Preliminary Hearing of the Eljamel Inquiry, 10th September 2025

(Lord Weir, Chair of the Eljamel Inquiry):

Well, may I begin by welcoming all of those of you who have attended Waverley Gate this morning, and also all of those who are watching and listening to proceedings remotely. Today marks another important staging post in the progress of the Inquiry – this being the first public hearing to take place since the Cabinet Secretary formally set up the Inquiry in April of this year.

As its description suggests, the broad purpose of the preliminary hearing is to provide a forum for Senior Counsel to the Inquiry to provide an update on progress so far, and to provide an outline of what you can expect to happen as the Inquiry takes forward its investigations.

It also enables the recognised legal representatives of the core participants, if they choose to, to raise matters of interest or concern arising from what has been outlined.

In that respect, may I thank those responsible for submitting written submissions in advance of this hearing. That has enabled focus to be brought to bear on the matters of most immediate interest and concern to those whom you represent.

It is not my intention this morning to usurp Counsel's role by involving myself in the detail of how we have reached this point and the direction of travel hereafter; you will hear all about that in just a moment.

But I do wish to take this opportunity, publicly, to renew the commitment I made at the public hearings in October to lead an Inquiry that is at once independent, fair and thorough, but in a spirit of mutual cooperation and, where possible, consensus with the legal representatives of core participants and others.

I encourage engagement with the Inquiry – not least in relation to the List of Issues which has been published on the Inquiry's website – and to which core participants have been invited to contribute.

I also stated in October that I would not hesitate to use my statutory powers to call for and to recover evidence and in due course to compel the attendance of witnesses in order to exhaust the Terms of Reference now fixed by the Cabinet Secretary. Nothing has changed in that respect. Given their scope and inherent complexities, exhausting the Terms of Reference as they now stand will be a significant challenge for the Inquiry team as is the proposed timetable that is about to be outlined to you. It is a challenge which, with the assistance of all of you, my team and I embrace.

I have said before and I repeat that I will be flexible in my interpretation of the Terms of Reference, applying to them a broad rather than a narrow construction as to what they empower me to do.

At its best, healthcare provision in this country is of the highest order or excellence. That is why, when things have gone wrong, it is of very considerable public importance and obvious public interest to find out why and to learn what lessons there are to be learned.

That, in essence, is the challenge we have been set.

Finally, I hope you will allow me to say at the outset that I do attach considerable importance to the spirit in which I intend this inquiry to be conducted now that we are moving away from its establishment phase.

It is more than likely that this hearing and those to come will be difficult for many. But, consistent with the Inquiry's own Statement of Protocols and Principles, published on the Inquiry website, I would ask that all those in attendance at or otherwise involved in the work of the Inquiry interact with others with courtesy and with respect, whether at this hearing or subsequently.

It is in that spirit that the Inquiry is likely to obtain the best possible evidence to support its investigations and that can only be to the advantage of us all.

I will now invite Mr Dawson KC to address the hearing. Uh, Mr Dawson, I understand that there is an intention to have a break at about half past 11 – may I leave it to you to decide when we've reached a suitable point?

(James T Dawson KC, Senior Counsel to the Inquiry):

Thank you very much, sir, and good morning.

I am Jamie Dawson KC. I appear as Senior Counsel Inquiry along with my learned junior, Ms Alex Price-Marmion, Advocate at this first preliminary hearing of the Eljamel Inquiry.

May I extend a warm welcome on behalf of the Inquiry team to all of those in the busy hearing room today as well as those who are joining us online.

Those coming to the work of this Inquiry today, whether they have been directly affected by its subject matter, whether they have been involved in it for a long or a short time, whether they have a complete or partial interest in our remit or whether they are members of the Scottish public more generally deserve to know what our work is about.

Sir, this Inquiry is about **patient care.** It is hardly surprising that this should be the case when our national health service aspires to make the improvement of patient care its ultimate goal. Section 1(1) of the National Health Service (Scotland) Act provides and provided that:

> "It shall continue to be the duty of the Secretary of State to promote in Scotland a comprehensive and integrated health service designed to secure—
>
> (a) improvement in the physical and mental health of the people of Scotland, and
> (b) the prevention, diagnosis and treatment of illness,
>
> and for that purpose to provide or secure the effective provision of services in accordance with the provisions of this Act."

> Where that goal had been lost sight of, forgotten or undermined, where it has been neglected or diminished, either in medical care or by corporate action or inaction, this Inquiry will seek to find out why.

This Inquiry is about **trust**. It is about when and how trust has been undermined and lost, how that loss of trust has manifested itself, whether and how it has been addressed and how harm has been compounded when it has not been.

This Inquiry is about **surgery**. In the field of surgery, it might be said that the requirements of patient care and trust are at a premium. Situations where surgical intervention is contemplated or undertaken are, by their nature, situations of extreme complexity, severity and vulnerability. Patients give of themselves to surgeons in a way which is, often, complete. Considerations of respect, dignity and humanity are thus paramount, both from those involved in the surgery and those involved when things go wrong.

This Inquiry is about **communication**. Communication is at the heart of good patient care, in particular in the surgical field, before, during and after the surgery and where things appear to have gone wrong. Communication is about the truth and the effective communication of it, both of which patients deserve. The Inquiry requires to look at the adequacy and candour of communication, often with vulnerable, distressed and harmed patients, both in the operative sphere and from and with the corporate structures around it. It is also about the maintenance of the ability to communicate the truth by the maintenance of clear and accurate records so that can be the case.

This Inquiry is about **responsibility**. Our national health service owes a legal and moral duty to patients in its care, beyond the more immediate duties owed by treating medical professionals. When patients go to hospital, they reasonably expect that they will be protected by a system beyond the individuals nominally in charge of their case, that that responsibility will extend to other professionals, the health board and other bodies with responsibilities accorded to them by law. The Inquiry will look at the whole system whereby health and wellbeing are meant to be promoted and maintained, and analyse whether that system was and is fit for purpose.

This Inquiry is about **improvement**. The Inquiry has a forward-thinking function to seek to make meaningful recommendations for change so that aspects of medical care which have not worked well will work well in future, in the ultimate service of patient care.

These key components of what the Inquiry is about are not of my invention. They run through our remit and, as I will explain in more detail in due course, were the key messages and priorities which were set out to the Inquiry in its public consultation exercise by those with an interest in our work. These were the key themes which emerged, in particular, from the contributions to that process made on behalf of Mr Eljamel's former patients, whom you have committed, sir, to put at the centre of our work.

It is on the foundation of these themes, and that advice received from those with whom we consulted that the Inquiry's bespoke principles of being trauma-informed, open-mindedness, independence, listening, co-operation, clarity and thoroughness have been constructed, that our planning has been based and our public facing work, which commences today, will proceed.

Sir, this hearing seeks to perform the functions which you have described preliminary hearings of the Inquiry will have under the Inquiry's public hearings protocol, which is published on our website, along with similar Protocols and Orders about the way the Inquiry will work.

In particular, the hearing will seek:

(a) To explain, in overarching terms, the background to the Inquiry and its Terms of Reference;
(b) To set out information concerning the nature of the Inquiry's work so far and its plans going forward as to how the Inquiry team intends to structure and undertake the fulfilment of the Inquiry's Terms of Reference; and
(c) To allow Core Participants to contribute on matters before you today, Sir, as part of their ongoing significant role in the work of the Inquiry.

The Inquiry's Core participants have been provided in advance of this hearing with a Note which was prepared by Counsel to the Inquiry, setting out the agenda of matters which the Inquiry intends to cover and information relating to each matter on that agenda. The CPs were all invited to make written submissions if they wished to do so and an opportunity has been extended to those who provided such written submissions to have an oral submission made on their behalf relating to matters which CPs consider will be of assistance to the Inquiry's ongoing work. Those who have contributed in writing or will do so orally today have been asked to limit their submissions to the matters covered by the agenda, in the interests of the efficient management of the Inquiry and this hearing. The Note by Counsel and the written submissions of the CPs made in response will be published at the conclusion of the hearing, for wider public information and consumption.

I will address you first, Sir, on matters of significance in our progress and planning. These submissions are intended for the members of the general public who take an interest in our work, including the media who wish to report on it, as well as core participants, designated in that capacity in light of the significant connection they have to our remit and to whose role in the Inquiry and the proceedings I will turn to in due course.

Some of them are represented at the hearing, some will make oral contributions, some have made written submissions on matters which they consider to be of relevance to the Inquiry from their perspective, as I will set out. In my submission, I will also seek to address points which have been raised in the written submissions of core participants, provided to us in advance, with the aim of trying to provide answers to their questions and comfort related to their concerns.

As such, I intend to make submissions to you today, on the following matters:

1) Core participants and representation on their behalf today
2) The commencement and progress of the Inquiry;
3) The Independent Clinical Review;
4) Approach to evidence and public hearings;

5) The Terms of Reference and List of Issues;
6) Rule 8 Requests/ Section 21 notices;
7) Disclosure of documents;
8) Instruction of Expert Witnesses;
9) Communication and the Inquiry's trauma-informed approach;
10) Protection of information; and
11) Future hearings dates.

Before proceeding to my more detailed submissions on these matters, I would like to say something about our audience today. These proceedings are being transmitted to those who cannot or do not wish to be here today via a feed which is available via YouTube. A video of the proceedings will be available after the hearing for those who wish to watch it back. The availability of this feed is part of your commitment, Sir, to making our work (including but not limited to what goes on at our public hearings) available to as wide an audience as possible, in the knowledge that there are individuals who take an interest in our work who cannot be here due to physical disability, geographical distance or due to the fact that attending would be too difficult for them for some other reason. Such individuals include but are not limited to members of the core participant body, upon whose active engagement in our work we do and will continue to rely.

The feed will be transmitted with a delay of a few minutes. This mechanism is part of the systems we have in place to try to prevent any confidential information being transmitted to the wider public which should not be. It is unlikely that this will happen today, given the preliminary nature of our discussions. However, in the event that something is said by me or by any other contributor which seems to us to contain information which ought not to have been referred to, I will instruct those who are managing the YouTube transmission to "Cut the feed". They will stop the transmission and we will, most likely, have a short break to work out how we need to proceed. My apologies in advance for any interruption which we need to make of the submissions of others for this purpose – this is why it will be necessary to do so. I would ask those contributing orally to avoid revealing any matters which are likely to be potentially confidential, including people's names. Any such information which is inadvertently referred to must not be referred to or otherwise shared outwith this room

and is subject to the Inquiry's First Order, covering those in attendance, including members of the media.

This hearing is taking place at a hearing room at Waverley Gate, a premises in central Edinburgh. When not available to us, the space is used for the hearings of the Scottish Covid-19 Inquiry, another public inquiry set up by the Scottish Ministers. As that inquiry needs to use the space for its work imminently, we are somewhat restricted in the way in which we were able to configure the room today.

Within the hearing room today, my colleagues within the Inquiry secretariat have, however, managed to use the seating arrangements as they are currently so that every patient who applied, along with at least one supporter if they wanted one, as well as all representatives of our other core participants who wished to be here have been offered a seat. This was no small logistical feat and explains why we have had to accommodate some people in the rows behind the legal teams where we have asked legal representatives and their clients from our corporate core participants to sit. This has bene done to accommodate everyone who applied, in particular former patients of Mr Eljamel and their supporters, who are most welcome here today. Their presence (either in person or online) is of fundamental importance to the work of this Inquiry and consistent with the public commitments you have made, Sir, to put former patients of Mr Eljamel at the centre of our work, a theme to which I will return.

The accommodation in which we find ourselves today will be the home of this Inquiry for its public hearings going forward. The fact that this Hearings space is already equipped for the work of a public inquiry has enabled this Inquiry to avoid the inevitable considerable delays which would be associated with finding a new premises, which has occurred, at times, in other public inquiries in Scotland. We hope that its central Edinburgh location, right next to the main train station will prove beneficial to those who wish to attend, including CPs, witnesses and members of the public. For a period, we will share the Hearings venue with the Scottish Covid-Inquiry which will impact to a degree on our flexibility. We hope that this temporary phenomenon will be outweighed by the property's other considerable advantages to our work.

Core participants and representation on their behalf today.

Those wishing to take a formal role in the Inquiry were invited to apply to become Core participants, within the meaning of Rule 4 of the Inquiries Scotland Rules 2007 ("the 2007 Rules").

The applications for Core participant status have been considered by you, Sir, in accordance with Rule 4 of the 2007 Rules, which provides:

4.(1) The chairman may designate a person as a core participant at any time during the course of the inquiry (but only with the consent of that person).
(2) In deciding whether to designate a person as a core participant the chairman must have particular regard for the desirability of including as core participants persons who–

a. played, or may have played, a direct and significant role in relation to the matters to which the inquiry relates;
b. have a significant interest in an important aspect of the matters to which the inquiry relates; or
c. may be subject to significant or explicit criticism–

(i) during the proceedings at the inquiry, or
(ii) in the report (or any interim report) to be delivered under section 24 of the Act (submission of reports).

(3) The chairman may, before the end of the inquiry, specify in writing that a person ceases to be a core participant."

In making determinations, the Chair considered whether, in each case, the application fulfilled the criteria set out in Rule 4(2) in relation to the issues which the Inquiry will investigate.

He exercised his wide discretion, bearing in mind a number of features. The Chair considered the applications in light of his obligation to run the Inquiry as thoroughly and as efficiently as possible, bearing in mind the Inquiry's wide-ranging Terms of Reference and

the need for the Inquiry process to be rigorous and fair. As is set out in the Core Participant Protocol, the Chair was obliged to assess very carefully whether applicants could assist the Inquiry in its work and whether their designation would actively contribute to the efficient and thorough operation of the Inquiry. As that document sets out, the Inquiry expects those who have been so designated to be active participants in our work. This Inquiry will accord to those CPs rights, roles and responsibilities which exceed the rights they derive automatically from the law, to ensure that they have every opportunity to participate actively in our work as they and you expect.

The Inquiry received 182 applications for Core participant status which were not withdrawn. You, Sir, have designated 158 of those applicants as core participants, all of whom are legally represented. They are the following:

(a) 133 former patients of Mr Eljamel and 19 representatives of former patients of Mr Eljamel represented by Levy & McRae, Solicitors as individual core participants. These patient core participants are represented by MLFs Joanna Cherry, KC and Clare Connelly. Thay appear on behalf of this group today, have provided you with a written submission in advance relating to matters on the agenda. Ms Cherry will address you after I have spoken.

(b) NHS Tayside – they have provided a written submission (relating primarily to a matter to which I will return in a moment), are legally represented at this hearing by Tracy Turnbull of the Central Legal Office but do not intend to make any oral submission.

(c) Healthcare Improvement Scotland – they have not provided any written submission and are legally represented at this hearing, by Michael Stewart of the Central Legal Office. No oral submission will be made on their behalf today.

(d) NHS Education for Scotland – again, they have not provided any written submission and are legally represented at this hearing by Mr Stewart. No oral submission will be made on their behalf today.

(e) The Scottish Ministers – they have not provided any written submission. They are represented at this hearing by MLFs Laura Thomson KC and David Blair. I understand that they represent the Scottish Ministers in their capacity as core participants in the Inquiry only and that no oral submission will be made on their behalf today.

(f) The University of Dundee – they have not provided any written submission and are not represented at this hearing.

