LIST OF ISSUES TO BE ADDRESSED BY THE ELJAMEL INQUIRY

Background to the List of Issues

1. As per paragraph (f) of the Explanatory Notes to the Terms of Reference, the Terms of Reference of the Eljamel Inquiry do not attempt to present a definitive list of every issue that or every person whose evidence the Inquiry will consider. Instead, they specify matters which the Inquiry is empowered to investigate. The Inquiry will interpret its Terms of Reference flexibly, in the public interest and (where appropriate) in consultation with core participants.

2. In order to provide a more detailed explanation of the issues which the Inquiry will seek to examine and determine, the Inquiry has decided to create this List of Issues, in accordance with its principles of clarity and openness, to guide its investigative work.

3. The Inquiry recognises that there may be a degree of overlap between the sections of this List of Issues set out below. This is the result of an attempt on the part of the Inquiry to reflect the full breadth of the various parts its Terms of Reference, the fact that there is a degree of natural overlap between those parts and the desire of the Inquiry to list all relevant issues and not allow any to fall between the different parts of the Terms of Reference.

4. It is likely that the List of Issues will change over time, as the Inquiry uncovers and analyses more information and understands its remit more fully. Thus, issues may be added, deleted or reformulated as the investigative work of the Inquiry progresses. Nothing should be taken to indicate that the Inquiry or the Chair has taken any views on the issues or questions listed. The Inquiry will follow the evidence to resolve these issues.

5. As per the commitment made by the Inquiry in its Core Participant Protocol, core participants will be invited to contribute to the List of Issues, which will be updated

after consideration is given to their suggestions for issues to be included. Any such suggestions from core participants should be sent to Counsel to the Inquiry.

Interpretation

6. The "relevant period" is a phrase used throughout the List of Issues as the Inquiry considers that it would be too prescriptive to seek to define the exact time period relevant to any issue. It will be inevitable that the period relevant to any particular issue will vary depending on the nature of the issue under investigation. The time periods under investigation should be viewed in the broad context of the wide time periods set out in the Terms of Reference which require the Inquiry to investigate matters pertaining to the entire professional practice of Mr Eljamel with NHS Tayside from 1995 and indeed beyond that in certain instances.

7. For the avoidance of doubt, references to the NHS Tayside as a corporate entity would include parts of it (or any of its statutory predecessors), such as the neurosurgery department, clinical governance bodies or human resources department and key individuals within it (or any of its statutory predecessors), including Board members, medical directors, associate medical directors or lead clinicians in the neurosurgical department of Ninewells Hospital, Dundee.

A. <u>NHS Tayside document management processes</u>

Term of Reference 14 - To investigate document management and retention systems within NHS Tayside relating to the professional practice of Mr Eljamel during the course of his employment there (for the avoidance of doubt including medical records and other documentation relating to his practice), including but not limited to the extent to which reviews or investigations into his professional practice during the course of that employment were to any extent undermined by lack of available documents.

<u>Systems of document management within NHS Tayside</u>

In relation to systems governing document management generally, including (for the avoidance of doubt) corporate records as well as medical records:

Management of records relating to Mr Eljamel's practice prior to 2014

1. What systems of document management existed within NHS Tayside (which were relevant to the neurosurgical patients of Mr Eljamel) in the period of his employment there between 1995 and 2014?
2. In particular, how were records generated, stored and processed in or relating to patients being treated in the neurosurgical department of Ninewells Hospital over the relevant period?
3. How were corporate and medical records generated, stored and processed within NHS Tayside, insofar as relevant to the practice of Mr Eljamel?
4. To what extent were medical records accessible and understandable to patients during the course of their treatment? Were systems in this regard adequate?

Retention of records relating to Mr Eljamel's practice

5. What systems were in place in the period before May 2014 to ensure the retention of records relating to cases where there had been adverse outcomes or reports of sub-standard practice and how did they operate?
6. What systems of document management and retention have been in place since Mr Eljamel's employment with NHS Tayside came to an end in May 2014 in connection with his neurosurgical practice?
7. In particular, what systems were in place since May 2014 to ensure the retention of records relating to cases where there had been adverse outcomes or reports of sub-standard practice and how did they operate?
8. Were these systems adequate in the interests of patient information and safety?
9. What changes have there been to document management and technologies which are relevant to the retention of the records relating to the practice of Mr Eljamel?

Documents available relating to the professional practice of Mr Eljamel and relating to his patients

Non-retention of records

10. What documents relating to the professional activities of Mr Eljamel in his work with NHS Tayside exist?
11. To what extent are key documents missing from the records available relating to Mr Eljamel's professional practice in his work with NHS Tayside (including medical records)?
12. Why are key documents or is key information relating to the professional practice of Mr Eljamel missing? Ought these documents to be available?
13. To what extent have key documents and/ or key information relating to the professional practice of Mr Eljamel in his work with NHS Tayside been lost or destroyed?
14. If so, what broad classes of documents were lost or destroyed? When and by whom were they lost or destroyed? What kinds of information might they have contained?
15. If documents were destroyed, under whose authority were they destroyed?
16. Were they reasonably destroyed in the circumstances?
17. Was there a reasonable excuse for documents having been lost, to the extent that they were?

Accuracy of medical and other records

18. In broad terms, has information relevant to the professional practice of Mr Eljamel (or those acting under his supervision) been recorded accurately in available documentation (including medical records)?
19. If not, what types of information have been inaccurately recorded?
20. If information which has been recorded is broadly inaccurate, what were the reasons why?
21. Is there a common pattern? If so, what does this common pattern suggest?

Conclusions

22. To what extent have the systems of document management and their operation within NHS Tayside relating to the professional practice of Mr Eljamel in his work with NHS Tayside been adequate, in the circumstances?
23. Were any failures in this regard excusable?
24. Is there a common pattern to the types of document or information which have not been available when requested/ required without reasonable excuse? If so, what does this common pattern suggest?
25. Broadly, what effect have any such failures had on the ability of former patients or their representatives to access their records or other records relating to the professional practice of Mr Eljamel?
26. In particular, as part of its document management system, have NHS Tayside generally complied in accordance with its legal obligation to do so with subject access requests for access by former patients of Mr Eljamel to medical records? If not, why not?
27. Further, as part of its document management system, has NHS Tayside adequately complied with its obligations to protect the data of former patients of Mr Eljamel, as contained in medical and other records under their control? If not, why not?
28. To what extent have any failures in any of these respects contributed to a lack of understanding about what happened to Mr Eljamel's patients or otherwise undermined their confidence in NHS Tayside's systems of document management, in particular as regards their desire to know why they came to harm and/ or why the truth about the reasons why did not come to light earlier?

NB – see Issues relating to the role of document management in complaints systems and in connection with investigations below

B. Roles and appointment processes

Term of Reference 1 - To investigate the processes leading to the appointment of Mr Eljamel to key positions he held in his professional capacity in Scotland, including (a) Consultant Neurosurgeon, Ninewells Hospital, Dundee on around 9 October 1995 (b) Head of

Department /Section for Surgical Neurology, University of Dundee in around 1996 and (c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee in around 1998, including any induction he may or may not have received upon assuming such roles and the adequacy of the systems in place in that regard within NHS Tayside and the University of Dundee.

