one off his hand or his arm, where they could get a blood sample, and they found that the one that was coming from his line had staphylococcus epidermidis and the one that was coming off, as a fresh draw off his hand or another place, was coming back negative. So the line was actually infected.

Q Okay, that is really helpful. Thank you.

Now, I think for those who want the references, it is paragraph 40 of Mrs Gallagher's statement and I think we can see that the admission was on 30 December. Would that be right?

A (Nods).

Q And as you have indicated, eventually a line infection found; is that right?

A Yes.

Q And it is staphylococcus epidermidis, or "epidermidis", something like that?

A Yes.

Q And did he require more antibiotics at this point?

A Yes. So they were treating him with all the neutrophil fever antibiotics, because they thought that it was an infection, and they continued that after they had taken the line out.

Q Yes.

A Until they could get a cannula in.

Q So the line was removed again?

A Eventually, yes, it was removed a day or so later; and they had a cannula put in for the antibiotics.

Q Yes. And the peripheral blood test or blood samples, they would have been taken using cannulas as well; is that right?

A Yes.

Q Now, I think we can see that there were further admissions in January 2019, into February. I think he attended day care; and he got immunotherapy; is that right?

A Yes.

Q And more chemo; is that right?

A No, he was on oral chemotherapy.

Q Oral chemotherapy?

A Yes.

Q And we don't need to go into the detail of this, Mrs Gallagher, but I think there were more temperature spikes over this period; is that right?

A Yes.

Q And when was your son's last admission?

A His last admission was February 2020.

Q Yes. And where was that?

A He was admitted to the hospital and then they put him up into 3B which was the orthopaedic ward.

Q In the children's hospital?

A In the children's hospital. They put him up into the orthopaedic unit, because again it was a specialist vented room because he wasn't allowed to be in the general population.

Q And was that because he was spiking a temperature?

A He was spiking a temperature and he was still -- they considered him immunocompromised, so he is at risk of other things.

Q And was there an infection confirmed on this occasion as well?

A Yes.

Q What was that?

A I think it was adenovirus or the flu. Adenovirus.

Q And then just completing matters. Was your son's treatment, in effect, finished by this stage?

A He was nearing the final of his oral chemotherapy. They stopped that at the end of March.

Q And did he then go on to, is it essentially a review process?

A Yes, it was just another review process, yes.

Q Okay, thank you. That really completes the timeline aspect of things. And what I wanted to look at now was just to look at a comparison of wards 2A and 6A, because you give us some evidence in your statement about that matter.

So maybe I could just start by asking you to compare the facilities on Ward 6A with those that you had experienced in Ward 2A. Can you do that?

A So in part, and with Ward 6A, it felt like a prison. You were literally just stuck to your room. Again, you are either in source isolation or -- because there was nothing, there was no facilities at all on that ward for the children to do anything. The views were about the only good thing about it, because you could see the city of

Glasgow, you could have a look around and watch the planes coming in, but there was no place to come out and have a break. There was no place to kind of meet anybody. You could see faces walking past the room, but there was no contact with anybody or anything, and there was nowhere. You were literally just living in your room.

Q Was this a greater amount of isolation than there had been on 2A?

A Yes.

Q What about from the point of view of parents? What facilities were there for parents on 6A?

A There were no facilities for parents.

Q By way of, for example, a parents' kitchen; was there anything like that?

A Nothing. We were offered meals from the trolley if need be, but again, the kids are not eating it. Are you going to eat it? There wasn't edible food.

Q I mean, kids being fussy is not exactly unknown. Are you saying that that was something that was easier to deal with on 2A?

A Yes.

Q Why was that?

A Because if you knew the kids were -- [redacted] just loved milk, so you could go and get him milk, whatever he wanted. He wanted an ice lolly, I could get him an ice lolly. [redacted] loved toast and butter, I could make him toast. You couldn't do all those things on 6A. They actually stopped that when he was in isolation down on 2A because they felt that was a source of infection, but yes, we couldn't make anything like that, to keep him happy.