(g) The Royal College of Surgeons (Edinburgh) - they provided a written submission and are legally represented at this hearing by Christine O'Neill KC. No oral submission will be made on their behalf.

Additionally, given the unusual and significant work of the Independent Clinical Review set up by the Scottish Government under the chairmanship of Professor Stephen Wigmore, you have also invited that process to be represented at this hearing, have sent them the same advance materials as were received by CPs and extended to them the same rights of reply and participation, for the same objective of seeking to allow them to contribute to the efficient work of this hearing and of the Inquiry. Professor Wigmore has kindly taken you up on that invitation and is present at the hearing today, along with colleagues from the ICR process. I will return to the ICR as a separate item on the agenda in due course. The ICR is represented by Ewan McGillivray of Morton Fraser McRoberts, Solicitors. The ICR has provided a written submission and Mr McGillivray will address you on behalf of his clients later on.

May I extend my thanks to those who have made written submissions on behalf of their core participant clients and to those who intend to address you orally in advance, in the hope and expectation that the participation of these individuals and bodies will proceed in the spirit of co-operation and collaboration which you have outlined in the Inquiry's written materials and again in your opening remarks this morning.

I have the following matters to raise at this stage relating to the Inquiry's Core participants and the process by which they were designated by you, Sir, in that capacity:

Patients

Consistent with the commitment made by you to put patients at the centre of the Inquiry, your approach to Core participant designation has been to seek to engage a large number of patients in the process, to grant individual Core participant status (as opposed to status to a group) in order to seek to allow the voices of those who have been designated to be heard, to seek to include within the patient Core participant body as full a range of patient experiences both of the professional practice of Mr Eljamel and the systems which surrounded it as possible and to involve representatives of patients where they have applied.

NHS Tayside

In the written Note by Counsel, the Inquiry invited NHS Tayside to consider addressing the issue of the extent of its representation of its former employees, both medical and administrative, including Mr Eljamel himself, and the Board's role in the provision of evidence by any such individuals to the Inquiry, either in writing or orally at this hearing. This request was supported in the written submission on behalf of the patient CP group at paragraph 2(b).

NHS Tayside addressed the matter in its written submission to the effect that:

"NHS Tayside does not represent individual or current employees" (para 3)

"NHS Tayside wishes to support its employees [in the provision of written statements] but is mindful of the need to ensure that its processes are acceptable to the Inquiry" (para 5)

"It seeks guidance from the Inquiry as to the practical support which it should offer to such witnesses" (para 5)

The submission refers to a circular sent to former employees and states that "This includes a section on separate representation – ie. not by the NHST lawyers" (para 6)

It suggests that NHST can offer “pastoral support to former and current employees” (para 7)

It suggests that NHST can offer “practical support” which appears to be limited to offering time off work, arranging secretarial support and access to documents (para 8)

The Inquiry’s processes for seeking and finalising witness statements from corporations and individuals are set out in its Protocol on Approach to Evidence ad Written Statements which is available on the Inquiry’s website. Insofar as the NHST written submission seeks the input of the Inquiry on the approach which it expects NHST to take, the Inquiry’s approach to the provision of witness statements requested of individuals is that though they are provided by the individuals themselves as their sworn evidence to the Inquiry, it would be anticipated that such witnesses would be supported in their employer and their employer’s legal representatives in the completion of those statements, when the tenor of those statements will relate to matters which fell within the scope of their employment. We would imagine that employees of NHS Tayside would expect such support, as patients will expect and receive such support from their lawyers (if they have one) and ministers or civil servants will expect and receive such support from the legal team instructed by the SG. As far as the NHST’s request to the Inquiry to clarify whether it should offer the practical support to the Inquiry is concerned, the answer is yes. The Inquiry does not expect to have to offer such a service to witnesses whose evidence relates to their work for NHS Tayside. As set out in the Inquiry’s processes, it will review drafts of statements and require more or better information, where necessary, including the issuing of any required section 21 demands. The Inquiry’s approach has been that it will provide only limited support for witnesses when there is a good reason why they cannot be represented or supported by NHS Tayside, the employer of the individuals whose evidence they seek.

Beyond that, the Inquiry finds the submission made by NHST hard to follow, in particular, reconciling the suggestion that NHST that it might provide assistance or support with statements or otherwise provide pastoral support but it does not represent the individuals who worked on its behalf and has signposted them to seek separate representation. It is far from clear how far this would extend and why legal support would not be offered to employees which carried out the work of the Board and discharged its responsibilities on its

behalf. It is far from clear why support would be offered by NHST and its lawyers to corporate employees who are providing corporate statements and not to others – are they too not simply employees of the Board providing evidence about the way that the Board, through its employed agents acted in connection with matters falling within the Inquiry's Terms of Reference?

For the sake of clarity, the Inquiry could not offer such legal support and would not expect such employees to have to seek their own advice in that regard, when their statement is provided as an individual agent through whom NHS Tayside transacted its contact with the outside world.

As NHST have indicated that they do not intend to speak at this hearing, I do not expect a response on this issue today. However, the Inquiry will be following it up in early course and will expect a clear answer.

Scottish Government

The Scottish Ministers are represented at this hearing by Counsel only in their capacity as CPs in the Inquiry. I will return to this in the context of my submissions about the Independent Clinical Review but it had been hoped that this hearing might be used as a means of making progress with the SG, in its role as the financial sponsor of the Inquiry and indeed of the ICR. Though that is unlikely to be possible, I will return to what might be achieved in that regard in any event, in due course.

It should be added that my understanding is that in recent conversations with their representatives, the Scottish Government have revealed that they do represent and will provide legal support to ministers and civil servants, current or former, who may be called upon to give evidence to this Inquiry. This stands in contrast to the approach being taken to the Inquiry by NHS Tayside on grounds which (as I have said) are not easily understandable to the Inquiry. Clarity will be sought I this regard in early course and CPs will be kept informed of progress.

It should be stressed that it not necessary for an individual or organisation to be a Core participant in order to provide information or evidence to the Inquiry. Many individuals and organisations beyond the CPs will have relevant information to provide in relation to

matters being examined in the Inquiry, either to the Inquiry directly or indirectly via participation in the Independent Clinical Review (see below). In due course, the Inquiry will be approaching a range of individuals, organisations and bodies to seek information, to gain their perspective on the issues raised in the Inquiry's remit and, where appropriate, to ask for witness statements and documents and to force their production, if that proves to be required. We hope that the use of those powers will not be necessary, given the legal and moral obligations of the mainly public bodies and public servants who have evidence to provide in connection with the Inquiry's remit. The Inquiry will not hesitate to use them if this proves not to be the case.

The commencement and progress of the Inquiry

By way of update, I will focus on events since the Inquiry's public consultation on its Terms of Reference in October 2024 though I will also set out broadly what occurred before that time, as certain Core participants and Recognised Legal Representatives were not involved in that process.

The Inquiry was announced by the then Cabinet Secretary for NHS Recovery, Health and Social Care on 7th September 2023. On 29th February 2024, the Cabinet Secretary appointed you, Sir, as Chair of the Inquiry.

Draft terms of reference were drawn up by the Scottish Ministers. These were passed to the Inquiry. Though the Inquiry was prohibited from considering evidence before its formal set-up[1], publicly available information was considered by Inquiry Counsel. This included what was contained in publicly available media where the Inquiry found a considerable number of the views and experiences of many of those who have been harmed. Before considering any evidence, this provided some considerable insight to us into what appeared to be important matters, potentially for investigation by the Inquiry. As a result, the draft Terms of Reference were revised by the Inquiry team. The updated draft was agreed by the Scottish Ministers for the purposes of public consultation.

On 14th September 2024, the Chair announced the launch of a public consultation process on the Inquiry's draft terms of reference so that public concerns and issues could be

[1] As per section 5(2) of the 2005 Act

reflected in the final Terms of Reference and inform the scope of the Inquiry's investigations.

Interested members of the public were asked whether the Inquiry's draft terms of reference covered all the areas that they thought should be addressed. The public consultation was open to everyone with an interest in the Inquiry's work, and the public could contribute to the discussion at public events which were held in Dundee on 7th October 2024 and online on 10th October 2024. The first event was attended by 134 people. 34 devices were logged in to attend the second event.[2] The texts of the Chair and Senior Counsel's addresses to these meetings were made available publicly after the events. Interested parties were asked to make any written submissions they wished to contribute in response to a series of questions about the Inquiry's remit. The consultation ran for 6 weeks, until 25th October 2024.

The Inquiry received 31 written responses to its public consultation, of which 26 came from former patients of Mr Eljamel or family members of deceased former patients of Mr Eljamel, 2 came from legal representatives of groups of former patients and 3 came from organisations with an interest in the Inquiry's work. Inquiry Counsel carried out an assessment of the responses (both written and oral), and the helpful suggestions made by those with an interest in the work of the Inquiry as to how they might be altered (either by addition or deletion), so as best to serve the purposes of the Inquiry process and the wider public interest.

Sir, as I have said, certain themes emerged from the public consultation process and the responses we received. These Inquiry has put and continues to put these themes at the heart of its work and planning, insofar as the Terms of Reference and the statutory regime underpinning the Inquiry allow. Amongst them were:

(a) The very visible and palpable harms which have clearly been experienced by the former patients of Mr Eljamel who have taken an interest in our work, their justified longing for justice and their commitment to achieve it;

[2] Some logins to the event involved more than a single person attending

(b) The clear determination of the patient group to be forward facing, to make sure that harm which they have experienced should not occur again;
(c) The clear theme of delay and the harms which have been experienced and compounded as a result of it and the consequent need to do what we can to avoid delay in our process;
(d) The efforts which numerous members of the patient group were prepared to go to provide detailed and helpful suggestions to add to the Inquiry's remit in an effort to make its work meaningful; and
(e) The complexity of the subject of clinical governance, its many features and components.

In light of the information which had been shared via the public consultation process, on 20th November 2024, you wrote to the Cabinet Secretary proposing certain amendments to ensure greater clarity and reach in the Inquiry's remit, based on the Chair and the Inquiry team's understanding of what the Scottish Ministers had intended that the broad purposes of the Inquiry should be. These included a number of proposed changes to the consultation draft which had been circulated in advance of the consultation, based on proposals which had been made by respondents to the public consultation process, including:

d. The expansion of Term of Reference 1 to include other key positions held by Mr Eljamel in his professional capacity in Scotland beyond those listed in the draft;
e. A clarification that Term of Reference 3 covered the operation and adequacy of NHS Tayside's clinical governance systems;
f. Expansion of Term of Reference 3 to include whistleblowing and reporting processes and the extent to which any clinical governance systems within NHS Tayside were adequately engaged and participated in by those working in NHS Tayside;
g. The addition in Term of Reference 6 of NHS Education for Scotland and its predecessor bodies;
h. The addition in Term of Reference 6 of the predecessor bodies of Healthcare Improvement Scotland;

i. The expansion of the role of the Scottish Executive/ Scottish Government in the investigation by their addition to Term of Reference 6;
j. Clarity that the remit of Term of Reference 14 would include document management systems relating to medical records, as well as administrative records, given concerns expressed by patients who had tried to recover their medical records;
k. Clarity around the statutory limitations of the Inquiry to determine any fact or make any recommendation which was not wholly or primarily concerned with a "Scottish matter" in terms of section 28 of the 2005 Act in Explanatory Note (b);
l. Clarity around the Inquiry's responsibility to analyse and criticise by the insertion into in Explanatory Note (c) of its ability 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; and
m. Expansion of in Explanatory Note (e) to cover the ability of the Inquiry to make recommendations about bodies other than health boards.

In January 2025, the Cabinet Secretary responded, accepting the changes that had been proposed with some minor, non-substantive amendments. For the sake of clarity in case there is any misunderstanding or misapprehension, the main focus of the Inquiry's investigations will be NHS Tayside. They are the main or a main focus of the investigative remit under 11 of the 14 Terms of Reference. This is because they were responsible for most of the systems which were in place to try to prevent things going wrong in neurosurgical care, as is clearly alleged to have occurred.

The Chair of the Inquiry provided an update on developments in the Inquiry's work to those who had registered an interest in the work of the Inquiry on 27th November 2024, informing them (amongst other things) of his report to the Cabinet Secretary on the Terms of Reference, the issuing of "Do Not Destroy" letters to key organisations, the development of the Inquiry website, the creation of the Inquiry's Protocols and the work which would be required before formal set-up.

The Chair of the Inquiry provided a further update on progress to the same recipients on 27th February 2025, informing them, in particular, of the need for the finalisation of the Inquiry's Terms of Reference to await the Terms of Reference of the Independent Clinical Review being similarly fixed by the Cabinet Secretary, progress with the completion of a Memorandum of Understanding between the Inquiry and the Independent Clinical Review, the development of the Inquiry's website, the publication of certain Protocols, updates on recruitment, training and accommodation and plans for this preliminary hearing.

The 'set up date' of the Inquiry was confirmed to be 3rd April 2025, at which time the Inquiry was formally opened. This was announced to the Scottish Parliament in response to a written question by Liz Smith MSP. Parties who or which had taken a interest in the Inquiry's public consultation exercise were informed of this in advance, on 2nd April 2025.

The Inquiry's website was also launched on 3rd April 2025. It will be used as the Inquiry's main means of public communication, with news items being uploaded regularly as to the Inquiry's progress. It will also be the place where documents will ultimately be published.[3]

The Inquiry has also published a number of Protocols relating to its work. These set out the structures and operational processes which the Inquiry and those who interact with it will use to underpin the investigation of our Terms of Reference, with the ultimate objective of producing a comprehensive, evidence-based report. On 3rd April 2025 the Inquiry published a Statement on Protocols and Principles.[4] These principles – to which I have referred - emerged, in part, from representations made to the Inquiry at its public consultation exercise.

The Protocols themselves (which can be accessed on the Inquiry's website) currently comprise:

n. Core Participant Protocol dated 3rd April 2025;[5]
o. Legal Expenses Protocol dated 26th June 2025;[6]

[3] As opposed to disclosed to core participants – see below
[4] https://www.eljamelinquiry.scot/key-documents/statement-protocols-and-principles
[5] https://www.eljamelinquiry.scot/key-documents/core-participant-protocol
[6] https://www.eljamelinquiry.scot/key-documents/legal-expenses-protocol

p. Protocol on the Production, Handling and Retention of Documents dated 8th May 2025;[7]
q. Protocol on Disclosure, Publication, Restriction and Anonymity dated 10th June 2025;[8]
r. Protocol on Restriction Order Applications dated 10th June 2025;[9]
s. Protocol on the Approach to Evidence and Written Statements dated 10th June 2025;[10] and
t. Public Hearings Protocol dated 10th June 2025.[11]

Although these Protocols bear the hallmarks of the approach taken by other public inquiries, dictated by the statutory framework which is common to them all, they represent a genuine attempt on the part of the Inquiry team and ultimately the Chair to seek to tailor the work of this Inquiry to its particular background, its particular remit, it particular stakeholders and it particular ambitions. In particular, they seek to take account of matters raised with the Inquiry about its structure and approach as part of the public engagement with interested parties.