NB – as Term of Reference 1 covers all key roles held by Mr Eljamel in his professional practice in Scotland, which is construed as covering all roles which are relevant to his NHS practice, the Inquiry will add necessary roles and issues relating to them as it uncovers evidence of the roles he held and assesses which fall within this definition.

<u>Mr Eljamel's employments with NHS Tayside</u>

29. What were the terms upon which Mr Eljamel conducted each of these roles? What practising privileges did he enjoy?
30. What were his responsibilities in each of these roles, including which hospitals these responsibilities covered?
31. What standards was he expected to adhere to under (i) the terms of his employment and (ii) his professional obligations?
32. What restrictions, if any, applied to his ability to undertake private work in addition to his NHS responsibilities?
33. What shift patterns and on call obligations did he have?
34. What responsibility for the training and supervision of others did he have?
35. How was responsibility for the allocation of work to junior colleagues arranged?

<u>Employment as a consultant neurosurgeon from 1995</u>

36. What interview/ assessment process was undertaken in connection with Mr Eljamel's appointment to this role?
37. What qualifications and other experience did he present as part of his application?

38. What investigation was undertaken by NHS Tayside of the material presented in support of his application including, in particular, any concerns which had been raised about his professional practice before his time in Tayside?
39. What was the outcome of those investigations?
40. What reliance was placed on the information presented in awarding him the role?
41. How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?
42. What assessment was undertaken by NHS Tayside of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?
43. What assessment was undertaken by NHS Tayside of Mr Eljamel's (a) communication skills (internally and externally) and (b) ability to train others? Was that assessment adequate?
44. Ought Mr Eljamel to have been awarded the position?

<u>Head of Department /Section for Surgical Neurology, University of Dundee in around 1996</u>

45. What interview/ assessment process was undertaken in connection with Mr Eljamel's appointment to this role?
46. What qualifications and other experience did he present as part of his application?
47. What investigation was undertaken by NHS Tayside of the material presented in support of his application, including, in particular, any concerns which had been raised about his professional practice before his appointment?
48. What was the outcome of any such investigation?
49. What reliance was placed on this information presented in awarding him the role?
50. How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?
51. What assessment was undertaken by NHS Tayside of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?
52. What assessment was undertaken by NHS Tayside of Mr Eljamel's (a) communication skills (internally and externally) and (b) ability to train others? Was that assessment adequate?
53. Ought Mr Eljamel to have been awarded the position?

Lead Clinician for Neurosurgery and Pain, Ninewells Hospital Dundee from around 1998

54. What interview/ assessment process was undertaken in connection with Mr Eljamel's appointment to this role?
55. What qualifications and other experience did he present as part of his application?
56. What investigation was undertaken by NHS Tayside of the material presented in support of his application, including, in particular, any concerns which had been raised about his professional practice before and his appointment?
57. What was the outcome of any such investigation?
58. What reliance was placed on this information presented in awarding him the role?
59. How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?
60. What assessment was undertaken by NHS Tayside of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?
61. What assessment was undertaken by NHS Tayside of Mr Eljamel's (a) communication skills (internally and externally) and (b) ability to train others? Was that assessment adequate?
62. Ought Mr Eljamel to have been awarded the position?

Inductions into the key roles assumed by Mr Eljamel

63. What was the nature of the inductions which Mr Eljamel received for the roles listed in Term of Reference 1?
64. In particular, what induction (if any) did he receive relating to systems and responsibilities relating to his duties of candour with patients and other relevant bodies?
65. What induction (if any) did he receive relating to standards required of him in relation to (a) the training and supervision of his junior colleagues and (b) the importance of communication (both internally and externally)?
66. Were those inductions adequate, in light of the nature of the role and Mr Eljamel's particular qualifications and experience?

67. What measures were taken to ascertain whether the induction (if any) was adequate and that at the completion of it, Mr Eljamel was adequately informed and equipped to perform his duties in the role?

Other key roles

68. What other significant professional roles or positions did Mr Eljamel hold in his academia, in the NHS or associated with his NHS roles?
69. What assessments were done of his professional competency to perform these roles/ hold these positions?
70. In particular, what was NHS Tayside's Specialist Services Group Clinical Governance Committee? What role did Mr Eljamel play on it? What assessment was done as to his professional competency to hold such a position?
71. What advisory role (if any) did Mr Eljamel hold with the Scottish Government? What were Mr Eljamel's responsibilities in that regard? What assessment was done as to his professional competency to hold such a position?
72. What professional affiliations did Mr Eljamel hold? What assessment was done as to his professional competency to hold such professional affiliations?
73. What assessment was done as to his professional competency to hold the position of "Honorary Professor" at the University of Dundee, to which position he was appointed on 22 September 2009?

C. Mr Eljamel's professional practice with NHS Tayside

Term of Reference 2 - To investigate the role, if any, of the following factors in contributing to adverse outcomes for former patients of Mr Eljamel during the course of his employment with NHS Tayside:

(a) Mr Eljamel's private practice;

(b) Mr Eljamel's supervision of professional colleagues within the NHS, including but not limited to the circumstances in which surgeries were undertaken by trainee

surgeons on Mr Eljamel's patients and any allegations of bullying or intimidation of professional colleagues by him;

(c) Workload pressures within NHS Tayside;

(d) Mr Eljamel's employment by or appointments within the University of Dundee; and

(e) The role of any research undertaken by Mr Eljamel on or involving his former patients.

<u>The professional activities of Mr Eljamel and those working under him within NHS Tayside</u>

74. What types of work were undertaken by Mr Eljamel in his professional practice in the period between 1995 and 2013?
75. How many patients were under his care over that period, divided over time periods and by type of medical issue being treated?
76. How did the numbers under his care over that period compare with averages for patient numbers under the care of neurosurgeons at his various levels of seniority?
77. How complex were the medical issues with which Mr Eljamel's patients presented for treatment/ care?

<u>Sub-standard care</u>

78. What broad patterns of sub-standard practice occurred in the pre-operative care of patients Mr Eljamel's patients by Mr Eljamel and/ or the team working under his supervision within NHS Tayside?
79. In particular, what broad patterns of sub-standard practice occurred involving:

(a) Inadequacies in informed consent being taken from the patient;

(b) Inadequacies in the accuracy or completeness of information provided to the patient more generally;

(c) Misdiagnosis; or

(d) Inadequacies in any steps which would normally be taken prior to surgery (such as investigations including tests, scans etc) which were not.

80. What broad patterns of sub-standard practice occurred in the surgical treatment of Mr Eljamel's patients within NHS Tayside?
81. In particular, what broad patterns of sub-standard practice in treatment occurred involving:

(a) Technical flaws in the performance of surgery;
(b) Unperformed surgery;
(c) Incomplete surgery;
(d) Unnecessary surgery;
(e) Excessive surgical intervention;
(f) Surgery not otherwise performed in accordance with the agreement arrived at with the patient; or
(g) Surgery occurring at the wrong operative site.

82. What broad patterns of sub-standard practice occurred in the post-operative care of Mr Eljamel's patients within NHS Tayside?
83. In particular, what broad patterns of sub-standard practice occurred in post-operative care involving:

(a) The accuracy/completeness of information provided to the patient post-operatively;
(b) Candour with the patients about anything which had gone wrong; or
(c) The way in which issues raised by the patient about the treatment/care which had been received were dealt with.