Q If you wanted those things on 6A, toast or milk or whatever, how did you go about getting them?

A You would have to buzz for someone to come, or I would just go down to the shop, to Marks & Spencer's and bring milk up.

Q In your statement, you indicate something about the impact on the staff, as a result of this arrangement. What was that?

A I don't think they had any facilities. And they were always forced to go outside to have their breaks away off the wards.

Q But in terms of the absence of facilities for the parents to make toast or a meal or get a glass of milk, did that mean that everything had to go through the staff?

A Yes.

Q So what effect does that have on the staff, then?

A It would increase their workload ten times, because not only have they got a couple of parents or patients wanting something to eat, they will probably want it at the same time, in a ward of, I think, probably 21 patients and then their parents. That then makes it 50 people to look after, instead of just the kids.

Q Yes. Now, on Ward 6A, did the televisions work?

A Sometimes. I'm just trying to think. Yes, they were better than what they were down the stairs in Ward 2A, yes.

Q There was an issue there as well. And you are indicating that it was, in fact, worse on 2A?

A Yes.

Q We have had quite a lot of evidence about televisions not working. In what way does that impact upon a parent looking after a neutropenic child in an isolated environment?

A It's soul destroying. You don't have any distraction. You are basically sitting watching your child lying in bed, either sleeping or being sick or feeling miserable. There's no distractions. And you really become cut off from the world outside. You really don't know what's happening.

Q Is your son somebody who likes stimulus?

A Oh yes, yes. He would be quite happy with his iPad on, the telly on, and something else going on in the background. He is very much in -- it helps to distract him, because of his autism. So he needs that distraction, because that is often what we would use to get him to comply with some of the treatment demands.

Q Is that what you mean when you say in your statement that you need an arsenal of activities?

A Yes. We spent a fortune on multiple things just to get him through what we needed to get him through.

Q Have you got any other reflections on Ward 6A? I am going to ask you some questions about water in a minute, but besides water, do you have any other reflections on Ward 6A?

A It just seemed like a soulless place. The staff were sad. They have lost their comfort, you know? And again, in the Schiehallion, it did seem like a wee small community. Everybody was just isolated and stuck, and I think they were so saddened that they had left their place of work.

Q Did it still feel like a community?

A No.

Q I want to move on now and ask you some questions about issues to do with water. Thinking back to Ward 2A and the initial stages of your son's treatment, what advice were you given about the use of water on Ward 2A?

A There was no advice, other than not to drink tap water. There was bottled water available in the parents' kitchen. There was filters. We were to use sinks with filters fitted. So there was filters fitted in the rooms. But that was essentially all the advice we were given, was to use bottled water for drinking, and filter taps.

Q For those who want the statement reference, it is paragraph 54. I have got a few further questions for you about what you have just said, Mrs Gallagher. Who was it that provided the advice that you have just referred to?

A It was one of the doctors, Sarah, and the nursing staff on the ward, the auxiliaries that would come round and ask if you want water.

Q What was your understanding of why you were not to drink the tap water?

A They just said that it was done to make sure that the water was clean. There was nothing -- it wasn't

specifically said that it was down to any kind of bacteria or anything. It wasn't until the doctor had mentioned that there's maybe something with the water.

Q Okay. Do you have a clear recollection of that conversation or is it just something that you've got a vaguer recollection of?

A That was done when we were down in clinic. We were always cautious, because in the clinic area there was no filters on the taps, so she would just say: make sure you wash your hands with the filters, because some of the toilets even down the main atrium didn't have filters on. In fact, I don't think they all had filters on them. It was just Ward 2A.

Q She was indicating: use taps with filters?

A With filters, yes.

Q What about drainage? Did you ever come across any issues in relation to, for example, the use of showers?

A Yes. Every room pretty much flooded. Room 24 was particularly bad. You had to have quite a few towels rolled up on the floor to stop the water draining out in the main room, and [redacted] was quite impressed with himself one day because he managed to block the

toilet and flood the room, so he was quite pleased with himself that day. He was sploshing about in it.