In accordance the principles of open-mindedness and collaboration, you Sir, are prepared to entertain the possibility of adapting the Inquiry's approach and the contents of the Inquiry's Protocols in the event that better systems of operation come to light, whether as a result of suggestions made by Core participants or otherwise.[12]

The Inquiry encourages those with an interest in its work to read them and consider their terms. The Inquiry has deliberately sought to set out the contents of these Protocols early in its work, even though some set out plans and systems will be of more relevance to later stages in the process. This approach is intended to show those with an interest in the Inquiry's work the direction of travel and to seek to promote a cohesive structure to our

[7]https://www.eljamelinquiry.scot/key-documents/protocol-production-handling-and-retention-documents
[8] https://www.eljamelinquiry.scot/key-documents/protocol-disclosure-publication-restriction-and-anonymity
[9] https://www.eljamelinquiry.scot/key-documents/restriction-order-application-protocol
[10]https://www.eljamelinquiry.scot/key-documents/protocol-approach-evidence-and-written-statements
[11] https://www.eljamelinquiry.scot/key-documents/public-hearings-protocol
[12] Inquiry Statement on Protocols and Principles, para 9

whole process. It is anticipated that the Inquiry will publish further protocols in early course, in particular in relation to expert evidence, statutory warning letters and claiming witness expenses.

The Inquiry provided further updates on key developments and progress in its work to those who had registered an interest in the work of the Inquiry in June 2025, relating (amongst other things) to the launch of the Inquiry's invitation for application for Core participant status, the publication of the Inquiry's provisional List of Issues and correspondence received from a group of MSPs about aspects of the Terms of Reference.

The Independent Clinical Review

Prior to the announcement of the Inquiry, the then Cabinet Secretary announced an intention to offer independent clinical reviews into cases of former patients of Mr Eljamel, where one was wanted.

When the Inquiry was announced, the then Cabinet Secretary said on 7th September 2023 that:

"…a full public inquiry will not necessarily answer each former patient's clinical questions about their own circumstances.

For that reason, I still consider that an independent case review of patients' individual clinical cases—where that is what individual patients want—remains necessary. That will allow a person-centred and trauma-informed review of each patient's clinical case, addressing their individual needs and circumstances and attempting to offer answers in a bespoke and personalised way that an inquiry will not offer."[13]

In terms of the Inquiry's Term of Reference 16, this Inquiry will be obliged to take account of the ICR's findings in its work. The intention is that the ICR will set out what went wrong

[13] https://www.parliament.scot/chamber-and-committees/official-report/search-what-was-said-in-parliament/meeting-of-parliament-07-09-2023?meeting=15420&iob=131572

clinically. The Inquiry's role will then be to investigate what systems should have existed to detect and prevent those things going wrong and harm occurring and whether those systems were in any way defective.

Communications received by the Inquiry indicate that there remains a degree of concern and misunderstanding about the role of the ICR, its objectives and the way in which it intends to work with the Inquiry. In accordance with its fundamental principle of clarity, the Inquiry hopes that the preliminary hearing can be used as a mechanism for increasing understanding of and engagement with the ICR. As a non-statutory process, the ICR does not have the powers and structures available to it that the Inquiry does to enable it to hold hearings in the same way as we can. We and the representatives of the patient CPs have made and continue to make considerable efforts to seek to achieve progress via the vehicle of this hearing today, to which I will return.

The independence of the ICR is confirmed by its Terms of Reference.[14] That means that it is a process which requires to be independent of the State (including Scottish Government and the NHS) and indeed the Inquiry. As the Inquiry requires under its Terms of Reference to use the evidential product of the ICR to inform it about the clinical picture relating to the treatment of former patients of Mr Eljamel, the two processes have required and will continue to require to work together to achieve their mutual aims. The independence of the ICR is, at all times, enshrined in the clinical independence of the expert neurosurgeons whom it will instruct to carry out its main work.

In light of concerns expressed to the Inquiry about the ICR, the Inquiry is committed to seeking to assist in explaining the function and process of the ICR and I have a number of observations about important features of the ICR and its interaction with the work of the Inquiry:

u. Given the importance of the two processes working together, the Terms of Reference of each require the processes to set out publicly how they intend

[14] Para 1 of the ICR's Terms of Reference - https://www.gov.scot/publications/eljamel-independent-clinical-review-terms-of-reference/

to work together operationally.[15] This has been done in a Memorandum of Understanding which was entered into between the Chairs of the two processes dated 3rd April 2025.[16]

v. In order to be able to provide the expert neurosurgeons who will compile reports on cases with material from which they can conduct their analysis, the Inquiry will recover medical records using its statutory powers of recovery. That process is already underway (see below). The material which will be made available to the experts in each case will comprise:

- Full available hospital records from NHS T;
- Full available GP records;
- Full available private hospital records (in appropriate cases); and
- A statement provided to the ICR by the applicant ("the applicant statement")

w. The ICR and the Inquiry have agreed that these materials are necessary to provide the experts with sufficient information to enable a meaningful analysis of the cases and also to enable the applicants to have their voice heard, their recollections of events considered, and their positions understood and taken into account in the analysis. Where there are gaps in hospital records (a concern legitimately raised by a number of patients), the aspiration is that the contents of GP records and/ or the applicant statement will supplement, and at times fill, the factual picture.

x. The purposes of the ICR are to produce expert clinical reviews of cases of former patients of Mr Eljamel for applicants and to provide a clinical body of evidence related to possible sub-standard care on Mr Eljamel's part or on the part of those working under him. As the evidence which the ICR produces will form a large part of the clinical basis upon which the Inquiry's systemic investigation will proceed, the Inquiry has a strong interest in making sure

[15] Inquiry Term of Reference 15; and Para 15 of the ICR's Terms of Reference
[16] https://www.eljamelinquiry.scot/key-documents/memorandum-understanding

that the material available to the ICR experts is provided in a timely, orderly and informative manner and form, and that the ultimate neurosurgical reports are produced in an independent, comprehensive, evidence-based and well-reasoned way. Thus, though the ICR's clinical independence is enshrined in the MoU[17], the ICR has agreed to allow the Inquiry to have input into the ICR's processes in the following important ways:

- The Inquiry has been involved in the compilation of the template which will be used for requesting applicant statements[18] and the standard form letter of instruction which will be sent to the neurosurgeons[19], in particular to ensure that the questions which are asked cover the range of matters on which the Inquiry requires the ICR's clinical input;
- The Inquiry will be permitted to comment on, and suggest revisals to, drafts of each applicant statement[20] and each neurological report[21], in order to serve the same objectives in relation to the answers provided; and
- The ICR has shared with the Inquiry copies of other important ICR documentation (such as its Terms of Reference, registration form, consent form and privacy notice), to which the Inquiry has been permitted to suggest revisals, in order to ensure that the documents are accurate, informative and comprehensive and that the operation of two processes is streamlined for the mutual benefit of each.

y. The ICR processes the information which it receives on the basis of the applicant's consent – the internal process of the ICR is a voluntary one as the ICR is not a statutory process with the same powers as the Inquiry. By way of contrast, the Inquiry has statutory powers of recovery which it will use to recover evidence relevant to its remit. This may include materials held by the

[17] Memorandum of Understanding, para 40
[18] Memorandum of Understanding, para 24
[19] Memorandum of Understanding, paras 34-35
[20] Memorandum of Understanding, para 25
[21] Memorandum of Understanding, para 39

ICR, where the use of such powers is deemed appropriate, though the Inquiry hopes that applicants to the ICR will consent to the material in the ICR's possession in which they have an interest being passed to the Inquiry to inform and thus help with its work.

z. Because the ICR is a voluntary process, it is possible that clinical cases of importance to the Inquiry's remit and which come to the Inquiry's attention by other means may not be part of the ICR process. For example, the patient in question may have passed away or moved abroad. In such cases, the ICR has agreed to accept referrals for review from the Inquiry.[22] As it would be preferable that such cases would include an applicant statement alongside the records for the expert's information, the Inquiry will endeavour to contact the patient in such cases, to offer the opportunity of making an application to the ICR within a reasonable timeframe. If that does not happen, the case will process to neurosurgical review in any event.

aa. The ICR has agreed that cases will be processed and neurosurgical reviews conducted in an order which is set by the Inquiry. This is so that cases which appear to the Inquiry to be of the greatest representative or systemic significance will be analysed first, to enable the work of the Inquiry to proceed without undue delay. The two processes have agreed systems whereby the cases which appear to the Inquiry to be of greatest systemic significance will be processed to review first.[23]

bb. The expert neurosurgeons selected for instruction will be so selected by the ICR. Professor Wigmore, the Chair of the ICR, is taking the lead in that process, ensuring the genuine independence of the experts, in particular from NHS Tayside.

cc. Ultimately, all evidence emanating from the ICR which the applicant consents to being shared with the Inquiry, or which the Inquiry requests by the use of its statutory powers, will become evidence in the Inquiry. Thus, the ICR will provide the Inquiry with a large body of clinical evidence and expert analysis of it. This will include clinical evidence which emerges from later cases which

[22] Memorandum of Understanding, para 37
[23] Memorandum of Understanding, para 32

go through the ICR process, which will be available to the Inquiry (where there is consent or a request by the Inquiry) and which will be factored into its analysis and decision-making. The greater the number of people whose cases are analysed by the ICR, the greater the amount of potentially relevant clinical evidence will be able to inform the Inquiry's systemic investigation.

dd. Ultimately, reports compiled by the expert neurosurgeons will be made available to the applicant, as well as to the Inquiry.

ee. The ICR will also provide the Inquiry with summary report(s) relating to key clinical themes which have emerged from the ICR's work.[24]

Operational documents have been agreed as between the two processes, with particular regard to the complexities and sensitivities relating to data protection, in light of the nature of the medical information which will pass between the two processes. It is understood that the ICR has already received a considerable number of registrations.

The next steps will be that those who have registered will receive the ICR's privacy notice and a consent form to sign, which will allow information to be passed to the Inquiry for the process to move forward. The applicants will be given an applicant statement form with questions to answer. The answers to those will constitute the applicant's statement, which will be completed after the Inquiry has provided what are hoped will be helpful and constructive comments, which will be passed back to the applicant for consideration via the ICR. Once the applicant statement is signed, it will be passed to an expert for review in the order of priority set out by the Inquiry, along with available records which the Inquiry will have processed and bundled together for the ICR to pass to the expert, who will receive a letter of instruction on a case by case basis in a standard form.

Entirely understandable concerns have been expressed to the Inquiry about its intentions with regard to the publication of material emanating from the ICR, which will ultimately become evidence in the Inquiry and hence be subject to the obligation of the Inquiry to publish it under section 18 of the 2005 Act. Before publishing an applicant statement, or neurosurgical report or any attached medical records, the patient in question will be given

[24] ICR Term of Reference 17; Memorandum of Understanding, paras 12 and 38

the right to apply to the Inquiry for anonymity before the applicant statement is disclosed to others or published. I will return in due course to the processes involved in that regard.

Sir, I have recognised that patients and patient representatives have expressed significant concerns with the ICR and its process. There is a good deal of misunderstanding about these matters. The submission made on behalf of the patient CPs has set out some of these concerns and more. What I have set out to do is to try to provide some clarity and I hope we have achieved that at least to some extent. We remain open to assisting with any such questions as do the staff of the ICR going forward.

Those with an interest in the work of the ICR may wish to understand the following relevant matters:

(a) The ICR is a creation of the Scottish Government. It chose to put it in place. It continues to require to support it and to provide funding for it to carry out its work. From the Inquiry's perspective, as I will set out in a minute, there is undoubtedly a need for progress with the ICR's work so that the Inquiry can fulfil its stated remit within its specified timescales.

(b) The ICR is a separate process from the Inquiry. The Inquiry has powers from the law but the ICR was invented for this project and so does not have the same powers and needed to be set up from scratch, a process which has been largely left to Professor Wigmore, with assistance from the Inquiry team. This assistance was given willingly as the evidence which comes from the ICR will be very important to the Inquiry's investigations into systems and to findings. The Inquiry team has worked hard to make sure that the ICR has systems which fit with what evidence it needs the ICR to provide. However, these systems need to be set up. They need to operate efficiently. The setting up and operation of the systems are not matters within the Inquiry's control.

(c) The ICR offers a patient specific, independent expert review of the case of any former patient of Mr Eljamel who wants it, chaired and organised by a highly eminent surgeon. On the face of it, this is a generous and potentially rewarding offer. As the Cabinet Secretary recognised when announcing the inquiry, such an

approach would never be expected of a public inquiry, in particular given this Inquiry's systemic remit.

(d) However, this does not mean that the concerns and misgivings of patients about the process are not genuine and reasonable – they are. I have recognised that they are and I am sure Professor Wigmore does so also. As a result of the considerable concerns about the ICR, the legal representatives of the patient CPs proposed a meeting take place to discuss and hopefully resolve these concerns, in particular an apparent impasse relating to aspects of the process within the SG's and beyond Professor Wigmore's or the Inquiry's control. That meeting was attended both by representatives of the Inquiry (including myself) and by Professor Wigmore and his team, as both recognised the importance of listening to patient concerns, working co-operatively and, we hope, in a reassuring and productive manner. It is a matter of regret to the Inquiry that that meeting was not attended by representatives of the Scottish Government, holding as they do the power to resolve patient concerns and to resolve them quickly. I understand that MLF Ms Thomson is not instructed to speak on behalf of her clients, the Scottish Ministers, in their sponsorship capacity, meaning these matters will also not be resolved today.

(e) That said, I understand it to be the position that the Scottish Government continues to insist that the structural matters relating to the representation of applicants in the ICR are matters for the Chair of the Inquiry or the ICR. That is not so. Funding arrangements are within the gift of the Cabinet Secretary and can be resolved by him and his advisers alone. I would urge him to do so as a matter of immediate priority, in accordance with his stated commitment to the former patients of Mr Eljamel, the Inquiry and the ICR. Viewed now, from the Inquiry's perspective, the ICR has not been provided with the structure to assist applicants with the provision of their statements – it has not staff to assist with the taking of applicant statements in any sense. Further, there is a clear need for advocacy support by their representatives in providing them, in the interests of the ICR process and ultimately the Inquiry to whom the applicant statements will pass as evidence in due course. Many of the applicants are traumatised. Many of them are in pain or disabled. I expect most if not all are unfamiliar with the process of providing witness statements. I would urge the Cabinet Secretary to engage with patients' representatives on the matters within

his control as a matter of urgency, in the interests of patients and of both projects. Equally, the Inquiry will expect a reasonable approach on the part of the patients' advisers, both in the staffing of their ICR support team and their engagement with government, in the interests of achieving the progress which so many of their clients told us they reasonably expected.

This is particularly pressing, as, as far as the Inquiry is aware, all of the documentation is now in place which will enable cases registered with the ICR to be progressed. The recovery of medical records for cases of interest to the Inquiry is well underway. The next stage will be for applicant statements to be sought and completed, before the instruction of the expert reviews.

The Inquiry has compiled a list of priority cases, which (as per the provisions of the MoU). There are 50 such cases which have been identified so far as being ones of clinical priority. This has been done based on a triage system which the Inquiry has devised to try to get as wide a flavour of what went wrong clinically, in as wide a variety of surgical cases, over as wide a timescale as possible. This does not mean that all cases are not important – they are. This does not mean that all applicant statements and all reviews will not be examined by the Inquiry – they will be. We have devised this system to allow us to make progress on as sound a basis as we can at present, in light of where the ICR has found itself at this moment. Evidence from subsequent cases which are reviewed will come to the Inquiry in due course, will add to the clinical picture and will be added into our analysis as we go along.