84. What broad patterns of sub-standard communication with patients occurred beyond those referred to above?
85. Over what time periods and in what particular areas of neurosurgical practice did this sub-standard professional practice occur?

86. In particular, how significant were these examples of sub-standard treatment and/ or care by Mr Eljamel and/ or his team, compared to accepted clinical guidance at the time of the occurrence?
87. Were there significant patterns of sub-standard treatment or care with regard to their timing and/ or the type of sub-standard practice involved in the treatment of Mr Eljamel's patients?

Involvement in and impact of commitments to private practice

88. What patterns and types of private work were undertaken by Mr Eljamel over his career?
89. What proportion of the work undertaken by him was in the private sphere?
90. What mechanisms existed to control the way in which Mr Eljamel arranged his respective commitment to his private and NHS work?
91. In particular, to what extent did a system exist to monitor and control the timing and extent of his respective commitments to private and NHS practice within NHS Tayside? Did any such system operate adequately?
92. What impact did his private commitments have on his engagement with his NHS practice?
93. How did his commitments to private practice manifest itself in the care which was provided to his NHS patients?
94. In broad terms, was the harm suffered by Mr Eljamel's patients (if any) impacted upon by his private commitments? In what way?

Supervision of professional colleagues

95. What professional standards existed to regulate the manner in which professional training of junior neurosurgeons was carried out by consultant neurosurgeons and the supervision of them was undertaken in the relevant period?
96. What responsibilities did Mr Eljamel have for the supervision and training of professional colleagues in the treatment and care of his NHS patients?

97. What mechanisms existed to control the way in which Mr Eljamel trained his junior neurosurgical colleagues?
98. What proportion of professional responsibilities in the care and treatment of Mr Eljamel's patients was undertaken by him and what proportion was undertaken by junior colleagues in training?
99. How did these arrangements manifest themselves in the care which was received by Mr Eljamel's NHS patients?
100. In broad terms, what harm (if any) was suffered by Mr Eljamel's patients impacted upon by these arrangements? In what way?

Bullying and/ or intimidation by Mr Eljamel

101. To what extent did Mr Eljamel bully or intimidate junior colleagues whilst he trained or supervised them?
102. In what forms did such bullying or intimidation manifest themselves?
103. How common were they?
104. Was harm broadly suffered by Mr Eljamel's patients as result? In what way?
105. In particular, to what extent did any such conduct on Mr Eljamel's part result in inadequate compliance by junior staff members in whistleblowing or other clinical governance mechanisms, in which they might otherwise have participated?

Workload pressures within NHS Tayside

106. How was the amount and allocation of work undertaken in the neurosurgery department of Ninewells Hospital, Dundee arranged and controlled between 1995 and 2014?
107. In comparison with surgical standards over the relevant period, was the workload undertaken by Mr Eljamel and his NHS team excessive?
108. How did any excess workload manifest itself in the way in which patients were treatment, in particular with regard to the seniority of surgeons undertaking that treatment?

109. What oversight was undertaken of the way in which work was allocated to Mr Eljamel and within his team?

110. Was any such oversight adequate to protect the interests and rights of Mr Eljamel's NHS patients?

111. In broad terms, what harm (if any) was suffered by Mr Eljamel's patients impacted upon by these working arrangements and any lack of oversight of them? In what way?

Mr Eljamel's employment by or appointments within the University of Dundee

112. Other than work connected to research (see below), what was the nature and extent of any employment which Mr Eljamel held within the University of Dundee in the period between 1995 and 2014?

113. What oversight of Mr Eljamel's other work for the University of Dundee was undertaken by NHS Tayside or the University of Dundee?

114. Was any such oversight adequate to protect the interests and rights of Mr Eljamel's NHS patients?

115. How did his commitment to these posts within the University of Dundee affect the care which was received by Mr Eljamel's NHS patients?

116. In broad terms, what harm (if any) was suffered by Mr Eljamel's patients impacted upon by these arrangements? In what way?

117. What other academic commitments did Mr Eljamel have, for example relating to the authorship of articles or textbooks?

118. How did these commitments affect the care which was received by Mr Eljamel's NHS patients?

119. In broad terms, what harm (if any) was suffered by Mr Eljamel's patients impacted upon by these commitments? In what way?

The role of any research undertaken by Mr Eljamel on or involving his former patients

120. What was the nature and extent of any research projects in which the former patients were enrolled by or on behalf of Mr Eljamel?

121. What was the objective of such research projects?

122. Broadly what was the nature of the information provided to patients about their enrolment in such projects? Was that information adequate to obtain their informed consent to participation?

123. What steps were taken to keep patients so enrolled and, separately to protect their best interests?

124. Were the best interests of patients so enrolled adequately protected by Mr Eljamel and his clinical team?

125. What oversight of Mr Eljamel's practices in enrolling patients in such research projects was undertaken by NHS Tayside or the University of Dundee?

126. Was any such oversight adequate to protect the interests and rights of the patients so enrolled?

D. <u>Professional candour</u>

Term of Reference 7 - To investigate whether (and if so to what extent) Mr Eljamel concealed or failed to disclose evidence of sub-standard professional practice by him from or to his former NHS patients, former professional colleagues, NHS Tayside or relevant regulatory bodies during the period of his employment with NHS Tayside.

<u>Professional obligations and systems relating to sharing of information by doctors about what had gone wrong</u>

127. What professional obligations existed during the period between 1995 and 2013 relating to the duty on medical professionals to share information with their patients about things that had gone wrong in their medical treatment or care, and why they had gone wrong?

128. What professional obligations existed during the period between 1995 and 2013 relating to the duty on medical professionals to be share information with their professional colleagues information about things that had gone wrong in the treatment or care of their patients, including why they had gone wrong?

129. What professional obligations existed during the period between 1995 and 2013 relating to the duty on medical professionals to be share information with the General Medical Council and their employing Health Board information about things that had gone wrong in the treatment or care of their patients, including why they had gone wrong?

130. Broadly, to want extent was information about the clinical circumstances in which things had gone wrong and why adequately shared with (a) patients and/ or their families (b) professional colleagues outwith the clinical team (c) the General Medical Council and (d) NHS Tayside by Mr Eljamel and/ or his clinical team?

Operation of systems

131. What systems existed to facilitate and regulate an adequate level of information sharing about the clinical circumstances in which things had gone wrong between Mr Eljamel/ his clinical team and his patients and/ or their families?

132. What systems existed to facilitate and regulate an adequate level of information sharing about the clinical circumstances in which things had gone wrong between Mr Eljamel and his professional colleagues outwith his team, including but not limited to the adequacy of morbidity and mortality meetings/ patient reviews/ surgical audit?

133. What systems were in place to ensure that an appropriate level of candour between Mr Eljamel/ his clinical team and (i) the General Medical Council and (ii) NHS Tayside was properly maintained?

134. Broadly, did those systems operate adequately in light of prevailing professional guidance at the material time/ in the best interests of patients?