Q The showers, is this something you experienced in more than one room?

A Yes. It was particularly worse in 24, but Room 1. Room 20 wasn't as bad. And the other rooms, just a small amount.

Q Was this something that you discovered yourself or was it something you were told about in advance?

A Actually, probably something I found out myself on the first day. Then one of the auxiliaries came in with an extra towel and said: that's for the floor.

Q How bad was the flooding? If you imagine the worst occasion when there was flooding from a shower; how bad was it?

A In Room 24, it was literally coming up to the actual door of his shower area.

Q It was coming up to --

A Up to the wooden door, which was like the two door partition of the room.

Q Are you indicating that it was coming up to the door that separated the room from the bathroom, or are you --

A Yes.

Q Yes. And over the whole of the period that your son was in hospital, what did you use to wash him?

A I scrubbed him within an inch of his life every day, soap and water from the shower. I didn't want to -- I know parents used baby wipes or water, but in my background, it's soap and water, even though -- I didn't know at the time it could have been causing an infection, but I thought it would be much better to scrub him and dry him hard and to remove as much bacteria as I can off his skin.

Q When you say you didn't know at the time, are you indicating that beyond what you have already told us about drinking water, are you indicating that you were unaware of any other issues?

A (Nods).

Q Now, I want to move on and ask you about some other concerns you had about the hospital and that you have set out in your statement. The first of these is at paragraph 80, for those who want the reference. Do you recall, Mrs Gallagher, being aware of a smell either in the hospital or outside the hospital?

A Yes, it was pretty rancid,

the smell of sewage. It hit you from when you drove into the campus or even over at Marion House. The smell, you could tell -- in fact, you could always tell at 5 o'clock in the morning when the toilets were all getting flushed and drained. The smell was just so off-putting that you didn't want to eat your things. It was one of those things that you became accustomed to it, but yes, you certainly couldn't ignore it.

Q Were you ever aware of it in the hospitals?

A (Nods). It was particularly pungent in the ward. In my statement, [redacted] was in Room 20, which had an outdoor ventilation, which was one of the specialist ventilation rooms, and the smell was particularly bad in that room, the smell of sewage. And you would have thought, with it being a filter specialist room, that you shouldn't be able to smell any kind of odour from outside, because it should be a clean environment. If you can smell it, then there must be something coming in with the smell.

Q Did the smell have any effect upon either you or upon your son?

A Yes. [redacted] was particularly getting quite distressed with it. It was sometimes off-putting. He didn't want

to eat or drink or anything. He just didn't want to kind of -- it just was there. There's nothing you could do.

Q Now, you mentioned, I think it's at paragraph 84 of your statement, a different matter. You mentioned being given some sort of written warning about accessing the hospital, I think in August 2018.

A Yes.

Q Can you tell us a wee bit about that?

A So that was when they were taking the cladding off the hospital, on the kids side. We used to park in the kids car park, which was next to the building, so you could walk straight through and go up in the lifts. But according to this letter, they assumed with the cladding coming off, it was exposing or re-emerging some bacteria that was falling down to the ground. So theoretically it could be falling on to your clothes that you could take into the wards. So they were advising us to park at the furthest away car park and walk in through either the main entrance of Queen Elizabeth or the discharge lounge entrance, past patients and relatives.

Q Now, I want to move on to another topic that you mention. In fact, it's really three things, I think, all to do with pigeons. I think in your

statement, at a number of points, you mention issues that you came across, all related one way or another with pigeons. Do you want to tell us a bit about all of that?

A Yes. So obviously with us moving over to the other entrance, if I was coming over to park the car and the other car park which was further away, but as you are coming through the dead spaces, there was lots of pigeon excrement all over the place and the actual car park itself and on walkways. And when you were going to come through the discharge lounge entrance or the main entrance, you are passing people that are smoking and there was pigeons and things around. When I was up in the Ward 6A with [redacted], one day, I looked out of the window and I could see dead pigeons all across the roof of the building; that's between the Royal Hospital for Children and the Queen Elizabeth, which is a theatre block. And it had a kids play area and there was just several dead pigeons all lying out on top of the roof space.