A timetable has been issued to Professor Wigmore indicating when he will need to have the neurosurgical experts available to compile their reports to fit with the Inquiry's investigative and hearings timetable. That only leaves the apparent impasse between the legal representatives of the patient CP cohort and the SG to be resolved – the Inquiry expects this to be achieved. The Inquiry's need for a sufficient clinical base for its investigations means that a resolution of this issue is now critical.

In any event, at the meeting arranged by the patient CP representatives on Friday, Professor Wigmore and I were able to explain aspects of the planned processes, which we were told were both clear and reassuring to the patient CPs' representatives. The matters raised at

paragraph 2(c) of the written submission provided on behalf of the patient CP group were covered, as I understand to their representatives' satisfaction insofar as was possible in the absence of a representative of the SG.

Approach to evidence and public hearings

Evidence contained in documents, including in ICR applicant statements and other witness statements provided to the Inquiry, will be deemed by the Inquiry to be evidence in the Inquiry which you, Sir, can consider in making findings and recommendations in the fulfilment of the Inquiry's Terms of Reference. Such evidence will be able to be relied upon without the need for it to be spoken to in oral evidence in hearings or otherwise adduced formally. You have determined that such formality would be inconsistent the inquisitorial nature of the Inquiry and likely to involve unnecessary cost.[25]

The Inquiry's evidential hearings will serve the purpose of the public ventilation of issues covered by the Inquiry's Terms of Reference, the challenge of evidence received by the Inquiry and the opportunity for Core participants to submit questions for consideration by the Inquiry's Counsel as part of its investigative process.[26]

Section 1 of the Inquiry's investigations is primarily concerned with setting the scene for the rest of the evidence to be heard by the Inquiry. It will be an introductory section at which it is intended that evidence will be heard relating to a number of areas which are designed to provide evidential context to the hearings sections to follow including:

ff. general background, structure and roles of the various key organisations, key people and key policies;
gg. evidence relating to ToR 1 (appointments), including evidence about the broad trajectory of the career of Mr Eljamel and statistical evidence about the nature and spread of his work, as well as the systems for complaints and areas in which complaints were made and when (ToRs 4 and 5);

[25] Protocol on Approach to Evidence and Written Statements, para 12
[26] Public Hearings Protocol, para 5(c) to (e)

hh. evidence relating to the systems underpinning Term of Reference 14 (document management systems within NHS Tayside);

ii. the broad ambit and findings of the investigations to be looked at under Term of Reference 12; and

jj. independent expert evidence instructed by the Inquiry on rules and systems relating to key areas covered by the Terms of Reference (see below).

A fuller provisional scope for section 1 of the hearings will be released to Core participants and published in due course. It should be emphasised that as section 1 of the evidence is intended to provide important factual context to the sections which follow, it will not be necessary for all issues to be ventilated with witnesses who are called to give evidence in section 1. It is intended that a fuller exploration of the detailed issues of controversy which arise from the analysis of the full range of evidence available to the Inquiry will be able to be undertaken at later sections of the Inquiry's plan. The Inquiry will be willing to consider having witnesses return to provide oral evidence again, at an appropriate later stage in its hearings, in line with this approach.

The Inquiry's investigations will then proceed to section 2, which will focus on the evidence of patients and the evidence which has emerged from the ICR of the timing, nature and extent of clinical issues arising from Mr Eljamel's practice.

In section 2, the Inquiry will hear evidence from a selection of patients and (if necessary) their representatives relating to (i) the key clinical themes of sub-standard practice experienced by patients, including factors listed in Term of Reference 2 and those with experience of the matters listed in Terms of Reference 8 to 11 (ii) key aspects of the Terms of Reference relating to the patient experience of relevant systems, including but not limited to complaints and feedback systems (Terms of Reference 4 and 5), campaigning for a public Inquiry and the experience of other investigations (Term of Reference 12) and lack of candour (Terms of Reference 7 and 13) and (iii) issues with document management and access (Term of Reference 14).

At paragraph 2(a) of the written submission provided on behalf of the patient CP group, the question is reasonably posed as to how patient evidence will be captured relating to:

(a) Bullying by Mr Eljamel;

(b) Interactions by Mr Eljamel with patients;

(c) Issues of failures of candour with patients on Mr Eljamel's part; and

(d) Misrepresentations and lack of informed consent.

All of these matters are covered in the applicant statement request which the applicants to the ICR will receive. Further, patients who are representative of key clinical failings and of systemic issues which they have experienced will be called to give oral evidence in section 2 of the hearings (and later if necessary). This will include those whose cases are selected for this purpose being able to provide further evidence to the Inquiry on the accuracy of medical records (that being part of the Inquiry's remit under ToR 14), about which they will be able to provide their position as part of general opportunity to comment as well as within the ICR applicant statement process.

At paragraph 2(d) of the written submission provided on behalf of the patient CP group, it is asked what the Inquiry would do if it were to uncover evidence that a patient had suffered an assault. The question of assault in the context of medical treatment is a complex one and, of course, the Inquiry has no power to make findings of criminality under the provisions of the 2005 Act, nor does the ICR under its ToRs. Any such discovery would be most likely to arise in the context of the ICR neurological [neurosurgical] review, though the question, I think, arises from the need for consideration of how such news would be broken to the patient, an entirely legitimate concern. As far as the Inquiry is concerned, it would be of the utmost importance for any such revelation to be handled as sensitively as possible and therefore to involve the patient's legal representatives. One further point of clarification – the Inquiry's inability to make findings of criminal liability under section 2(1) of the 2005 Act does not limit its ability (under section 2(2)) to undertake investigations, make findings or recommendations from which criminality might be inferred. The Chair of the Inquiry has the same responsibility as other citizens to report suspected criminality to the appropriate authorities.

In section 2 of the hearings, the Inquiry will also hear evidence from the Independent Clinical Review about its findings of sub-standard clinical practice on the part of Mr Eljamel or those working under his supervision from that process (Terms of Reference 15 and 16).

In section 3, the Inquiry will hear evidence from medical and possibly other professionals on a wide variety of aspects of the Terms of Reference, with a focus on Term of Reference 2 (matters affecting clinical outcomes), Term of Reference 3 (systems of professional clinical governance) Terms of Reference 7 and 13 (candour) and Term of Reference 8 (clinical supervision). Evidence will also be addressed from the General Medical Council, relating to their involvement in relevant matters, with a focus on Terms of Reference 8, 11 and 13.

In section 4, the Inquiry will hear evidence from other organisations which could or should have had a role in the oversight in the interests of Mr Eljamel's patients on a wide variety of aspects of the Terms of Reference, with a focus on Term of Reference 6 (relating to the role of these organisations).

In section 5, the Inquiry will hear evidence from representatives of NHS Tayside and the Scottish Government on a wide variety of aspects of the Terms of Reference, with a particular focus on Term of Reference 3 (corporate clinical oversight), Terms of Reference 4 and 5 (complaints etc), Term of Reference 6 (insofar as it relates to the actions of Scottish Government) and Term of Reference 12 (investigations). Terms of Reference 8 to 11 (the period from 2013 to 2015) and Term of Reference 13 (organisational candour) will also feature.

In section 6, the Inquiry will hear evidence relating to lessons which might be learned from the evidence that the Inquiry will have heard by that point in prior evidential sections, as well as recommendations which the Inquiry might make as part of its forward-facing function (Term of Reference 18).

The sections of the Inquiry's evidential approach have been designed to try to get going with evidential hearings as quickly as possible, in light of the patients' understandable desire for progress, considerations of efficiency and the availability of our hearings venue. By focussing on a witness-based as opposed to theme based approach, they aim to provide a degree of structure and clarity to our work. It also reflects the fact that witnesses may have

relevant evidence on a wide range of our Terms of Reference and our aspiration not to have to bring patients back to give evidence on multiple occasions, if possible. The fact that most sections will involve a wide range of aspects of the Terms of Reference is intended to retain an adequate measure of flexibility in our approach, in case unexpected evidence comes to light which needs to be ventilated, challenged or examined."

(Lord Weir):

Would this be a good moment for a break?

(JD):

It would indeed, sir, thank you.

(Lord Weir):

Thank you. Thank you everyone, we'll break now for half an hour and resume again at five to 12.

BREAK

(Lord Weir):

Yes, have a seat everybody, thank you. Mr Dawson, when you're ready.

(Jamie Dawson KC):

Thank you sir. In my submission, sir, I've reached number five – the Terms of Reference and List of Issues.

I have already set out the process of the development of the Terms of Reference, including the process by which the draft Terms of Reference were created for public consultation and additions made to them in light of that process. The Terms of Reference are wide-ranging and will enable and require a detailed investigation into systems surrounding the professional practice of Mr Eljamel over the whole span of his career in Scotland and beyond, as well as enabling and requiring the Inquiry to consider making recommendations for the future arising from that investigation.[27]

[27] Term of Reference 18

GMC/ HSE

The Inquiry has become aware of issues which have been raised relating to the role of the General Medical Council and the Health and Safety Executive. Though a matter for the Cabinet Secretary to have reached a view on as the minister responsible for setting the Inquiry's Terms of Reference, it is the Inquiry's current interpretation of the Terms of Reference that the role played by these bodies could not form part of the findings or recommendations of the Inquiry, nor could the Inquiry seek to use its powers to compel evidence designed towards making such findings or recommendations. This is because the roles of these bodies do not form part of the Inquiry's Terms of Reference. Particular attention need to be paid to paragraph (b) of the Explanatory Notes to the Terms of Reference, of which I've already made mention.[28] It is our interpretation that it was deemed by the Cabinet Secretary to be the position that the Inquiry could not investigate the roles of these bodies as they fall outwith the legislative competence of the Scottish Parliament and are thus beyond the ambit of a "Scottish Inquiry" as defined by sections 27(7) and 28 of the 2005 Act.[29]

For the sake of clarity, evidence will be sought by the Inquiry from the HSE and the GMC which will be considered but only insofar as that evidence may help inform the discharge of the Terms of Reference, as they stand. Just by way of example, the GMC will be called on to produce evidence relating to the role of NHS Tayside under Term of Reference 11 relating to the removal, voluntarily, of Mr Eljamel from the register. It is also worthy of note that the Inquiry has the power to investigate the roles of other bodies which could have played a role in the care provided by Mr Eljamel to his NHS patients, even if they are not listed in Term of Reference 6. If their role is not excluded by these legal considerations, the Inquiry could look into them, given the fact that the list in that paragraph is not exclusive.

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[28] *"The Inquiry is not to determine any fact or make any recommendations which are not wholly or primarily concerned with a "Scottish matter" in terms of section 28 of the 2005 Act"*

[29] See also Scotland Act 1998, Head G2 of Schedule 5; Medical Act 1983; and Scotland Act 1998, Head H2 of Schedule 5

Term of Reference 12

Sir, I would like to make mention of Term of Reference 12. This Term of Reference requires us to investigate the adequacy and timelines of previous investigations into issues surrounding the professional practice of Mr Eljamel. There are two connected aspects of the Inquiry's approach to this Term of Reference which I would like to explain. The first is the fact that, unlike many other public inquiries, this Term of Reference requires you to investigate the creation of this Inquiry itself. This is because we require to look at why there was not a public inquiry earlier, including the question of the Scottish Government's approach to public inquiries, what they are for, how they think they will operate, all of which are relevant matters relating to why a public inquiry was not set up sooner and why the ICR was offered as an alternative. This Term of Reference allows a degree of introspection on the purpose and existence of Scottish inquiries in the broader sense. Though the role and actions of the GMC and HSE are not included in our Terms of Reference, this ToR 12 will allow investigation of what consideration was given to what this inquiry would be about, its planned scope and the potential jurisdictional limitations of a Scottish inquiry to answer the legitimate questions which arose. Those who made decisions about that should be aware that these are matters which we intend to investigate. By way of example, we cannot make findings about the role of the HSE or the GMC but we can investigate what consideration was given to those limitations relating to the investigation of those bodies when the Inquiry was in contemplation and when it was announced.

Private cases

I would also like to make a point of clarification about our current interpretation of the remit insofar as it applies to private cases. The Terms of Reference do not require us to look at cases undertaken by Mr Eljamel in his private practice or systems which existed to minimise harm for patients treated there. This is an Inquiry which is predominantly about the NHS and the extent to which systems which existed in that service did enough to protect

Mr Eljamel's NHS patients from harm. The ToRs do, however, require the Inquiry under ToR 3 to look at whether clues from what was going on in his private practice could and perhaps should have been detected so as to protect NHS patients from harm. It also requires us under ToR 2(a) to investigate whether Mr Eljamel's private practice commitments contributed to adverse outcomes for his NHS patients.

Of course, it should be borne in mind that the ICR's remit allow it to provide clinical reviews of private cases. Evidence of sub-standard care in those will thus also be available to the Inquiry, to inform the matters which are included relating to private care to which I have referred.

List of Issues

During the public consultation on the Terms of Reference, a number of helpful suggestions were made by participants in that process as to matters which should be included in the Inquiry's remit but which were deemed to be too detailed or specific for the Terms of Reference; a broad and general document. A considerable number of these have been incorporated into the Inquiry's provisional List of Issues dated June 2025[30], which is a living document setting out in greater detail the matters which the Inquiry intends to investigate and ultimately to determine. The consideration and incorporation of these matters into the List of Issues is part of the commitment the Inquiry has made to listening and to collaboration with its stakeholders.

The Inquiry believes that the provisional List of Issues provides a proper framework in which to include all the issues and matters that the Inquiry is likely to inquire into, and (alongside the hearings timetable) a sufficient indication for persons and organisations who have relevant information and evidence, as well as Core participants, to be able to commence their preparations. The List of Issues to be addressed and indeed those to be addressed in

[30] https://www.eljamelinquiry.scot/about/list-of-issues

each of the Inquiry's evidential sections, however, will be further developed once the responses to Rule 8 requests for evidence have been received.

If there are broad matters or areas of inquiry that the Core Participants would additionally wish the Inquiry to consider or to consider as part of the provisional scope of its evidential sections, these will be considered.

In order to facilitate input in this regard, the Inquiry has sought the comments of Core Participants on the contents of the Inquiry's provisional List of Issues, as well as on a draft standard form letter of instruction for ICR neurosurgical experts (see above). It is anticipated that legal representatives of Core Participants will be able to seek their clients' instructions on these important documents, alongside their instructions being taken from them on the preliminary and opening statements hearings. I will return to the opening statements hearing in due course.

For the sake of clarity, the Chair has indicated that he will be prepared to construe Terms of Reference broadly in order to be as inclusive of matters of importance as possible. It should be understood that this cannot be extended to include interpretations which the Terms of Reference as written will not bear. For example, suggestions have been made to us recently that the Inquiry's investigations must look at primary care. The Inquiry is not empowered to look at matter beyond a reasonable construction of its Terms of Reference. However, the Inquiry is open to the consideration of proposed issues which CPs wish to argue should be included as part of that reasonable interpretative exercise. If they wish to propose that other issues should be included, the Inquiry will certainly listen to their positions as to why they should be deemed to be included under a reasonable interpretation of our Terms of Reference.

Rule 8 Requests/ Section 21 notices

The Inquiry has drafted formal requests for evidence, pursuant to Rule 8 of the 2007 Rules, to a significant number of organisations already, including the following:

NHS Tayside;

Scottish Ministers;

NHS Education for Scotland;

Healthcare Improvement Scotland;

Circle Healthcare;

The General Medical Council;

The Health and Safety Executive;

Police Scotland;

The British Medical Association;

Royal College of Surgeons (Edinburgh);

Royal College of Surgeons (London);

NHS Lothian; and

The BBC.