135. Who or what organisations was/ were responsible for any failings in those systems?

136. Was there a cover-up by or on behalf of Mr Eljamel?

E. Clinical and professional governance

Term of Reference 3 - To investigate the operation and adequacy of clinical governance and risk management processes in place within NHS Tayside for the oversight of Mr Eljamel's work during the period of his employment with NHS Tayside, including for the avoidance of doubt (a) any corporate and professional governance processes, including whistleblowing and reporting processes (b) the extent to which any such systems were adequately engaged and participated in by those working in NHS Tayside as well as (c) the interaction between NHS Tayside and any private provider of medical services for which Mr Eljamel also provided professional services or lack thereof.

Term of Reference 5 - To investigate any findings, lessons learned and recommendations from any complaints or feedback process or systems of oversight of the professional activities of Mr Eljamel during the course of his employment with NHS Tayside as well as the nature, adequacy and effectiveness of any systems or processes put in place to implement or otherwise act on any such findings, lessons learned or recommendations from those processes or minimise any risks to patient safety, quality of care or experience.

<u>General</u>

137. What is clinical governance?
138. What are the aims of clinical governance?
139. What is corporate clinical governance? What are its aims?
140. What is professional clinical governance? What are its aims?
141. What corporate, professional or clinical standards existed over the relevant period relating to the establishment and maintenance of systems of clinical governance, relevant to the NHS neurosurgical unit in which Mr Eljamel's patients were treated?
142. In what areas was there an expectation or requirement (legal, professional, ethical or otherwise) that systems of clinical governance would be established and maintained, eg risk management, training, professional development, peer review, performance appraisal etc?
143. To what extent did these standards strike an appropriate balance between clinical freedom and oversight?

The structure of NHS Tayside

144. What was the broad corporate structure of NHS Tayside over the relevant period?

145. What were the respective responsibilities of key bodies and individuals with regard to the clinical governance of the practice of medical professionals like Mr Eljamel, such as the NHS Tayside Board, medical directors etc?

146. Were lines of responsibility clear and structured in an efficient way with regard to the promotion of patient safety? If not, why not?

Corporate clinical governance

147. What systems of corporate clinical governance were operated by NHS Tayside over the activities of Mr Eljamel (including as regards the performance of junior colleagues under his supervision) during the course of his employment with them?

148. What were the aims and objectives of those systems?

149. Were those systems adequate? Was their planning and operation in the best interests of Mr Eljamel's patients?

150. What ongoing assessment was undertaken by NHS Tayside of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?

151. What ongoing assessment was undertaken by NHS Tayside of Mr Eljamel's professional responsibilities and patient care, including communication with patients? Was that assessment adequate?

152. What ongoing assessment was undertaken by NHS Tayside of Mr Eljamel's training and supervision of other surgeons? Was that assessment adequate?

153. In particular, what system of adverse incident review near miss review was undertaken in connection with the patients of Mr Eljamel? How did it operate? What did it find? Was that process adequate?

154. What internal training requirements was Mr Eljamel subjected to? What assessment was done as regards as his compliance with them?

155. What information sharing systems existed between NHS Tayside and other bodies with responsibility for the oversight of Mr Eljamel? Were these adequate?

156. To what extent did professional colleagues engage adequately with NHS Tayside's corporate clinical governance processes in connection with the professional practice of Mr Eljamel (other than as regards whistleblowing/ reporting processes, addressed below)? If not, why not?

Professional governance

157. What internal systems of professional governance existed within NHS Tayside over the relevant period?

158. Who was responsible for the establishment and effective operation of such systems?

159. Were the systems which operated within NHS Tayside in this regard adequate?

160. What broad impact did any inadequacies in these systems or their implementation/ operation have in outcomes for patients?

161. In particular, what ongoing assessment was undertaken by professional colleagues working within NHS Tayside of Mr Eljamel's (a) surgical/ technical capabilities and experience (b) communication and (c) training/ supervision of other surgeons? Was that assessment adequate?

162. What line management arrangements were applied to Mr Eljamel's professional practice? Were these adequate?

163. What ongoing assessment was undertaken by professional colleagues working within NHS Tayside of Mr Eljamel's professional responsibilities and patient care? Was that assessment adequate?

164. What regular appraisal of Mr Eljamel was undertaken by professional regulatory bodies, such as the General Medical Council? What awareness did NHS Tayside have of these/ what reliance was placed on them?

165. What internal professional training requirements was Mr Eljamel subjected to? What assessment was done as regards as his compliance with them?

Whistleblowing and reporting processes

166. What whistle-blowing policy existed within NHS Tayside over the relevant period?

167. What whistle-blowing or other similar systems existed for junior colleagues working under Mr Eljamel or other professional colleagues to report (a) sub-standard training by Mr Eljamel (b) sub-standard supervision by Mr Eljamel (c) inadequate allocation of work amongst Mr Eljamel's neurosurgical team to bring to the attention of other relevant bodies concerns or evidence they had about sub-standard professional practice on his part?

168. Were the systems which operated within NHS Tayside in this regard adequate?

169. What broad impact did any inadequacies in these systems or their implementation/ operation have in outcomes for patients?

170. What knowledge was available to his NHS medical colleagues of Mr Eljamel including (i) those in his neurosurgical team (ii) other medical colleague with whom he worked (such as neurologists, radiologists or anaesthetists) or (iii) other consultant neurosurgeons about broad patterns of sub-standard practice by Mr Eljamel?

171. What reports (if any) were made by his NHS colleagues about broad patterns of sub-standard practice by Mr Eljamel? To whom were they made? Were they made in an adequate and timely fashion?

172. What was the reasoning behind the reporting which took place and its timing/ why did it not?

173. Were the reports made adequate and timely, in light of what was known about broad patterns of sub-standard practice to his professional colleagues?

174. What steps should have been taken by his professional colleagues in light of what was known?

175. Broadly, what difference would any of these alterative courses of action made to Mr Eljamel's ability to continue to practise as he did and, by extension, outcomes for his patients?

<u>Private providers</u>

176. What information sharing systems existed between NHS Tayside and private healthcare providers as regards the professional activities of Mr Eljamel, including in relation to patients treated in both systems?

177. In particular, what systems existed for NHS Tayside to gather information about things which had gone wrong in Mr Eljamel's private practice or complaints which had been raised against him in the private sphere?

178. Were these systems adequate with regard to NHS Tayside's obligations towards its patients under the care of Mr Eljamel? If not, why not?

179. What key events did go wrong in the care provided by Mr Eljamel to his private patients/ what complaints were raised?

180. To what extent was information about these key events shared with NHS Tayside?

181. Was the extent of information sought by NHS Tayside about the standard of Mr Eljamel's private practice reasonable? If not, in what regards was it not?

182. If such information was shared with NHS Tayside, what action did that prompt on their part? Was that response adequate? If not, why not?

183. If such information was not shared with or acted upon by NHS Tayside, had such information been available to NHS Tayside and acted upon appropriately, what response would/ should that have prompted on their part? What broad difference would that have made to outcomes for patients?

<u>Clinical governance response based on clinical and professional governance systems</u>

184. What steps were taken to address any aspects of Mr Eljamel's professional practice which were known about by NHS Tayside resulting from its clinical governance system(s)? What steps ought to have been taken in light of that knowledge, including but not limited to sharing relevant information with patients?