Q Yes. And in relation to the pigeon excrement that you saw on the ground and I think you said it was on walkways, what was your particular concern about that?

A Again, it comes back to my passion about shoes. People are walking through these areas with it all on their feet. Walking through main areas, walking through the wards and essentially walking into my son's room with it on their shoes.

Q You also mention that at some point, you got a letter from the hospital or from the health board, something to do with fungal infections and pigeon droppings; is that right?

A Yes. I think it was something to do with the cryptococcus, yes.

Q Can you tell us a wee bit about that, if you are able to recall it?

A Yes. So that came to light because [redacted] was literally, he had completed his transplant, so he was back in as part of his line infection. And at that time, [redacted] was quite short of breath and needed oxygen to support his breathing, and they were trying to source the cause of his shortness of breath. He went for a chest x-ray and they couldn't find a cause, but that was the day, as I found out, that the cryptococcus infection was going about and my concern was that [redacted] was in isolation during this period of time. Was he subject to the same infection, because he was short of breath and they could find no cause. And that afternoon, literally, he was

safe to go home and we took him home.

Q Okay. Moving on to a different topic. I want to ask you some questions about communication with the health board, or rather communication by the health board or by the hospital with you and with parents generally. Just stepping back a bit. How would you assess the effectiveness of the communication by the hospital with parents, in relation to the problems that there appeared to be with the hospital building?

A There was no communication; and if it was, it was always directed through the medical and nursing staff, which is completely inappropriate. It's not their job role. It's not their aspect to do. And they were often quite hidden away and weren't transparent, I felt, and it put the clinicians and the nursing staff in a difficult position because they are the ones that are facing the consequences of burying their heads in the sand and not dealing with things at the time when it should have been dealt with.

Q Now, you mention there are a couple of Facebook groups that had been set up to maybe assist with communication. I think there was a parents one and there was a parents and a staff one; is that right?

A Yes, I think that's right.

Q Can you tell us a wee bit about those and also whether you think those were helpful?

A [audio missing] ... of some line of communication with the parents.

Q You also mention that a man called Professor Cuddihy has provided assistance in relation to contact between parents and patients and the health board; is that right?

A Yes, yes.

Q Is that something that you found quite useful?

A I do think that it has been extremely useful. It gives one single person, one point of contact, and able to vocalise and air what our concerns have been and take things forward.

Q Now, moving on then to another aspect of communication. You indicate that you were at a meeting with the then Health Secretary, Jeane Freeman, in September 2019. I wonder if you can recall anything in particular about that meeting that you would like to share with us?

A I was quite angered by the Health Minister when she was talking about the duty of candour and saying that the medical staff and the nursing staff had their duty of candour to divulge what was going on in the

ward and the hospital at that time. I had to disagree with her, I think, because as a professional myself, you would have a concern of saying that the place is not working or there's these issues going on, because you would be known as a whistleblower, and it would have an impact on your employment.

Q What was she saying about that matter?

A She said that the medical staff and the nursing staff were really to have the duty of candour, that there was no underhandedness. They should have been open and transparent with the patients, and that was their decision not to do that.

Q And can you remember what the view of you and other parents was at the meeting, as regards whether it appeared to you that the health staff had a free hand to say what they wanted to say?

A I can't speak for other parents, but I know certainly from my perspective, the nursing staff and the medical staff probably were not able to be open and honest and say -- I don't know if maybe my consultant was a bit more open with me, because I would have probably asked the questions as to: why is he on this, why is he on that? And she felt that she was able to

either try and say what was happening, without going across -- to being open and honest with what actually was really going on.

Q Now, I want to ask you about something else now. In your statement, you indicate that your son was part of something we know is the case note review; is that right?