Before outlining the planning in more detail, it is important to make clear that the Inquiry has powers to do a number of things which derive from the 2005 Act and from associated legal rules.[31] These powers exist in order to assist the Inquiry with the investigation with which it will be charged, to enable it to carry out a reasonably thorough investigation of its remit and ultimately to be able to make authoritative findings about what happened, what went wrong and who was responsible. Though the initial reasonable requests of parties will be made in the normal course by way of rule 8 request, the Inquiry (as you have made clear already, Sir) will not hesitate to use its powers of compulsion if and as soon as it requires to

[31] The Inquiries (Scotland) Rules 2007 are also an important source of the Inquiry's powers

do so. Its powers include the ability to take certain legally prescribed steps to compel participation in its work, if necessary.

It is currently planned that the rule 8s for section 1 of the hearings will be served on particular individuals whose evidence is considered to be relevant to the provision of relevant background and context as to how issues relating to the professional practice of Mr Eljamel came to light. As section 1 of the hearings will focus on systemic and introductory matters to provide a context in which later evidence can be considered, the focus in this section will be on corporate written statements. If it proves necessary to seek written statements from particular individuals, the Inquiry will issue rule 8 requests to them in the usual way. Rule 8 requests for a wider range of documents from these organisations and others will be issued, as the Inquiry deems necessary, in early course. The plans for the processing of these documents are set out in the Inquiry's protocols.

The Rule 8 requests are being issued on an iterative basis, as part of which further requests will be made of recipients, focusing on particular issues or topics which arise later in the Inquiry's process. Further Rule 8 Requests will be issued, on a rolling basis, to organisations and witnesses as issues come into greater focus. Insofar as the Inquiry's consultation on its List of Issues is concerned, if this gives rise to the need for further issues to be ventilated with corporate or individual witnesses, further rule 8 requests can be issued relating to those issues, as necessary.

The Inquiry has already gone about starting to recover medical records and complaints files from NHS T (using its powers of statutory recovery under the 2005 Act) relating to certain former patients of Mr Eljamel, whose cases appear to the Inquiry to be of particular significance to its remit and in anticipation of these cases being ones which it will refer to the ICR for review, or reviews of which will be of particular significance to the Inquiry, if the patient has applied to the ICR in the normal way. Patients whose medical records are being recovered will be informed by the Inquiry. Particular measures which the Inquiry has put in place relating to the protection of confidential or irrelevant medical information I will return to momentarily.

At paragraph 2(f) of the written submission provided on behalf of the patient CP group, it is suggested that some patients resident in Fife received after care from NHS Fife and so their

records from that source should be recovered. As presently advised, and as described, these records are likely to be relevant to the ICR but not to the Inquiry's remit. This is a matter on which further discussion with the ICR is likely to be necessary, though the Inquiry would be happy to consider what steps it could legitimately take to assist in that process.

Measures which will routinely be taken to restrict access to certain general types of information are set out in the Inquiry's General Restriction Order dated 7 May 2025.[32] The Inquiry intends to apply ciphers over material redacted as per the categories set out in the General Restriction Order so that recipients of it know why redactions have been applied and that thought has gone into why information requires to be restricted from publication.

Mr Eljamel

Though the remit of the Inquiry is predominantly systemic in nature, the Inquiry recognises that legitimate questions arise in connection with that remit, the answers to which would logically be assisted by evidence from Mr Eljamel himself. It is inevitable that evidence which the Inquiry receives will contain substantial criticism of Mr Eljamel, which, in turn, will require consideration of the Inquiry's obligations to serve warning letters under rule 12 et seq of the 2007 Rules.

In light of these considerations, the Inquiry has made efforts to locate Mr Eljamel since it was set up and acquired statutory powers to recover and consider evidence. The steps which have been taken to this point have comprised as follows:

The Inquiry received information that Mr Eljamel was working in a hospital-based role in Misrata, Libya, though it was not clear which hospital or hospitals. The Inquiry attempted telephone contact with the largest hospital in Misrata, Misrata Medical Center, and contacted it by email in April and again in May 2025, seeking information about how to get in contact with Mr Eljamel, without success or reply.

[32] https://www.eljamelinquiry.scot/key-documents/general-restriction-order

Further information received by the Inquiry suggested that Mr Eljamel may be working in a hospital called Al-Nadha Hospital. Further investigation suggested that there was a hospital of that name in Misrata, Libya which claimed to specialise (amongst other things) in neurosurgery, spine surgery and chronic pain. A letter was sent to Mr Eljamel at this address on 28th May 2025, intimating the Inquiry's process for applying to be a Core participant and seeking details of his contact information and any legal representation via various tracked methods. No reply has been received. Additionally, an email was sent to the hospital on 2nd July 2025 to which no response was received received.

The Inquiry had information available to it which suggested that two major medical defence organisations may have represented Mr Eljamel at some point in the past at least. Both have confirmed to the Inquiry that they do not act for him.

The Inquiry will continue to use what avenues are available to it to seek to contact Mr Eljamel. If Core participants or others are aware of additional information about his whereabouts or means by which we might contact him, the Inquiry would be pleased to hear from them in that regard.

Disclosure of documents

The obvious purpose of disclosure is to enable the Core Participants to participate effectively in the public hearings of the Inquiry and otherwise to inform their important role. This Inquiry will be as open as possible with its Core Participants and with the public in relation to the disclosure of documents, though the precise approach will inevitably depend on the speed with which documents are provided by material providers and any issues which the Inquiry experiences with that or the comprehensiveness of their response to the receipt of rule 8 requests or, if necessary, section 21 notices.

Process prior to Disclosure

The Inquiry's approach is to request material providers, through the Rule 8 process, to provide information and documents that are likely to be relevant to the issues and matters identified as part of the Inquiry's remit. Recipients of Rule 8 requests are being made aware of this obligation and of the strict duties the law places upon them in relation to the preservation and retention of documentation.

Draft initial Rule 8 requests which have been prepared or are being prepared are complex and wide-ranging, reflecting the width of the remit of the Inquiry as set out in its Terms of Reference. Though limited in its scope to the systems relating to the professional practice of a single individual, the initial indications in response to requests for information issued by the Inquiry suggest that tens of thousands of documents are potentially responsive to the Inquiry's Terms of Reference. Though a sizeable quantity of documents, this is a relatively small number in comparison to other public inquiries. The Inquiry is aware of the historic nature of the subject matter of much of its remit as well as the basis for its investigation under Term of Reference 14, namely the suggestion that key documentary materials may not have been created or, if created, retained. If this proves to be the case, the Inquiry will endeavour to seek witness evidence in the form of written statements via rule 8 requests and oral evidence, as appropriate. In any event, if documents are missing within the record of NHS Tayside, the Inquiry will wish to know why, as Term of Reference 14 requires.

Relevance reviews by the material providers will be expected when the rule 8s are formally served. Organisations have also been asked to ensure staff have the opportunity to flag particularly important materials so that the most crucial materials are identified and reviewed by the Inquiry as soon as possible, such that they can be processed, analysed and disclosed as soon as is reasonably practicable. The Inquiry will engage in dialogue with material providers to monitor progress, in accordance with its required timelines. Providers will be called to account for what they have produced and the time they have taken to produce it, in writing and in public hearings, if necessary.

Each document provider will be asked to provide an account setting out details of the nature of the review carried out, how the documents were originally stored and the search terms used or other processes used to locate documents. Where the Inquiry has any queries

or concerns about a provider's processes for locating relevant documents, it will raise and pursue them and, of course, as documents are reviewed and gaps identified, further documents will be sought to fill them.

The Inquiry will then itself have to review all such material prior to disclosure being given to the Core Participants. Having been analysed, this documentation will then be the subject of further focused requests, if necessary, which can be completed in advance of the detailed analysis of the material available to the Inquiry in later evidential sections.

Core Participants will not routinely be provided with copies of the Rule 8 requests made by the Inquiry. Disclosure to the Core Participants of the Rule 8 requests themselves (as opposed to the relevant documents and material generated by them) is not required by the 2007 Rules. However, where rule 8 requests are made in order to elicit a written statement, recipients will be asked to repeat in their response the questions they have been asked, so that the answers provided in the written statements can be understood in the context in which they were sought.

In addition, in order to ensure that Core participants are kept properly informed, the Inquiry will ensure that the Solicitor to the Inquiry updates Core Participants on a regular basis as to progress, including but not limited to the progress of Rule 8 work. Such updates would, in general terms, include details of what requests have been made, whether documents have been received, when further documents are expected, and when further Rule 8 requests have been made.

For the purpose of the introductory material which will be elicited and examined by the Inquiry in section 1 of its evidential approach, the majority of the written statements which will be sought and disclosed will be corporate written statements. The rule 8 requests for corporate written statements will also seek particular documents which are relevant to the matters being examined in section 1 of the hearings. Where it is deemed necessary and, in light of the introductory nature of section 1 of the hearings, individual rule 8 requests for written statements will be issued (as is set out above). These rule 8s will be prioritised so that progress towards disclosure of material can be made to allow Core participants to prepare it for the purpose of the section 1 hearings.

As with all material received by the Inquiry, the information and documents received will be assessed for relevance and then redacted in line with the General Restriction Order (so as to remove sensitive material, such as personal data, amongst other generally applied restrictions) and the two restriction-related Protocols which have been prepared and published.[33]

Shortly after the rule 8 requests for corporate (and possibly individual) written statements and documents for section 1, the Inquiry will issue wider documentary rule 8s, seeking documents more generally relating to the full ambit of the Inquiry, as appropriate to their involvement in the subject matter of the Inquiry. These will be processed and assessed as above, a process which the Inquiry anticipates will take a longer period of time due to the likely volume of material which will be sought.

Disclosure

The Inquiry anticipates that disclosure of the documents received in response to rule 8 requests will be done in an order which is appropriate to the way in which the Inquiry's hearings sections are structured. Given that the inquiry will, in section 2, focus on the evidence of patients and evidence emerging from the ICR, it is considered likely that disclosure for that section of the Inquiry's hearings will focus on written statements from patients and exhibits, applicant statements and exhibits and the ICR neurosurgical reports and exhibits. Material disclosed is likely mainly to comprise medical records, complaint files and other material which is closely related to the patient experience of, and perspective on, the subject matter of the Inquiry. The Inquiry has already taken steps to start to recover these documents.

It is neither necessary nor proportionate for the Inquiry to disclose every document that it receives, or every request that it makes, or every piece of correspondence. That is not required and would hinder the Inquiry in the performance of its functions. It would also be a

[33] See the Inquiry's General Restriction Order; Protocol on Disclosure, Publication, Restriction and Anonymity; and Protocol on Restriction order Applications in this regard

derogation of the Inquiry's functions were it to pass to the Core Participants all the material that it receives.

The disclosure of the relevant and redacted documentation will be in tranches, relevant to the sectional approach to the hearings (as I have set out).

The electronic disclosure system which will be used to provide documents to Core Participants will be Objective Connect. Details of how to access the system and use it will be provided to the Recognised Legal Representatives of Core Participants shortly before disclosure commences. Only those who have provided a signed undertaking to the Chair will be permitted access to the material that the Inquiry discloses to Core Participants.

The Inquiry is working to begin the process of disclosing materials to Core Participants as soon as possible. The current plan is that Core Participants will be asked to focus on various important elements of the Inquiry's work (set out elsewhere in this Note) and focus on their preparing and delivering an opening statement to the Inquiry at a dedicated hearing for that purpose which the Inquiry intends to hold towards the end of the year. Many patient Core participants will also be occupied providing applicant statements to the ICR over that time, to enable the process of the production of ICR neurosurgical reports to be progressed as soon as possible. The process of disclosure to Core Participants of materials recovered connected to section 1 of the hearings will begin by before the end of the year and as soon as possible.

Instruction of Expert Witnesses

As set out above, the Inquiry will benefit from the evidence of the independent neurosurgeons instructed to prepare clinical reports within the ICR process. However, the Inquiry will itself also appoint qualified experts in particular fields of expertise as experts to the Inquiry. They will assist the Inquiry, either individually or as part of a group of such persons, by way of the provision of written reports and opinions and, where appropriate, the giving of oral evidence at the public hearing. As per paragraph 2(h) of the written submission provided on behalf of the patient CP group, the Inquiry will ensure that its

experts are truly independent of NHS Tayside. Professor Wigmore has also take such steps on behalf of the ICR.

Alongside the neurosurgical reports provided by the ICR, such reports and evidence will inform and support the Inquiry's work during the public hearings, as well as the Chair's recommendations, by ensuring that its factual conclusions are soundly based and supported by the weight of the best expert opinion.

Such experts will have the appropriate expertise and experience for the particular instruction. They will be independent and objective and subject to an overriding duty to assist the Inquiry on matters within their expertise.

The identity of the expert witnesses and the questions and issues that they will be asked to address will be disclosed to the Core Participants before the expert reports are instructed. Core participants will therefore be provided with an opportunity to provide observations on the scope of the matters which the experts are being asked to address. Where there are significant differences of view or emphasis among the members of any group of experts, these will be made clear on the face of the reports and, of course, these can be tested during oral hearings.

The appointment of experts to the Inquiry, and whether they are assigned to a group of experts considering particular issues, are matters exclusively for the Inquiry, although it will consider suggestions from Core Participants as to who should be appointed.

The Inquiry has provisionally identified a number of specialist areas in relation to which expert witnesses are likely to be giving evidence in section 1. Additional suggestions from Core Participants are welcome.

These areas are likely to include:

(a) Neurosurgery – In order to supplement the significant body of expert neurosurgical evidence which the Inquiry will have available to it from the ICR, the Inquiry currently intends to seek expert evidence on matters including background to the types of surgery performed by Mr Eljamel, responsibilities of consultant neurosurgeons, issues raised about problems with surgery or care (Terms of

Reference 4 and 5), management of surgical lists, workloads (Term of Reference 2) and training of junior staff (Term of Reference 2);

(b) Medical ethics – including peculiarities of surgery/ neurosurgery as regards ethics, consent issues, duties of candour (Terms of Reference 7 and 13), pressures of private practice, (Term of Reference 2), obligations relating to research/ roles etc (Term of Reference 2), training of junior staff and associated obligations (Term of Reference 2), clinical supervision and suspension (Terms of Reference 8 and 9), duties when things go wrong, obligations with regard to making and retaining notes/ records (Term of Reference 14); and

(c) Health administration – including the responsibilities of health boards or other health bodies with regard to appointments and induction/ training (Term of Reference 1), management of workloads (Term of Reference 2), clinical governance, separation between professional and corporate clinical governance (Term of Reference 3), private hospital co-ordination (Term of Reference 3), requirements relating to complaints and feedback systems (T Term of Reference 4 and 5), investigative responsibilities (Term of Reference 12), duties of reporting to other bodies (Term of Reference 13), document management and associated obligations (Term of Reference 14).

In addition to the important background expert evidence to be sought by the Inquiry in connection with section 1, it is anticipated that experts will be re-contacted for further input, as necessary, as the Inquiry's investigations progress, including (but not limited to) its consideration of lessons learned and recommendations in section 6.