185. What information ought to have been brought to the attention of NHS Tayside in accordance with the proper operation of its actual clinical governance system?

186. What information would have been brought to their attention as a result of an adequate corporate governance system, if their actual system was inadequate? What

steps should have been taken in light of that knowledge, including but not limited to sharing relevant information with patients?

187. Broadly, what difference would any of these alterative courses of action made to Mr Eljamel's ability to continue to practise as he did and, by extension, outcomes for his patients?

F. Complaints and investigations

Term of Reference 4 - To investigate the adequacy and effectiveness of complaints and feedback processes operated by NHS Tayside relating to Mr Eljamel's employment with NHS Tayside, including processes relating to any complaints, concerns or feedback received from either his former patients or their representatives and/ or staff and how NHS Tayside communicated with those complainants.

Term of Reference 5 - To investigate any findings, lessons learned and recommendations from any complaints or feedback process or systems of oversight of the professional activities of Mr Eljamel during the course of his employment with NHS Tayside as well as the nature, adequacy and effectiveness of any systems or processes put in place to implement or otherwise act on any such findings, lessons learned or recommendations from those processes or minimise any risks to patient safety, quality of care or experience.

In this section of the List of Issues:

(a) Insofar as these ToRs require the Inquiry to look at complaints, concerns or feedback raised by staff listed, there is an apparent overlap with the issues arising connected to systems for reporting/ whistleblowing arising from ToR 3 (see above); and

(b) Complaints should be taken to have a wide definition, including complaints made informally, internally to the neurosurgical department (including feedback) or externally, including to any formal complaints system or body within NHS Tayside, which should be taken to include complaints intimated by way of legal claim.

Systems

188. What legal, professional or other obligations existed over the relevant period relating to patient complaints and feedback on the care or treatment they had received, insofar as relevant to the neurosurgical unit at Ninewells Hospital, Dundee?

189. Was this framework adequate?

190. What systems existed within NHS Tayside? How did these systems operate?

191. What information was provided to patients or their relatives about the complaints system? Was this adequate?

Complaints and feedback

192. What complaints were received relating to the professional practice of Mr Eljamel (including relating to junior colleagues under his supervision) during the course of his employment with NHS Tayside?

193. Broadly, when were they received?

194. How and where were they recorded?

195. How, when and by whom were they investigated, if at all?

196. Was the process by which they were investigate fair and comprehensive?

197. What was the outcome of the complaints?

198. How was this communicated to the relevant patient and/or relative?

199. How was this communicated to Mr Eljamel?

Effectiveness of complaints and feedback systems

200. To what extent were complaints or feedback relating to the professional practice of Mr Eljamel (including relating to junior colleagues under his supervision) adequately investigated and resolved by NHS Tayside?

201. In particular, to what extent were the complaints made or feedback provided by patients or their representatives taken seriously and handled fairly? Were patients adequately engaged and informed? If not, why not?

202. Were such investigations investigated in reasonable time? If not, why not?

203. What steps were taken to address any aspects of Mr Eljamel's professional practice which were known about by NHS Tayside resulting from feedback or complaints?

204. What steps ought to have been taken in light of that knowledge, including but not limited to sharing relevant information with patients?

205. Broadly, what difference would any of these alterative steps made to Mr Eljamel's ability to continue to practise as he did and, by extension, outcomes for his patients?

206. Whan complaints or feedback was received to what extent did this prompt a review of previous complaints or feedback, or other issues of concerns resulting from corporate or professional clinical governance processes relating to Mr Eljamel, so as to allow any fresh issue to be looked at in context? Were efforts made in this regard adequate? If not, why not?

207. To what extent was the investigation of feedback or complaints undermined by a lack of adequate (including reasonably accurate) records being available?

208. What difference would the availability of adequate documentation have made to the outcome of such feedback or complaints processes?

209. To the extent that was appropriate, what efforts were made to make information about professional complaints, how they were determined and steps taken in light of them available to patients or potential patients of Mr Eljamel to assist them with making choices about treatment? Was that information adequate for that purpose?

G. <u>Organisational candour</u>

Term of Reference 13 - To investigate whether and if so to what extent NHS Tayside concealed or failed to disclose evidence of which it was or ought reasonably to have been aware (either though any such investigations or reviews or otherwise) of sub-standard professional practice by Mr Eljamel during his employment with NHS Tayside including in the treatment of his former patients in that employment from or to his former NHS patients, relevant professional regulatory bodies, the or the Scottish Government.

NB – systems of clinical governance and their operation are dealt with above

Organisational obligations

210. What legal and other obligations were incumbent upon NHS Tayside to act on information about sub-standard professional practice and harm or potential being caused to patients?

211. In particular, what reporting obligations did they have to (i) the General Medical Council (ii) patients and/ or their relatives, both in individual cases and more generally relating to their right to be able to assess the risks for themselves and (iii) the Scottish Executive/ Government?

212. What consideration was given by NHS Tayside to what action it should take to comply with those obligations as a result of information which came to its attention about those matters relating to the practice of Mr Eljamel and/ or his team?

Actions and outcomes

213. What reports (if any) were made by NHS Tayside to (i) the General Medical Council (ii) patients and/ or their relatives, in individual cases and/ or more generally to (iii) the Scottish Executive/ Government or (iv) the police?

214. What was the reasoning behind the reporting which took place and its timing/ why did it not?

215. Were the reports made adequate, in light of what was known to NHS Tayside?

216. What steps should have been taken in light of what was known?

217. To what extent was there any cover-up of what was suspected or known about the professional practice of Mr Eljamel by NHS Tayside? If there was, who was responsible for that?

218. Broadly, what difference would any of these alterative courses of action made to Mr Eljamel's ability to continue to practise as he did and, by extension, outcomes for his patients?

H. The roles of other bodies

Term of Reference 6 - To investigate the role of any other bodies which played or could have played a role in the care provided by Mr Eljamel to his former NHS patients, including but not limited to:

(a) the Scottish Council for Postgraduate Medical and Dental Education and NHS Education for Scotland relating to the maintenance of standards in the training of doctors and surgeons;

(b) the Clinical Standards Board for Scotland, NHS Quality Improvement Scotland (NHS QIS) and Healthcare Improvement Scotland (HIS) relating to the maintenance of healthcare standards; and

(c) the Scottish Executive/ Government relating to its overall responsibility for the NHS in Scotland.

<u>General</u>

219. Beyond NHS Tayside and the General Medical Council, what other organisations were, could have been and should have been involved in the regulation of the professional practice of Mr Eljamel?

220. What were the legal and other responsibilities of the other bodies listed within Term of Reference 6 with regard to the maintenance of appropriate standards relating to the interests of patients such as those of Mr Eljamel?

221. What powers did they have to investigate and address any such concerns?

222. What systems did each maintain for the regulation of the maintenance of appropriate standards relating to the interests of patients such as those of Mr Eljamel?

223. Were these systems appropriate in light of the responsibilities of the bodies concerned?

(a) <u>The Scottish Council for Postgraduate Medical and Dental Education and NHS Education for Scotland relating to the maintenance of standards in the training of doctors and surgeons</u>

224. At what point, it at all, were concerns about Mr Eljamel brought to the attention of these bodies?

225. By whom were these concerns raised?

226. What was the nature of the concerns which were brought to these bodies' attention?

227. What action did they take as a result, including investigations of the concerns and measures taken to address them?

228. Were these actions adequate in light of the nature of the concerns, the outcome of any investigations and the powers and responsibilities of the body concerned?