A Yes.

Q And did that help you to understand some of what you had seen happening during your son's treatment?

A Yes.

Q Do you want to tell us a wee bit more about that?

A Yes. So again, going back to the original meeting I had with Teresa Inkster and Jamie Redfern, when I found out [redacted] had stenotrophomonas, I had asked if they could sample his specific infection and see if they could cross with that with the hospital or the home, because I was under the impression it could have been at the hospital or he could have caught the infection at home so I was kind of hopeful that we would have had some result or reference to that. At the case note review, they had said that probably his infection was linked to the hospital environment and not -- well, they just said it was probable,

because of the sheer numbers at the time, that he got the case note; and it had had a significant impact on his treatment at the hospital and his outcome or his treatment and his completion of his leukaemia.

Q And just thinking about another aspect of what you say about the case note review. Did it help you understand, perhaps, why the hospital either did not or was unable to tell you more about where the infection had come from?

A In terms of why they weren't as honest or open?

Q Well, did it give you any indication about the extent, for example, as to whether there had been testing for --

A Oh yes.

Q -- the infection or the bacteria that was involved in your son's infection?

A Yes. I was under the impression that I would have thought, with the outbreak that [redacted] was involved in, that they would have been taking quite a lot of samples in detail at the time, place, where it was found, the subtype of infection. From the case note review I was quite shocked to hear that, in actual fact, there was no testing done and if there was testing done, there was no indication of where

the test samples were received, what time they were received, or even if they were in the same year. There was no kind of transparency or recollection of when.

Q I think you have already told us that at the first meeting, the one in early September, that Dr Inkster had essentially said that she thought the infection had come from the hospital; is that right?

A Yes.

Q I think you also say, and it is at paragraph 64 for those who want the reference, that you have subsequently seen your son's medical records, and, in fact, you indicate that there is a report that indicated that they didn't think it had come from the hospital; is that right?

A Yes, it just says "not isolated", which means that it has probably never been isolated from the hospital environment.

Q Do you understand now, from what the case note review has said, what that phrase "not isolated" meant?

A Yes, they weren't testing.

Q And "not isolated" indicates an absence of testing or that there's tests not available or something of that nature; is that right?

A Yes, there is no evidence

to say it was there or not there, because they never did the testing.

Q I want to move on, then, and just think about one or two matters, and just move towards the conclusion of your evidence, Mrs Gallagher.

The first thing I want to ask you is about the impacts on your son from all of this; and I'm thinking in particular about the impact of the steno infection. How would you describe that impact?

A We were fortunate that [redacted] 's donor was able to go along with the changes to his schedule, that he was happy to delay treatment and give [redacted] the best chance, because the donation that he received was the best sampling that he could get; so they did a bone marrow aspirate, you know. It meant they went through quite a lot of suffering to get [redacted] where he is today and we were fortunate that his donor was able to go along with him and support him with that.

With the stenotrophomonas, if [redacted] had still had that in his line when he went for transplant, then we ultimately know what the consequence of that would have been, and he would not have been here today, if it had been allowed to continue, or if they had never found that out.

Q And in addition to that, are we right in understanding that also your son went through two lots of surgery, as a result of the infection?

A Yes. He actually went through three. So he went through his appendectomy, he then went through surgery to remove the line and then had to go back into surgery again to get a line placed.

Q Yes. And what about [redacted] during all of that? Was [redacted] aware of all of this and was he concerned, for example, about the postponement of the transplant?

A [redacted] was aware of his diagnosis. We couldn't do anything to him, unless he knew what was happening. He ultimately knew the consequences of him not getting treatment or if he got an infection, he knew that he could potentially die. So yes, we didn't really tell him when he had the line infection. We just told him that it was appendicitis and he wasn't fully aware of that side of things, but he was aware of the consequences.

Q I want to move on now, Mrs Gallagher, and have you think a bit about the impacts on you of these issues. What was the impact on you, on seeing him go through this, going through the line infection and everything that he went through in relation to that?