Communication and the Inquiry's trauma-informed approach

Communication

The means by which the Inquiry communicates with those with an interest in its work has recently gone through a phase of transition. The Inquiry previously corresponded with those interested in its work via (a) a contact list which was generated from those who were involved in the Inquiry's public consultation exercise and who wished to be kept appraised of the Inquiry's progress, and (b) a temporary website which was used until the Inquiry's proper website was set up and went live on 3rd April 2025. As is set out above, the Chair has now awarded Core Participant status to many of those who applied for it, based on their significant interest in the Inquiry's work. All of these Core participants have Recognised Legal Representatives.

These developments have altered the character of many of those with an interest in the Inquiry's work and their relationship with the Inquiry and set them on a more formal footing, in accordance with the 2005 Act, the 2007 Rules and the Inquiry's Core Participant Protocol. The Inquiry has invited direct contact and communication from Core participants in a number of ways, including in connection with the administrative arrangements for this preliminary hearing. The statutory framework and the Inquiry's own procedures (as set out in its Protocols and Orders) require various legal matters to be conducted via CPs' Recognised legal Representatives. Contact with them on various legal matters is formally necessary and in others more efficient. The Inquiry is, however, keen to ensure that its lines of communication with those with an interest in its work remain appropriate and effective, in order to allow it most efficiently to comply with its commitments to the principles of co-operation, clarity and listening.

As a result of this transitional position, the Inquiry invited contributions from Core participants at or in connection with this preliminary hearing as to their views on how they would wish the Inquiry to communicate with them about the multiple matters on which they may come into contact with its work. This is part of the Inquiry's commitment to listening to those with an interest in its work as to how they wish it to operate. No such suggestions have been received though the Inquiry remains open to suggestions in this regard.

In order to seek to improve the ways that that the Inquiry engages with those with an interest in its work, including its Core participants, the Inquiry intends to launch the following initiatives:

> The Inquiry's engagement strategy will set out the means by which the Inquiry intends to engage with those with an interest in and a role to play in the Inquiry's important work; and
>
> The Inquiry's trauma-informed policy will play an important part in the engagement strategy, given the number of key stakeholders in our work who have experienced trauma as a result of their experiences. Work on this policy is already underway. Key members of the Inquiry's staff have been engaged in it based on their experience of trauma-informed work in the charitable and legals sectors, separate from government and other State entities, like the NHS. The policy will be built around the trauma-informed principles of safety, trustworthiness, choice, collaboration and empowerment and will seek to create a bespoke approach for a trauma-informed public inquiry, based on the principles to which the Inquiry has already committed itself and the reasonable requirements of those who have suffered trauma and who are engaged in our work.

The Inquiry will publish more details about these initiatives in due course, once it understands more about how Core participants would like to receive and undertake communication with the Inquiry which, it is hoped, will be the product of thisy preliminary hearing and its associated work. Those details will include plans for engagement with the Inquiry's stakeholders about the initiatives, as a means of seeking to promote collaboration, listening and clarity.

In their written submission, Counsel for the patient CPs point to a lack of a lack of funded mental health support for participants in the Inquiry process. This is an important matter to raise. Even the basic details of what information has been provided about the sorts of issues

faced by members of the patient community – including cognitive impairments, the understandable risk of re-traumatisation, even histories in some cases of suicidal ideation demand action.

As part of its public consultation process and again today, the Inquiry has made available to those who wish to use it the support services provided by The Spark. These services were used by patients who attended the public consultation events and, I understand, appreciated by those who did. The Spark is a Scottish based charity which provides counselling and mental health support for individuals, couples, families, children and young people and has provided such services for 59 years.

This aspect of how the Inquiry engages with and support its patients who wish to participate in the Inquiry will form part of our engagement strategy. In accordance with our trauma-informed approach, before setting up such systems we will need to engage with the patient community to understand what they need and want in this regard. Those members of the patient community will understand, I hope, that the Inquiry is an investigative and not a therapeutic process. The Inquiry understands that it will inevitably be hard for those who wish to participate in our process to do so, at times. The Inquiry is fully aware that many of the patients who are involved with our work have significant physical and or mental impairments and disabilities. Though it is not part of our function, not indeed part of our remit, to provide treatment or resolution of these, this does not mean that we will not continue to provide support for those who have difficulty engaging with our process. In part, that is part of the function of the patient legal representatives whose involvement in the Inquiry is funded by it. The Inquiry wishes to investigate what more it can add to this important aspect of the way it will operate - we wish to discuss with you as part of our engagement process what further support services could reasonably be provided to support and to assist with the difficulties which participants with a right to be part of the Inquiry's work will inevitably experience. We have provided such reasonable support to this point as we can and will continue to do so going forward. It would be wrong of us to put in place such systems in without consulting with the patient community first about what can reasonably be done.

Protection of information

The Inquiry is aware of concerns which have been expressed by former patients of Mr Eljamel in the past and more recently relating to the handling of personal data, in particular material contained within medical records, and the Inquiry's obligation under section 18 of the 2005 Act to publish material which comes into its possession in connection with its investigations. The Inquiry takes these concerns and its obligations in this regard seriously.

As a result, the Inquiry has worked to create systems to respect and address these legitimate concerns, whilst also recognising the need for it to obtain, analyse, disclose and publish such information in the conduct of its work. As such, the Inquiry has set out its approach to the disclosure and publication of medical information in its General Restriction Order and other Protocols. Medical information will not routinely be published unless appended to applicant or witness statements or the ICR's neurosurgical reports, or otherwise necessary for the purposes of the Inquiry's oral hearings.[34] It will not be published if not relevant to matters falling within the Inquiry's Terms of Reference.[35] Where material falling within the category of potentially relevant evidence comes to be considered for disclosure and publication, individuals to whom medical information relates will have the opportunity to apply for:

> Anonymity[36] – you, Sir, have set out a process by which the opportunity to apply for anonymity will be accorded to those who provide an applicant statement to the ICR or witness statement to the Inquiry or otherwise, as material containing sensitive information comes to be considered for disclosure.[37] Though open to all, he has indicated that he would be minded to grant such applications in cases of former patients of Mr Eljamel[38]; in addtion

[34] General Restriction Order, paras 6 and 7
[35] General Restriction Order, para 14
[36] General Restriction Order, paras 8-11
[37] Protocol on Disclosure, Publication, Restriction and Anonymity, para 42 et seq, Protocol on the Approach to Evidence and Witness Statements, para 18
[38] Protocol on Disclosure, Publication, Restriction and Anonymity, para 41

A Restriction order otherwise limiting the nature of the material which will be disclosed and published is also provided for in the Inquiry's protocols.

Any material disclosed to Core participants or others will in any event be disclosed subject to the provisions of the Inquiry's First Order.

At paragraph 2(j) of the written submission provided on behalf of the patient CP group, it is suggested that there is a lack of clarity around the right to apply for anonymity. It is the obligation of the Chair to publish information which comes into to his possession as a result of his investigations – it is, in the first instance a "public" inquiry. That will necessarily include information relating to patients, in this Inquiry. **However**, the Chair does not require to public information which is subject of a restriction on its publication under the terms of section 19 of the Act. In this Inquiry, by the Inquiry's General Restriction Order and its Protocols, the Inquiry has already created a system which recognises the need for patient anonymity, and provides a presumption that it will be granted. This system has been instituted out of respect for the importance of patient anonymity in the process. Steps will be taken to redact adequate information to protect a person's identity who has been granted anonymity and still allow their evidence to have meaning.

It should also be stressed that, though no such presumption will be applied, the Chair would equally be open to consider applications from non-patients for anonymity. It is entirely feasible that reasonable grounds could, for example, be put forward for anonymity to be granted to medical professionals who wish to reveal aspects of their professional experience which merit their evidence being presented in that way. It is hoped that individuals with a story to tell will come forward to tell it, with the possibility of anonymity being granted, in appropriate cases.

As sensitive medical information will necessarily pass between the Inquiry and the ICR, which will be the process with which many patients first come into contact, the Inquiry and the ICR have worked together to ensure that the ICR's internal and public facing documentation will make clear what the Inquiry's intentions and processes are with regard to the ultimate publication of the material which the ICR will consider and produce, and which will ultimately become evidence in the Inquiry. For the sake of clarity, medical

information will be held within both the Inquiry and the ICR in secure document storage systems designed for each process. These are systems which are similar in nature but each will operate its own system. Both the Inquiry and the ICR have a management system which will be accessible only to the individuals working within either the ICR or the Inquiry, respectively or under their control. Secure systems and processes have been put in place to enable medical information to be securely passed between the processes.

I am particularly pleased that the Inquiry has the benefit of an interim Secretary in Dan Farthing who has many years of experience of working for the benefit of vulnerable individuals in the charitable sector and also a Solicitor in Lynn Carey who has many years of experience of dealing with harmed individuals in her former role as a solicitor in private practice. They will be central to the role of the Inquiry in forming and adhering to its trauma-informed policy and its engagement strategy, consultation about which will begin in early course. They will be primarily responsible for overseeing the system related to the publication of documents as I have outlined.

Next steps - Future Hearings Dates

The public hearings of the Inquiry will be live streamed. Transcripts of evidential hearings will be published on the Inquiry's website.[39]

The Inquiry is aware of the relatively historic nature of its subject matter and the considerable length of time many have waited to obtain answers to their legitimate questions. Our timetable reflects the need which has been expressed to the Inquiry (amongst other places through its public consultation on the Terms of Reference) to move things forward, in a way which the Chair hopes will provide an appropriate balance between speed and reasonable thoroughness.

A further hearing will be held late November/ early December 2025 at the Inquiry's hearings venue in Edinburgh. The principal purpose of this hearing will be to allow the Inquiry's core

[39] Protocol on Disclosure, Publication, Restriction and Anonymity, para 15

participants to deliver opening statements to the Inquiry. Given the importance which the Inquiry attaches to engagement by and with its Core participants, it has been deemed appropriate to hold this separate opening statements hearing, as opposed to allowing opening statements to be delivered at the first evidential hearing of the Inquiry. This has been done in order to make sure that contributions made on behalf of Core participants can be made at a time when they can have a real impact on the Inquiry's work, whilst also allowing Recognised Legal Representatives sufficient time to take instructions on their contents. It is likely that the opening statement hearing will also facilitate the public communication of a further update on the Inquiry's progress, as per paragraph 7 of the Inquiry's Public hearings Protocol.

The precise format and date of this opening statement hearing will be announced in due course. It is likely to be in the last week in November 2025. This is because the Inquiry will require to gauge the wishes of the Core participants as regards whether they wish to make an opening statement and the matters they would like to address. It is currently envisaged that a hearing of one or two days is likely to be necessary and sufficient for this purpose.

Evidential hearings

At paragraph 2(a) of the written submission provided on behalf of the patient CP group, it is suggested that a provisional timetable would be of comfort to the patient group. That is an entirely reasonable expectation and consistent with a trauma-informed approach and the Inquiry's other principles of clarity and collaboration.

The public hearing in evidential section 1 will take place in Edinburgh (with live streaming) in February 2026 – a three week slot from 9th February has been allocated to us. Holding hearings in February 2026, we anticipate, will to allow sufficient time for preparation for the hearings.

It is likely that the first set of evidential hearings in section 2 will take place in the spring of 2026. Further information about those hearings will be made available to Core participants as soon as possible. At paragraph 2(a) of the written submission provided on behalf of the

patient CP group, it is queried whether the Inquiry is confident that the ICR process will be complete by that time. The answer to that question is that the inquiry is not confident that it will be but that it does not require to be for those hearings to proceed. As I have set out, the Inquiry has identified as set of 50 priority cases and a timetable for its completion to the ICR. These cases have already been triaged as being of particular clinical significance of the Inquiry's remit. The timetabling aims to have these cases completed in time to be considered for inclusion in the list of witnesses for the spring 2026 hearings. In any event, the Inquiry currently plans to have a second set of section 2 hearings, likely to be in the autumn of 2026. This will allow further progress to be made with the ICR for further patient and ICR evidence to be heard at that time.

Information about the conduct of those evidential hearings and the broad outline of the process which will be followed in advance of it and at it is as set out in the Inquiry's Public Hearings Protocol.[40]

I have set out the planning for the opening two sets of hearings sections, which will take place based on current projections in February and spring of 2026 and have pointed out that, for a period we will require to work around windows of availability in our shared hearings venue. It would not in our view, be trauma-informed to create false expectations for future hearings where the evidence gathering of the Inquiry is yet to get fully underway. We have, however set out a clear picture (I hope) of the plans for the content of future hearings sections. We do, however, recognise the need for patients to have a broad picture of our plans and will keep CPs appraised of them as soon as we can confidently share them.

It is hoped that the subsequent evidential hearings of the Inquiry will be able to take place at times when the hearings space is generally more available for the Inquiry's use. This will enable the Inquiry to plan these hearings with a greater degree of flexibility. Details of the timing of and arrangements for these hearings will be announced to Core participants as soon as possible.

Conclusion

[40] Public hearings protocol, from paras 14 et seq

All public inquiries run the risk of appearing slow or even distant to those with an interest in their remit. I can assure those who would wish to know that this is never the case. However, though I hope that that statement provides some degree of reassurance, it is our ongoing responsibility to do what we reasonably can to inform those who have a legitimate interest of our work what we are doing and how we intend to move towards our ultimate goal, answering the questions we have set ourselves and thereby fulfilling our Terms of Reference.

The Inquiry has made significant efforts to make sure that it adheres to its principles. It has done so in light of the general context of all public inquires and the particular context of this one. The general content of which those with an interest in our work should be aware is that, despite having considerable powers to seek to compel evidence with its requirements in an effort to meet its objective, a public inquiry is reliant on many other parties to help it.

Material providers who are called upon to provide documentary evidence will be expected by this Inquiry to comply with requests by the set deadlines and that those deadlines will be met and met fully. Those who are called upon to provide written statements will be expected to do so as requested. Necessary resources require to be allocated or to be put in place in advance to meet them. The ICR and its expected will be expected to make progress with its work, as per our timetable and as the MoU requires it to do – this will include those who sponsor it and participate in it.

The Inquiry relies on these parties to perform their/its role, in the way and within the time they have been required to do it, although the need to do so may be an irritant to some, costly for others or even at times, painful. Parties upon whom the Inquiry relies includes not only its core participants, witnesses and material providers but also the Scottish Government, which provides systems and sometimes staff to assist the Inquiry in its work. As is the case with those other parties, the Inquiry will not hesitate to make every effort to ensure that the SG performs its supporting role in accordance with the legitimate expectations of our participants and the plans developed on the back of them by this Inquiry.

The Inquiry will continue to place what it considers to be reasonable and, where necessary, sensitive demands on those to whom it requires to rely, in accordance with its stated principles. It will continue to expect that those entities on whom it must rely will carry out what has been required of them in a full and timely fashion. It will continue to make clear where it sees any failings as lying, in public hearings like this one, if necessary.

Patients have rightly represented to us that delay is intolerable, that delays have been experienced since treatment was administered, in the process of seeking to find redress in various investigations, in the process of seeking a public inquiry and in the now two year period since this Inquiry was announced. They have represented to us that these delays have caused and compounded harm. We cannot contribute to that delay. Those who are represented will be expected to be able to answer for what their clients have or have not done, in all capacities.