229. Beyond the remit of the concerns raised with them, what steps were taken by these bodies to investigate and regulate the professional practice Mr Eljamel (including relating to junior colleagues under his supervision)?

230. In light of the remit of these bodies, were the steps taken in that regard adequate?

231. What other educational bodies (such as the University of Dundee and the Department for Medical Education) took steps to examine the adequacy of Mr Eljamel's professional practice? What did any such investigations find? Were the investigations undertaken or actions taken adequate?

(b) <u>The Clinical Standards Board for Scotland, NHS Quality Improvement Scotland (NHS QIS) and Healthcare Improvement Scotland (HIS) relating to the maintenance of healthcare standards</u>

232. At what point were concerns about Mr Eljamel brought to the attention of these bodies?

233. By whom were these concerns raised?

234. What was the nature of the concerns which were brought to these bodies' attention?

235. What action did they take as a result, including investigations of the concerns and measures taken to address them?

236. Were these actions adequate in light of the nature of the concerns, the outcome of any investigations and the powers and responsibilities of the body concerned?

237. Beyond the remit of the concerns raised with them, what steps were taken by these bodies to investigate and regulate the professional practice Mr Eljamel (including relating to junior colleagues under his supervision)?

238. In light of the remit of these bodies, were the steps taken in that regard adequate?

(c) <u>The Scottish Executive/ Government relating to its overall responsibility for the NHS in Scotland</u>

NB – the role of the Scottish Government in its investigations relating to Mr Eljamel which were actually undertaken and the possibility of a public or other governmental inquiry are addressed below. For the avoidance of doubt, references to the Scottish Executive/ Government as a corporate entity would include parts of it, such as its directorates or key individuals within it, including relevant ministers or key civil servants, such as the Chief Medical Officer for Scotland.

239. At what point were concerns about Mr Eljamel first brought to the attention of the Scottish Executive/ Government?

240. By whom were these concerns raised?

241. What was the nature of the concerns which were brought to the Scottish Executive/ Government's attention?

242. What action did they take as a result, including investigations of the concerns and measures taken to address them, insofar as not covered in the section relating to investigations below?

243. Were these actions adequate in light of the nature of the concerns, the outcome of any investigations and the powers and responsibilities of the body concerned?

244. Beyond the remit of the concerns raised with them, what steps were taken by the Scottish Executive/ Government to investigate and regulate the professional practice of Mr Eljamel (including relating to junior colleagues under his supervision)?

245. In light of the overarching responsibilities of the Scottish Executive/ Government for the NHS in Scotland (including NHS Tayside), were the steps taken in that regard adequate?

I. Restrictions relating to Mr Eljamel's practising privileges

a) Clinical supervision on 21 June 2013

Term of Reference 8 - To investigate the circumstances and processes which led to the clinical supervision of Mr Eljamel which was imposed by NHS Tayside on 21 June 2013, its timeliness, adequacy and effectiveness.

246. Why was Mr Eljamel placed under clinical supervision on 21 June 2013?

247. What process was followed to lead to that restriction on his practicing privileges?

248. How appropriate was it that he was placed under clinical supervision at that time?

249. What consideration had been given by NHS Tayside to imposing clinical supervision or other censure on Mr Eljamel before that time? Why was it not? Ought it to have been? How would that have affected broad outcomes for patients?

250. Why was it considered appropriate that that measure should be taken as opposed to any other form of restriction or censure?

251. What intimation was made to the General Medical Council by NHS Tayside of the fact of and reason for the imposition of clinical supervision of Mr Eljamel? Ought it to have been? What would the outcome of such intimation have been?

The operation of the clinical supervision

252. What were the practical requirements/ consequences of being under supervision for Mr Eljamel?

253. Why were these considered adequate at the time? Were they appropriate?

254. What alternatives were considered? Why were they rejected?

255. In practice, what measures were actually imposed on Mr Eljamel under the clinical supervision order?

256. Was the restriction imposed adequate, in practice?

257. How effective were the measures in monitoring and improving Mr Eljamel's clinical practice?

258. What were patients told about the fact of and the reasons for Mr Eljamel's clinical supervision?

259. Were patients adequately informed of these matters, to enable them to make informed choices about treatment and care which was being offered by him/ his team?

b) Suspension of practising privileges on 10 December 2013

Term of Reference 9 - To investigate the processes and circumstances which led to the suspension of Mr Eljamel by the Board on 10 December 2013, including whether he was suspended timeously.

260. Why was Mr Eljamel suspended on 10 December 2013?

261. What process was followed to lead to that restriction on his practicing privileges?

262. How appropriate was it that he be suspended at that time?

263. What consideration had been given by NHS Tayside to imposing a suspension or other censure on Mr Eljamel before that time? Why was it not? Ought it to have been? How would that have affected broad outcomes for patients?

264. Why was it considered appropriate that that measure should be taken as opposed to any other form of restriction or censure?

265. What intimation was made to the General Medical Council by NHS Tayside of the fact of and reason for the imposition of a suspension of Mr Eljamel? Ought it to have been? What would the outcome of such intimation have been?

c) Resignation on 31 May 2014

Term of Reference 10 - To investigate the processes and circumstances in which Mr Eljamel came to resign from his position on 31 May 2014, including the impact of the resignation on any investigation into or censure imposed on him.

266. Why did Mr Eljamel resign from his post on 31 May 2014?

267. What discussion took place between NHS Tayside and Mr Eljamel in the period between his suspension in December 2013 and his resignation in May 2014?

268. What was the purpose of the events which took place over that period?

269. What further investigation had taken place over that period?

270. What views had been reached by the time of Mr Eljamel's resignation by NHS Tayside and why had they been reached?

271. What consideration had been given by that point (May 2014) by NHS Tayside to imposing any other censure on Mr Eljamel before that time, including dismissing him from his post? Why was it not? Ought it to have been?

272. Had any other course of action been taken over that period (including in dismissing Mr Eljamel from his post), what effect would that have had on Mr Eljamel's ability to continue his medical practice?

273. What intimation was made to the General Medical Council, patients or the Scottish Government by NHS Tayside of the events relating Mr Eljamel which took place between December 2013 and May 2014? Ought it to have been? What would the outcome of such intimation have been?

d) Voluntary erasure from the GMC medical register in 2015

Term of Reference 11 - To investigate the role of NHS Tayside in the process by which Mr Eljamel came to erase his own name from the General Medical Council's medical register in 2015.

274. What were the reasons why Mr Eljamel came to remove his name from the medical register voluntarily in 2015?

275. What consideration was given by the GMC to the possibility of him being struck off?

276. What investigation by the GMC had been undertaken by the time he voluntarily removed his name from the medical register in 2015 into his professional practice?

277. In particular, what information was provided by NHS Tayside into that process?

278. Was the information which was provided by NHS Tayside adequate? Was it accurate and comprehensive? Was it provided in a timely fashion? If not, why not?

279. To what extent was the GMC investigation undermined by a lack of adequate (including reasonably accurate) records being available from NHS Tayside?