A Well, to be fair, I probably have a lot of anxiety and mistrust in some of the -- I have definite mistrust in the health board. But it's watching your son suffer and you can't do anything to help him, and he's got an infection that you're trying your hardest to protect him from, and you're doing all your best and you have put him into a place where you think he should be safe, because he was isolating for weeks on end in a hospital room with no contact with anybody. And you have put him in that place, thinking he is safe.

Q Again, if I can ask you to step back a bit and just think about the whole period that your son was in the hospital. Did you have an awareness, over that period, of discussion in the media about issues to do with the hospital?

A Not until the latter end.

Q The latter end. I mean, for example, you have indicated to us one thing that you found out through the media was about the move, or about the closure of Ward 2A; is that right?

A Yes. It was always done through the public media.

Q And you found out about other things towards the end; is that right?

A (Nods).

Q How did it make you feel, to be finding out things from the media, rather than from the hospital?

A I suppose I found it hard. It was just the lack of transparency. They were not honest and trustworthy, and underhanded in how they handled the whole situation. If they were upfront and honest, if there was an issue, we would never have shouted or been upset with them. That is a challenge. What can we do to make it better? What can we do to fix it? It is not about burying our head in the sand.

Q How do you feel about the fact that your son went through surgery, as you say, three times because of an infection maybe linked to the hospital?

A Angry. He should have been there in a place of safety. They were supposed to look after him. I feel bad because we had to put him through that, and he had unnecessary risks due to another general anaesthetic. More pain and time away from his sister at home, because essentially that would have been his recovery time where we could have made memories. Those could have been his last memories we could have made. But he was stuck in a hospital

or going back and forward, trying to protect him.

Q Moving on now, just to really have you give us your concluding reflections. You have done that in your statement, beginning at paragraph 134. I am not going to have you read all of that out just now, Mrs Gallagher. But I wonder if you could have a look at paragraph 138. You say a number of things in particular about the clinical team. I wonder maybe if you just want to read paragraph 138 to us. Read it quite slowly.

A Yes: "I think it's time that somebody answered for what was happening. I think Professor Gibson and her team have taken quite a lot of flak unnecessarily when all they have ever tried to do is their best for the kids, that's ultimately what they've ever tried to do. Even if they gave treatment that wasn't necessary in some parents' eyes, it was all about maintaining the kids' lives and giving them the best chance, so hats off to Professor Gibson's team for what they did try to do. It's not a reflection on them."

Q Thank you. What about the hospital and how do you feel about the problems that you experienced, and were aware of, at the hospital?

A I don't want to be there. I don't feel safe. I still, weirdly enough, love the place because I still have my son, but every time you go there, you just don't feel -- you just wonder what you're actually going to come back with, or is there a risk of [redacted] being back in there? So if anything, we try to avoid it and keep contact to a minimum on clinic days.

Q Is there anything else you want to say before you conclude your evidence today, Mrs Gallagher?

A Obviously [redacted] is aware of the situation. He knows about the inquiry and he was very keen to have his say at the inquiry, but he's aware that he's too young and we probably would be here forever. But he did want me to say, he had said, "Mum, please let them know that it's not the doctors' or the nurses' fault. It is the hospital that is sick, not them. It is the doctors and nurses that should have -- you know, it's not them. It's not their fault."

MR DUNCAN: Thank you, Mrs Gallagher. My Lord, those are all the questions for Mrs Gallagher.

THE CHAIR: Thank you very much, Mrs Gallagher. Thank you for giving your statement and thank you for coming and answering questions. That's now the end of your evidence

and you are free to go. Thank you very much.

A Thank you.

(The witness withdrew)

THE CHAIR: Now, Mr Duncan, the timetabling would have, I think, Mr Gallagher at 2 o'clock. Do you want just to stick with that?

MR DUNCAN: I think that might be best, my Lord.

THE CHAIR: Well, we will rise, and we will sit again at 2.

12:40

(End of Morning Session)