External organisations and individuals with whom we come into contact in our work will be expected to bear in mind the historic nature of this Inquiry, the length of time patients, other stakeholder and the general public have waited to get answers to their reasonable questions. These and all organisations and individuals who have deadlines with the work of the Inquiry have a part to play in its success. Meeting targets and making progress are part of that success. The preliminary hearing in November will serve as an opportunity to provide a public update on progress in this regard. The Inquiry will not hesitate to ventilate issues it has had with meeting its reasonable targets and to identify those who have contributed to any delay

The specific context to which I am referring is one of considerable public concern about the way in which public inquiries have been or are being conducted in Scotland, including a recently announced parliamentary committee investigation into the cost effectiveness of Scottish (by which I mean Scottish Government sponsored ones) public inquiries. From this, it might reasonably be deduced that there is public concern about and interest in the existing public inquiry system. There is a legitimate need, both from the point of view of those with an interest in our specific remit and the public more generally for this Inquiry to proceed efficiently, though consistently with our other principles. This will be expected by the Inquiry team, as it will be expected by our core participants and the wider public.

This Inquiry's principles and systems have been devised to try to be sensitive to its particular remit, its particular timing, its particular stakeholders and the need to avoid perceived mistakes which have been made by other investigations, both into the Eljamel affair and other public inquiries. This is the least our participants can expect and our statutory responsibilities demand. Where these expectations and the Inquiry's ambitions are frustrated by others, we will make every effort and take every step to seek to put a stop to that.

In particular, it is important to recognise that the Inquiry has devised its systems and processes to allow significant participation by the patient body, whom you have committed, Sir, to putting at the centre of your Inquiry. The opportunities for participation also apply to its other CPs, whom the Inquiry expects to assist with its backward and forward looking functions. These opportunities for real, active participation in the work of the Inquiry are, in my submission, reflected by the measures the Inquiry has put in place or will put in place to maximise such engagement, which are not mandatory in terms of the statutory rules which govern us but which have been adopted by this Inquiry. For example:

- Those rules do not require a public consultation on the Terms of Reference – this Inquiry had one;
- Those rules do not require designation of large numbers of former patients or their representatives as core participants as individuals – you have designated over 150 such individuals in that capacity;
- Those rules do not require the designation of core participants of a wide range of organisational interests in the Inquiry's work – you have designated core participants representing the health board, governmental interest in our work as we well as others from the fields of surgery, education and training of medical professionals and healthcare improvement;
- Those rules do not require contributions to the issues to be examined by the Inquiry to be made by core participants – this Inquiry is inviting such contributions;
- Equally, those rules do not require similar contributions to letters of instruction for individuals providing expert evidence – this Inquiry welcomes them;

- Those rules do not require an Inquiry to set aside a separate hearing to allow core participant opening statements – this Inquiry will have such a hearing;
- Those rules normally require funding awards to patients to be made subject to means assessments – this Inquiry does not; and
- Those rules do not require an engagement strategy or a truly trauma-informed approach – these will form an important part of this Inquiry, alongside the Inquiry's stated principles which are equally not requirements of statute.

These are the means by which this Inquiry seeks active engagement from its core participants and from a wide range of perspective and experience. We look forward to those core participants rising to the challenge of the opportunities which we expect that these measures and processes will provide.

At this stage, one might legitimately ask the question - what does success in this Inquiry look like. My definition at this stage, Sir, is as follows:

a) It means the conduct of a comprehensive investigation into all of the issues arising from the Terms of Reference, with access to evidence from available sources;
b) It involves an investigation which is efficient, balancing the need for speed of progress which our stakeholders demand and reasonable thoroughness in our work;
c) It means actual real participation by our Core participants in the setting of our remit and the guidance of our investigation;
d) It involves a process in which stakeholders in our work are actively engaged in a process they can trust;
e) It means conducting ourselves in accordance with our stated principles, in a trauma-informed way;
f) It involves assessing and challenging the evidence we receive in a way which is informed, fair and truly independent of the State; and
g) Ultimately, it involves enabling you to reach clear, evidence-based findings and recommendations in a clearly-expressed report or reports, in which patients are

invested and on which they can rely , the findings and recommendations of which are accepted and implemented by government for the betterment of patient care in Scotland.

To these measures of success, we remain committed. We hope that the structures and processes which we have put in place facilitate their achievement. We look forward to collaborating further with our stakeholders to make sure our stated objectives are met.

Thank you for your time and for your attention, in particular to those in the public gallery and those watching online.

Thank you, sir. We will now take a break.

(Lord Weir): Thank you very much indeed. Ms Cherry, I think we're going to hear from you next – would two o'clock be convenient?
Thank you everybody. We'll stop now for lunch and if we can aim to resume again at 2 o'clock we'll hear from Ms Cherry at that point.

LUNCH

(Lord Weir): Yes, have a seat everybody. Now we're going to invite Ms Cherry KC to make submissions on behalf of the core participants represented by Levy & McRae. Thank you.

(Joanna Cherry KC):
Good afternoon Lord Weir, and good afternoon to everyone else who is here. My name is Joanna Cherry and I appear as Senior Counsel for the core participants who are former patients of Mr Eljamel and for their personal representatives which I will refer to in my submission as the patient group.
I am assisted by my learned junior, Clare Connelly, and we are looking forward to working with the Inquiry to assist it in discharging its Terms of Reference and we seek to ensure that, above all, there's effective patient engagement, both in respect of the inquiry but also in respect of the Independent Clinical Review.

We are, sir, acutely conscious of the importance of this process to those whom we represent.

Many of them have suffered catastrophic injury and psychological trauma which is ongoing and which may be exacerbated by their engagement with the public inquiry and with the independent clinical review.

We were very pleased this morning to hear Counsel to the Inquiry acknowledge the long and hard fight that has produced this public inquiry. Now that we are all here, we want to work in collaboration with the inquiry to ensure it can fully fulfil its terms of reference and we welcome this opportunity to make oral submissions at the preliminary hearing.

These are in addition to the written submissions which we submitted in advance, and I'm very grateful to Counsel to the Inquiry for his very full engagement with many of the concerns that we set out in those written submissions.

What I have to say this afternoon is grouped under the same two chapters as were in the written submissions.

The second chapter will deal with some issues arising from Counsel's Note. Many of those have been dealt with this morning to my satisfaction, but I still have a few points that I wish to make.

But perhaps most importantly, chapter one of what I have to say addresses the main concern of the patient group and that is the extent to which they will be involved in a patient-centred and trauma-informed process and the extent to which it is recognised that the group will require adequate support and assistance for their legal team to engage with both the Independent Clinical Review and the public inquiry.

Now, in my written submissions, I said there had been a lack of clarity over the patient-centred and trauma-informed approach. But I'm very grateful to Senior Counsel to the Inquiry for the clarity that he had provided this morning in relation to the engagement process that the Inquiry intends to undertake in relation to the issue of providing support and psychological support and a trauma-informed approach.

This of course should be at the heart of both the inquiry and the independent clinical review. That is what the Cabinet Secretary promised on 7th September 2023 when he set up the public inquiry and said that the independent case review would run alongside it. He said and I quote: "that will allow a patient centred and trauma-informed review of each patient's clinical case".

The Memorandum of Understanding between the independent clinical review and the public inquiry also recognises in principle 11F F that both processes require to undertake their work in a trauma-informed way. And of course, paragraph 91B of council to the inquiries note reaffirms that a trauma-informed approach is central to the work of the inquiry. We are very grateful to council for the clarity he provided this morning about the inquiry's patient centred and trauma-informed approach.

But we still have some concerns. in particular.

Firstly, we are concerned that the provision being made available to support the patient group through the independent clinical review process is not sufficient to enable their legal team to provide the advice and advocacy necessary for them to participate in the independent clinical review effectively.

And secondly, we are concerned at the absence of any provision of funded mental health support for patients to participate in the independent clinical review process. Now sir, separately you will be aware that those instructing me are in correspondence with you about what they perceive as a lack of flexibility in the arrangements envisaged by the Section 40 award made in respect of the patient group's legal representation.

And all I will say about that is it needs to be borne in mind that those instructing us are unlike the inquiry legal team not engaged full-time on this inquiry and have responsibilities professional responsibilities to other clients as well as their professional responsibilities to the patient group.

But the focus of what I have to say relates very much to the independent clinical review subject to one or two provisos.

Now, having met with most of the patient group in consultations last week, it is very clear to myself and my learned junior that proper support from their legal team is absolutely necessary.

Not only due to the cognitive impairments which they suffer, but also because of the potentially retraumatising impact that engagement with the independent clinical review may cause. And this will require access to funded mental health support for extremely vulnerable individuals as has occurred in other similar processes.

Most of the patient group have suffered serious mental health consequences following their engagement with Mr. Eljamel and NHS Tayside.

These include but are not limited to post-traumatic stress disorder and suicidal ideation. The process of engagement in both the independent clinical review and the inquiry is potentially retraumatizing patients who have already been denied their voice as legitimate complainers for many years by both Mr. Eljamel and NHS Tayside.

Paragraph 33 of Counsel to the Inquiry's note acknowledges representations of concern that have been made in respect of the Independent Clinical Review and sets out how those particular concerns, for example, in relation to incomplete medical records will be resolved by reference to GP records.

Now, this section of the Note states that the patient experience will be captured but we submit that the complexity of this process and most importantly the trauma resulting from patient re-engagement has not been properly recognised and is not provided for in the proposed model of patient support for the independent clinical review.

Inadequate funding for the legal support of the patient group in the Independent Clinical Review is a concern and I'm afraid to say it has also been a concern in relation to the Inquiry and we raise this because it could undermine the aspiration for a patient centred and trauma-informed approach.

In relation to the Inquiry, it has been stipulated that all affected patients must be represented by one law firm. But the legal team at that law firm feel that they're not being afforded the flexibility in the funding award to meet their professional obligations to the patient group and their other clients.

A further concern is that there has already been one attempt to restrict the ability of the patient group's Counsel to consult with them in a meaningful way. And this occurred when those instructing me made an application for funding for the first part of the Inquiry and received a letter dated 13th August from the Solicitor to the Inquiry saying that the application sets out that it is intended that there will be consultations with patients led by Counsel and that each consultation would be with a group of 10 patients.

The Inquiry does not consider that this is a necessary or economical approach and that instructions can be obtained from solicitors in the normal course who would thereafter provide instructions to Counsel subject to the general requirements under paragraph 44 of the Legal Expenses Protocol.

And I'm afraid to say, sir, it took an online meeting to confirm that I and my learned junior could indeed consult with the patient group in advance of this preliminary hearing.

However, we were advised that there was no guarantee that would be that there would be any payment for consulting with the patient group and that any payment would be at the discretion of the Inquiry.

Now, this is really quite extraordinary, sir, because on no reasonable basis can Counsel be expected to fulfill their legal and ethical obligations without consulting with the patient group.

And whilst we do appreciate that for very good reasons there are limitations to recovery of fees for reasonable and necessary work, we cannot see on what basis client consultations could be regarded as other than reasonable and necessary particularly in the circumstances I have outlined and we very much hope that this will not be a problem going forward.

But I return to the main concern which is the issue of the Independent Clinical Review. Those instructing me were initially informed that there would be no role for legal representatives in in respect of the Independent Clinical Review. When it became clear that patients' statements to the Independent Clinical Review may form the sole evidence to the Inquiry for many patients, those instructing me pushed for the patients to have the support of their legal representatives within the Independent Clinical Review process.

It was felt that this would be particularly necessary in relation to the provision of statements and advice to people in the patient group on issues of consent and privacy. It is understood that the Scottish Government intends to commission the Citizens Advice Bureau Patient Advice and Support Service to provide what they describe as a bespoke service to assist the patient group with the I independent clinical review process. My agents have asked for details of what this service is expected to consist of and how patients might access it and they have been advised by the government that this package has still not been finalised.

We are, sir, particularly concerned that the Scottish Government intend to involve the Citizens Advice Bureau in the provision of support to patients who already have legal representation. We do not consider that that is appropriate and furthermore we fear that it risks further retraumatising patients by their involvement with yet another third party with whom they have not yet met.

In the meantime, those instructing me have received confirmation from the Scottish Government that they are willing to provide limited funding for legal assistance in relation with the Independent Clinical Review, but only strictly in relation to points of law that may

arise in the course of a former patient narrating their experience or review of statement for points of law or review of patients individual reports when issued to provide legal advice. The Scottish Government remain of the view that the re-drafting and assistance with drafting of statements and questionnaires would be provided by the Citizens Advice Bureau. They also insist that medical records will be recovered by the Inquiry and sent to the Independent Clinical Review and onto the neurosurgeon without the patient group seeing these prior to providing those statements.

Now, whilst this is a very sat unsatisfactory state of affairs, those instructing me in the spirit of trying to move forward have agreed to that limited funding on a trial basis. However, they're waiting for that agreement to be formalized by the Scottish Government and they understand that a number of steps require to be completed by the Scottish Government internally to ensure compliance with government financial controls.

And there is, I'm afraid to say, at present, no clear information available from the Independent Clinical Review or the Scottish Government on what mental health or counselling support the patient group will be afforded during this process.

So to summarise, sir, despite extensive correspondence with the Scottish Government in their capacity as sponsor of the Independent Clinical Review and indeed of the public inquiry, those instructing me do not as yet have sufficient reassurance on the issue of legal support for the patient group in the Independent Clinical Review.

Some considerable reassurance was afforded on other matters at a round meeting which those instructing me convened last week with representatives of the public inquiry and the independent clinical review and as you have heard sir from Counsel to the Inquiry that meeting took place on Friday.

Unfortunately, the Scottish government declined to attend, citing the fact that they were a cord participant in the inquiry despite it having been made crystal clear that they were invited as their in their capacity as a sponsor.

And I'm sorry to say that we have found the approach of the government to the whole matter obtuse. And I would wish to associate myself with what Counsel to the Inquiry said about the need for the Cabinet Secretary to get this matter sorted out with further without further delay.

We absolutely appreciate that these problems that I've outlined in relation to the Independent Clinical Review cannot be resolved by either the chair of the inquiry or the chair of the independent clinical review.

But the failure of the Scottish Government to resolve these issues jeopardises both processes and will cause unnecessary stress and trauma to the patient group if it's not sorted out without further delay. Those instructing me are simply concerned to be able to provide effective legal representation to the patient group in line with their professional responsibilities.

And that is the focus of their concern and the knowledge that the proper functioning of the independent clinical review is integral to the success of the inquiry.

Without proper patient engagement, the legitimacy and purpose of both the independent clinical review and the inquiry risk being adversely affected.

And if both bodies wish to fulfil their commitment to a trauma-informed approach, this necessitates that patients are properly supported to engage with the Independent Clinical Review and are provided not only with the support and guidance of their legal team but with appropriately funded mental health support through both processes.

Now I will leave that chapter stressing as I did before that I understand that neither you sir, as chair of this inquiry, nor Professor Wigmore as chair of the Independent Clinical Review, have it in their power to resolve the issues which those instructing me have with the Scottish Government and it is for the Scottish Government to step up to the plate and it's very much a matter of regret that they've not felt able to participate in this preliminary hearing in their capacity as sponsor answer and it means we won't be able to move these issues forward today, but I hope that we will be able to move them forward in the days to come.

I turn now to chapter two of my submissions which very much focuses on issues identified by Counsel to the Inquiry in his note for the preliminary hearing.

I'm pleased to say, sir, that many of the issues which I and my learned junior raised in our written submissions have been dealt with to our satisfaction by Counsel to the Inquiry this morning.