280. What difference would the availability of adequate documentation have made to the outcome of such feedback or complaints processes?

281. What response was provided by NHS Tayside to the application by Mr Eljamel to the GMC to remove his name from the medical register voluntarily? What were NHS Tayside's reasons for adopting that course?

282. Had Mr Eljamel's name been removed from the GMC's medical register as opposed to removing his name from the register voluntarily, what effect would that have had on Mr Eljamel's ability to continue his medical practice?

J. <u>Reviews and investigations</u>

Term of Reference 12 - To examine all previous reviews or investigations undertaken (a) by, on behalf or on the instructions of NHS Tayside or (b) the Scottish Executive/ Scottish Government into the professional activities of Mr Eljamel during the course of his employment with NHS Tayside and to consider the adequacy and timeliness of these

reviews or investigations, including the adequacy of steps taken in light of the findings and recommendations of them, including but not limited to the following:

(a) Royal College of Surgeons report relating to Mr Eljamel commissioned by NHS Tayside dated 2013;
(b) Interim report of NHS Tayside relating to Mr Eljamel dated October 2013;
(c) Final report of NHS Tayside relating to Mr Eljamel dated 6 December 2013;
(d) The NHS Tayside review of complainant cases relating to Mr Eljamel 2014/15;
(e) The External Review by the Executive Medical Director of NHS Lothian to review the process and decision-making regarding the management of Mr Eljamel 2018/2019;
(f) The Scottish Government Review of Unresolved and Outstanding Concerns regarding Mr Eljamel, Former Consultant Neurosurgeon at NHS Tayside 2022;
(g) The NHS Tayside Executive Medical Director Response to Patient A on undertaking a detailed review of surgery carried out and matters arising in theatre 2023;
(h) The NHS Tayside look back at operative cases during the period of Mr Eljamel's supervision (June 21 2013 to December 10 2013) June 2023;
(i) The NHS Tayside Executive medical director report relating to Mr Eljamel dated 25 August 2023; and
(j) The NHS Tayside due diligence review of documentation held relating to Mr Eljamel dated 25 August 2023

<u>General</u>

283. What systems dictated the circumstances in which reviews/ investigations of the nature listed above would be ordered by the bodies which ordered them?

284. Were the systems which governed how these reviews/ investigations were ordered adequate for the types of concerns which gave rise to them? Did these systems permit intervention by corporate bodies in the right way/ at the right time, in light of their responsibilities for the safety of patients such as those of Mr Eljamel?

<u>The reviews/ investigations</u>

285. By whom were these reviews/ investigations ordered?

286. What information and/ or concern had led to the investigations being ordered?

287. What was the remit of the reviews/ investigations? Was their remit adequate to meet the concerns which had prompted them being commissioned?

288. Was the type of investigation ordered adequate to meet the concerns which had prompted them being commissioned?

289. Why were reviews or investigations of the nature listed into the professional practice of Mr Eljamel not ordered earlier?

Conduct of the reviews/ investigations

290. How and by whom were the reviews/ investigations conducted?

291. Were they sufficiently independent and comprehensive?

292. To what extent were the purpose, nature and findings of the reviews adequately intimated to former patients of Mr Eljamel or their relatives? If not, why not?

293. Was evidence/ the point of view of former patients of Mr Eljamel or their relatives taken into account in these reviews/ investigations? If not, why not?

294. To what extent were these reviews or investigations into the professional practice of Mr Eljamel undermined by a lack of available documents or reasonably accurate written information?

295. In particular, why were documents not retained from before 2012 to inform reviews which took place in 2023?

296. What difference would adequate records of what happened have altered the outcomes of these review or investigations?

Outcomes of the reviews/investigations

297. What were the outcomes of the reviews and investigations?

298. Were their findings adequate? What was the reason for any inadequacies?

299. What action was taken in light of the reviews and investigations?

300. Was the action taken in light of them adequate? If not, why not?

301. Did adequate communication of the remit, methodology, limitations and findings of the reviews/ investigations take place with patients or their representatives? If not, who was responsible?

302. Why were so many reviews/ investigations necessary?

Aspects of particular reviews/ investigations

Royal College of Surgeons

303. To what extent were the recommendations made in the Royal College of Surgeons report in 2013 addressed by NHS Tayside? If they were not, why were they not?

304. Were suitable measures put in place as a result? If not, why not?

Scottish Government

305. In particular, what were the reasons why the Scottish Government announced the establishment of (i) the Independent Clinical Review in April 2023 and (b) a public inquiry in September 2023?

306. What consideration had been given to establishing a public inquiry earlier? Why was it not? Should it have been?

Lessons, recommendations and reports

Term of Reference 18 - To identify any lessons and implications for the future and make recommendations, including interim recommendations if the Inquiry considers them appropriate.

307. What lessons can be learned from the evidence considered by the Inquiry and the findings it has made arising from that consideration?

308. What efforts have been made by NHS Tayside and broadly by the wider NHS in Scotland to try to address the issues which have been identified by the Inquiry's investigations and findings? When were these efforts made? Should more have been done sooner?

309. What are the implications for future practice and systems within NHS Tayside and the wider NHS in Scotland of the Inquiry's findings?

310. What can be done to try to improve systems within NHS Tayside and the wider NHS in Scotland to maximise patient safety and experience of neurosurgical care in future?

June 2025

Appendix A – The Eljamel Inquiry Terms of Reference

The Inquiry is a public inquiry under and in terms of the provisions of the Inquiries Act 2005 ("the Act") and the Inquiries (Scotland) Rules 2007 ("the Rules") and has the powers and responsibilities of a public inquiry established by the Scottish Ministers under the provisions of the Act and the Rules.

The Inquiry's Terms of Reference are listed below in accordance with section 5 of the Act. They contain the matters to which the Inquiry relates, in connection with which the Inquiry has the power to exercise its powers under the Act and the Rules, and other matters relating to the scope of the Inquiry specified by the Minister. The terms of reference have been set after consultation with the Chair of the Inquiry in terms of section 5(4) of the Act.

Appointment processes

1. To investigate the processes leading to the appointment of Mr Eljamel to key positions he held in his professional capacity in Scotland, including (a) Consultant Neurosurgeon, Ninewells Hospital, Dundee on around 9 October 1995 (b) Head of Department /Section for Surgical Neurology, University of Dundee in around 1996 and (c) Lead Clinician for Neurosurgery and Pain, Ninewells Hospital, Dundee in around 1998, including any induction he may or may not have received upon assuming such roles and the adequacy of the systems in place in that regard within NHS Tayside and the University of Dundee.

Mr Eljamel's professional practice with NHS Tayside

2. To investigate the role, if any, of the following factors in contributing to adverse outcomes for former patients of Mr Eljamel during the course of his employment with NHS Tayside:

(a) Mr Eljamel's private practice;
(b) Mr Eljamel's supervision of professional colleagues within the NHS, including but not limited to the circumstances in which surgeries were undertaken by trainee surgeons on Mr Eljamel's patients and any allegations of bullying or intimidation of professional colleagues by him;
(c) Workload pressures within NHS Tayside;
(d) Mr Eljamel's employment by or appointments within the University of Dundee; and
(e) The role of any research undertaken by Mr Eljamel on or involving his former patients.

Clinical governance

3. To investigate the operation and adequacy of clinical governance and risk management processes in place within NHS Tayside for the oversight of Mr Eljamel's work during the period of his employment with NHS Tayside, including for the avoidance of doubt (a) any corporate and professional governance processes, including whistleblowing and reporting processes (b) the extent to which any such systems were adequately engaged and participated in by those working in NHS Tayside as well as (c) the interaction between NHS Tayside and any private provider of medical services for which Mr Eljamel also provided professional services or lack thereof.

4. To investigate the adequacy and effectiveness of complaints and feedback processes operated by NHS Tayside relating to Mr Eljamel's employment with NHS Tayside, including processes relating to any complaints, concerns or feedback received from either his former patients or their representatives and/ or staff and how NHS Tayside communicated with those complainants.

5. To investigate any findings, lessons learned and recommendations from any complaints or feedback process or systems of oversight of the professional activities of Mr Eljamel during the course of his employment with NHS Tayside as well as the nature, adequacy and effectiveness of any systems or processes put in place to implement or otherwise act on any such findings, lessons learned or

recommendations from those processes or minimise any risks to patient safety, quality of care or experience.

6. To investigate the role of any other bodies which played or could have played a role in the care provided by Mr Eljamel to his former NHS patients, including but not limited to:

(d) the Scottish Council for Postgraduate Medical and Dental Education and NHS Education for Scotland relating to the maintenance of standards in the training of doctors and surgeons;
(e) the Clinical Standards Board for Scotland, NHS Quality Improvement Scotland (NHS QIS) and Healthcare Improvement Scotland (HIS) relating to the maintenance of healthcare standards; and
(f) the Scottish Executive/ Government relating to its overall responsibility for the NHS in Scotland.

Candour

7. To investigate whether (and if so to what extent) Mr Eljamel concealed or failed to disclose evidence of sub-standard professional practice by him from or to his former NHS patients, former professional colleagues, NHS Tayside or relevant regulatory bodies during the period of his employment with NHS Tayside.

Restrictions relating to Mr Eljamel's practising privileges

8. To investigate the circumstances and processes which led to the clinical supervision of Mr Eljamel which was imposed by NHS Tayside on 21 June 2013, its timeliness, adequacy and effectiveness.

9. To investigate the processes and circumstances which led to the suspension of Mr Eljamel by the Board on 10 December 2013, including whether he was suspended timeously.

10. To investigate the processes and circumstances in which Mr Eljamel came to resign from his position on 31 May 2014, including the impact of the resignation on any investigation into or censure imposed on him.

11. To investigate the role of NHS Tayside in the process by which Mr Eljamel came to erase his own name from the General Medical Council's medical register in 2015.

Reviews and investigations

12. To examine all previous reviews or investigations undertaken (a) by, on behalf or on the instructions of NHS Tayside or (b) the Scottish Executive/ Scottish Government into the professional activities of Mr Eljamel during the course of his employment with NHS Tayside and to consider the adequacy and timeliness of these reviews or investigations, including the adequacy of steps taken in light of the findings and recommendations of them, including but not limited to the following:

(a) Royal College of Surgeons report relating to Mr Eljamel commissioned by NHS Tayside dated 2013;
(b) Interim report of NHS Tayside relating to Mr Eljamel dated October 2013;
(c) Final report of NHS Tayside relating to Mr Eljamel dated 6 December 2013;
(d) The NHS Tayside review of complainant cases relating to Mr Eljamel 2014/15;
(e) The External Review by the Executive Medical Director of NHS Lothian to review the process and decision-making regarding the management of Mr Eljamel 2018/2019;
(f) The Scottish Government Review of Unresolved and Outstanding Concerns regarding Mr Eljamel, Former Consultant Neurosurgeon at NHS Tayside 2022;
(g) The NHS Tayside Executive Medical Director Response to Patient A on undertaking a detailed review of surgery carried out and matters arising in theatre 2023;
(h) The NHS Tayside look back at operative cases during the period of Mr Eljamel's supervision (June 21 2013 to December 10 2013) June 2023;

(i) The NHS Tayside Executive medical director report relating to Mr Eljamel dated 25 August 2023; and

(j) The NHS Tayside due diligence review of documentation held relating to Mr Eljamel dated 25 August 2023.

13. To investigate whether and if so to what extent NHS Tayside concealed or failed to disclose evidence of which it was or ought reasonably to have been aware (either though any such investigations or reviews or otherwise) of sub-standard professional practice by Mr Eljamel during his employment with NHS Tayside including in the treatment of his former patients in that employment from or to his former NHS patients, relevant professional regulatory bodies, the police or the Scottish Government.

14. To investigate document management and retention systems within NHS Tayside relating to the professional practice of Mr Eljamel during the course of his employment there (for the avoidance of doubt including medical records and other documentation relating to his practice), including but not limited to the extent to which reviews or investigations into his professional practice during the course of that employment were to any extent undermined by lack of available documents.

Independent Clinical Reviews

15. To liaise with the Independent Clinical Reviews, which will run in conjunction and cooperation with the Inquiry and to set out publicly how the Inquiry intends to work alongside and cooperate with the Independent Clinical Reviews so as to best discharge the respective terms of reference of each process.

16. To consider any findings of the Independent Clinical Reviews, as the Chair deems appropriate in the fulfilment of these terms of reference.

Evidence

17. To consider any evidence or reports as the Chair deems appropriate.

Lessons, recommendations and reports

18. To identify any lessons and implications for the future and make recommendations, including interim recommendations if the Inquiry considers them appropriate.

19. To produce any reports (including any interim reports) to Scottish Ministers as soon as reasonably practicable.

Explanatory notes

a) As per the provisions of section 2(1) of the 2005 Act, the Inquiry is not able to make determinations of civil or criminal liability. However, the Inquiry is not inhibited in the discharge of its functions by any likelihood of any such liability being inferred from its investigations or findings;

b) The Inquiry is not to determine any fact or may any recommendations which are not wholly or primarily concerned with a "Scottish matter" in terms of section 28 of the 2005 Act;

c) The Inquiry is empowered to make findings about matters falling within its Terms of Reference, including (where appropriate) the identification of things which fell below a reasonable standard, why they did as well as who or what organisations were responsible;

d) The Inquiry will provide an opportunity for public acknowledgement of the suffering of former patients of Mr Eljamel and a forum for public consideration of evidence of their experiences;

e) This Inquiry is empowered to consider making recommendations, in part to seek to ensure that appropriate levels of governance and scrutiny are applied by Health Boards and other bodies covered by the Terms of Reference with responsibility for the maintenance of appropriate standards in the NHS in Scotland in future;

f) The Terms of Reference do not attempt to present a definitive list of every issue or every person that the inquiry will consider. Instead, they specify matters which the Inquiry is empowered to investigate. The Inquiry will interpret its Terms of Reference flexibly, in the public interest and (where appropriate) in consultation with core participants;

g) References in the terms of reference to Mr Eljamel mean Mr Muftah Salem Eljamel (also known as Sam Eljamel), former head of neurosurgery at Ninewells Hospital, Dundee; and

h) References to NHS Tayside should be construed as including Tayside Health Board, any predecessor of NHS Tayside, any part or agent thereof.