So I will restrict what I have to say this afternoon to those areas where we still have concerns.

The first relates to the designation of core participants. We share the inquiry's concerns about the extent of NHS Tayside's representation of its current and former employees.
We find their position as outlined by Counsel to the Inquiry this morning - because we've not seen their written submissions yet - but we find their position as outlined by council to the inquiry to be wholly unsatisfactory. It raises questions as to the extent to which the NHS side are aware of their obligation as core participants in this inquiry to achieve its terms of reference both in respect of current and former employees, and we are very apprehensive that this may impede the progress of the inquiry.
Having considered matters, sir, we wonder if it might be of assistance if NHS Tayside together with all core participants were asked to produce position statements in advance of the opening statements which are to be heard at the continued preliminary hearing.
The next chapter where we still have outstanding concerns I've dealt with largely already and that's the Independent Clinical Review. But I just wanted to add one point.
We did receive much reassurance last week at the round table. And we understand that the Independent Clinical Review are indeed exploring options for supplying trauma-informed support to patients who uh register with the independent clinical review.
However, we also understand that they are in dialogue with NHS Tayside regarding psychological support for the patient group and I wish to take this opportunity to emphasise that the patient group as a body have little or no confidence in NHS Tayside and that really any psychological support will require to be afforded by an independent provider.
The next chapter where we have some outstanding concerns is approach to evidence and public hearings.
We would, sir, wish to have input to the selection of patients to give evidence. We also seek confirmation that provision for a representative to give evidence includes a nominated spokesperson in line with a trauma-informed approach.
We note that the General Medical Council will be called to give evidence. We would wish to know whether it is likely that somebody from the Health and Safety Executive will also be called to give evidence given what is said in paragraphs 50 and 51 of Counsel's Note.
We wish to emphasise that issues such as informed consent and the evidence surrounding the same will not be capable of capture in a questionnaire that a patient completes without support from their legal representatives.

And finally, under the heading of approach to evidence and public hearings, paragraph 59 of Counsel's Note sets out the process whereby the Inquiry will recover patients medical and complaint records.

We wish to know what system or process will be in place to enable the inquiry and the Independent Clinical Review to ascertain the patients acceptance or otherwise of the accuracy and completeness of their records. This, sir, is an issue of concern to many in the patient group who are have become aware down through the many years that their medical records may be incomplete or that they may even have been falsified.

The next chapter where we have one or two outstanding concerns is in relation to rule 8 requests and section 21 notices.

Many of our core participant group were resident within NHS Fife's area. They were referred from NHS Fife and also received after care from NHS Fife. So we therefore remain of the view that rule 8 and section 21 notices should be served on NHS Fife to recover documents relevant to patients.

We believe that this is relevant to the inquiry's systemic inquiry into the continued referral of patients to Mr. Eljamel despite known concerns around his practice.

Next, I turn to the issue of disclosure of documents. We have heard the very full explanation given by Counsel to the Inquiry this morning of how the Inquiry intends to proceed and we're very grateful for that.

We simply seek some reassurance from the Inquiry that sufficient notice in advance of disclosure of documents will be provided to allow legal teams to make arrangements to provide proper consideration of the documents in advance of the relevant evidential hearings and the preparation of any rule nine applications that might be required.

I next turn to the issue of instruction of expert witnesses. We're very grateful for the reassurance that no expert witnesses will have been or will or will currently be employed by NHS Tayside nor will they have worked alongside Mr. Eljamel in the past.

For obvious reasons, this is an issue of the utmost concern to the patient group.

The final chapter I wish to address in relation to matters raised in Counsel's Note is the issue of protection of information.

We were very here very pleased to hear Counsel to the Inquiry acknowledge the patient group's concerns about the protection of information and data protection. This is something

about which the patient group feel very strongly and with good reason given various events that have occurred in the past.
But we continue to have one or two concerns about what was said about patient anonymity. As we understand it, there will be a presumption in favour of the granting of requests for patient anonymity, but that it will not be guaranteed.
It would be helpful and I'm sure of comfort to the patient group to know in what circumstances a request for anonymity of a patient would be likely not to be granted.
We also seek further clarification on the process of patients being able to review documentation, including their own medical records, in order to make a decision about applying for anonymity. This is particularly important for individuals who are cognitively impaired or those who might find the process of review retraumatising.
And clearly this is an area where support will be required from the legal team.
Sir, that's all I have to say at this stage except to say that on behalf of the patient core participants that I and my legal team represent, we look forward to assisting the Inquiry in discharging its terms of reference.
We are grateful for the open discussions we've had with the Inquiry so far and we very much hope that the commitment by both the inquiry and the Independent Clinical Review to a trauma-informed approach is fully realised and that the long-awaited opportunity for this public inquiry is not a lost opportunity for the former patients of Eljamel and unless I can assist you further, sir, I would leave it at that for now. Thank you very much.

(Lord Weir):
Thank you. Now, consistent with the uh agenda that has been set, the next stage involves me in inviting Mr. McGillivray of Morton Fraser McRoberts to speak to his submissions on behalf of the ICR. Mr. McGillivray will know that a relatively brief submission was tended in advance and it is to that which I will invite you to speak.

(Ewan McGillivray): Thank you sir and good afternoon to you all. Professor Wigmore as chair of the ICR is grateful for this opportunity. Professor Wigmore was here this morning but this afternoon he has had to leave. He is operating in patients. So unfortunately couldn't stay any longer.

Without any way prejudging the task in the ICR's own terms of reference, I'm instructed to begin by expressing sympathy to all those who have experienced suffering arising from being a patient of Mr. Eljamel, whether as a patient directly or indeed as the loved one of a patient.

The ICR and Professor Wigmore is very aware that this suffering has lasted for many years.

The ICR would also wish to pay tribute to those patients and family members who are able to assist this inquiry and the ICR with its work.

Their contribution will surely provide invaluable assistance in the work of both processes.

The process of the ICR has been designed to seek to uh minimise the trauma of those who participate but the ICR does accept that the process of participating in the ICR itself might be triggering.

Accordingly part of the ICR's commitment to supporting patients is to publish routes of access to mental health support.

The ICR, Professor Wigmore, is in discussions with NHS Tayside about that vital area.

However, I have noted what Miss Cherry said about that in her submissions before me and I will raise that with Professor Whitmore later today.

The ICR has sought to assist uh the public inquiry in any way it can so far and would wish to express thanks to you, sir, the Inquiry Senior and Junior Counsel and its solicitors.

All those just referred to and no doubt many others within the Inquiry who support them have worked cooperatively with the ICR during these past 16 months or so.

This has included and attending many meetings and reviewing documents in which the PI and the ICR have a joint and material interest. The ICR greatly appreciates all this.

By way of a very brief update as at quarter to 4 yesterday afternoon, 302 people had registered with the ICR for review. The consent forms with privacy notices pertinent to the consent forms to be sent to those have registered were finalised on Monday.

As of quarter to three yesterday afternoon, 37 have been sent out and four have been returned and I'm pleased to report that all four give consent for the ICR to share details with this Inquiry.

It is anticipated that in the course of the next two weeks the remaining consent forms and privacy notices will be sent out to everyone else who's participated and unless I can give further assistance, sir, those are my submissions this afternoon.

(Lord Weir): Thank you very much Mr. McGillivray. It would be my intention, Mr. Dawson, consistent again with the Agenda that we've fixed to ask you to reply to the matters that have been raised. I think that technically we might have afforded ourselves a break, but we're a bit ahead of time. Are you content to address matters now or you would you prefer to?

(Jamie Dawson KC):

We're very happy to proceed just now.

(Lord Weir):

Thank you. All right. Well, let's just do that.

(Jamie Dawson KC):

I'm very much obliged um to both of those who made contributions this afternoon and equally to others as I've said already who made written submissions. All of the matters which have been canvased with us will be able to be taken forward in further discussion in the event that that proves necessary but in the hope of trying to deal with some of the matters that have been raised at least this afternoon, I will attempt to do so.

The position advanced by me friend Miss Cherry with regard to the inadequacy in her submission of the funding of the ICR as a matter of the legal support for the ICR is a matter which I addressed at some length um this morning.

It is the inquiry's position that this is a matter which requires to be resolved by the Cabinet Secretary as a matter of some urgency.

Mr. McGillivray was able to provide an update as to practical progress with registrations to the ICR which serves to illustrate the point that the ICR must be able to progress to its next stage i.e. the completion of applicant statements as soon as possible. Beyond that, I think I've made the Inquiry's position adequately clear. It would be wrong in my submission, sir, for anyone interested in our proceedings, in particular patients to equivocate the funding issues for the ICR to which the inquiry has lent its support with the funding position relating to the Inquiry.

Counsel for the core participant patient group have seen fit in their written and oral submissions to assert that there is inadequate funding for the patients legal representatives in the Inquiry which they claim is undermining the aspiration of the Inquiry to have a patient centred and trauma-informed approach.

I must admit to finding it surprising that this this issue has been raised in public, in particular given the importance of many of the other matters which might have been preferred for discussion and the fact that it does not form part of the Agenda.

However, as this has been raised, I think it's important that I attempt to provide some clarity around the general systems within which funding is provided for legal representation within the Inquiry and the specifics of the application made on behalf of the patient group.

May I correct first of all my learned's assertion that all affected patients are represented by the Levy and McRae legal group. That is not accurate.

They represent a large cohort of those who applied for core participant status. But as I as I think is apparent from the numbers provided of Mr. Gillivray, there are a number a large number of affected patients who are not represented by LevY & McRae.

It is not clear I should say, sir, how widespread the concern about funding is amongst patients.

Though patients have engaged with us constructively in our public consultation and many have continued to do so uh since legal funding was awarded, the matter of legal funding has not been a matter that has been raised with us directly by any of them. Their engagement by contrast has been helpful and focused on more substantive matters such as the number of the matters which I addressed this morning.

I take it though seriously as Miss Cherry has advanced this argument on behalf of our clients that there must be such a concern. For clarity the Inquiry's ability to provide funding for legal expenses is derived from section 40 of the Inquiries Act 2005 and the Determination made by the sponsoring minister under that section which defines the very specific rules by which legal expenses can be awarded by the Inquiry.

The minister's Determination can be found on the inquiry's website. These rules provide that legal expenses can be awarded, but only where they are fair, reasonable, proportionate, and for work which has been effective, efficient, avoiding duplication and making the best of public funds.

You must satisfy yourself, sir, as must the solicitor to the Inquiry that these conditions are met before payment of legal expenses can be made. The processes for applying for legal funding are set out in the inquiry's legal expenses protocol which in turn includes statutorily prescribed processes from the inquiry Scotland rule 2007.

These involve a set procedure of needing to apply for funding in advance of carrying out work and then billing for it afterwards. This process has been followed by the Inquiry in relation to funding made available to Levy and McRae and their Counsel. It involved an application being submitted and the Chair making a determination in accordance with the rules incumbent upon him.

The Inquiry does provide funding for Levy and McRae's legal team including Counsel. That funding award was made in response to an application on the prescribed Inquiry form. Although not required by the rules, that award was sent out with an explanation about the extent of the award in broad terms and the reasons why it was framed as it was.

Again, though not also required, meetings were attended by members of the legal team on two occasions to help to explain what was being awarded and the rationale behind the award. It was also made clear at those meetings that your determination on that matter was final.

The Inquiry refutes any suggestion that this award is insufficient for the proper representation of the interests of the patient group who are clients of Levy and McRae. In particular, it is important to note that the inquiry has taken an incremental approach to the funding of the patient representative team, allowing funding in the first instance for the preliminary phase of the Inquiry, which precedes the evidential phase, which is defined as when we anticipate that evidential input from core participants will become possible around December on the estimates I set out this morning.

Though this was made clear to Levy and McRae in advance of them seeking funding, their application relied on the requirement for funding for certain tasks, including evidential analysis, which fell beyond the ambit of the award and were thus irrelevant to it.

The written submission continues in this misapprehension about the current funding award and its temporal limitation. The submission states that the process of engaging with and accounting for inaccurate or absent medical records will be a source of great stress and trauma. Though that is no doubt correct, it appears to be asserted that greater Inquiry funding is required to address that. In so far as the Inquiry is concerned, calls upon patients to provide such evidence will come at a stage beyond the preliminary funding award given the evidential nature of that work.

It is not relevant and suggests a misplaced frustration on the part of the patient core participants legal advisers against the funding of the ICR which is separate from the funding

of the Inquiry. As I have set out during the course of discussions about funding, it was asserted that hourly rates which were awarded in accordance with your determination, sir, were insufficient, though they were at the top end of the range which you entitled to award. That award contains full-time funding for Senior and Junior Counsel, supervisory hours to be split between two partners within Levy and McRae, a full-time senior associate award, a full-time assistant solicitor award and an equivalent award for one paralegal to be split between two people.

The Inquiry considers this to be an award which complies with the duties incumbent upon the Chair in making it. It is known to be a larger award than was made to a similar team representing twice as many patients and two charities in a UK inquiry with a far wider remit than this one.

It has been suggested I think that the ward the award is inadequate though no request for further hours to be covered has been made as I understand it.

In that regard the submission is academic. No specification has been provided of what extra work should be funded which is not currently. It has been suggested that this may result in an inequality of arms. The inquiry's position is that that is not relevant to what is an inquisitorial and not adversarial process and in any event is based on speculation about what resource is available to other core participants.

It may be a rather crude representation, but today the entire front row of the legal benches is made up of members of the patient core participant legal team unlike benches behind it which contain multiple teams. It has been suggested that the arrangement by my learned friend that this arrangement is insufficiently flexible. In your response to the determination, sir, you stipulated that you expected that a dedicated smaller team than had been requested. Working full-time or near full-time hours as opposed to multiple participating lawyers would be preferable. This, one might imagine, is no less than the represented patients deserve. It is consistent with the legal requirement that duplication be avoided, which a bigger team would necessarily cause. It seems that the request has been made though the Chair's determination on the matter, as I have said, is final.

The other business commitments of those who are being funded is not a matter which the Chair can or should appropriately take into account. You're entitled to expect that legal representatives will dedicate themselves to the service of their clients in the work of the Inquiry which they've been asked to undertake, as I am sure they will.

Mention is made of a purported restriction on Counsel being able to consult with clients. There has never been such a restriction. The statutory rules and ministerial boundaries within which this and all inquiries work cannot simply allow funding to be provided by way of a blank cheque. A proportionate approach needs to be taken.

My learned friend suggested that her agent suggested a guarantee of payment in advance. This is simply not how the system works as has been explained at present. As I have said, the work of the inquiry involves the work of the legal team to which I'm referring involves taking client's instructions on key structural elements of the inquiry's approach sufficient to allow meaningful appearance at this hearing and the opening statement hearing to come later in the year to contribute to important inquiry documents including the list of issues and letters of instruction for experts. Evidential work which will come later will be subject to a different award. No specification has been provided as to what these initial consultations were to cover or why their multiplicity was deemed to comply with the specified standard which the inquiry has to comply.

In any event, these matters will all require to be justified when the bill comes in in due course as per the prescribed statutory procedures. In any event, we understand as Ms Cherry has pointed out that Counsel have indeed consulted with their clients in advance of this hearing. As far as the patient centred and trauma-informed approach of the Inquiry are concerned, as I've set out, these will be advanced through direct engagement with the Inquiry team as well as via the support which will hopefully and inevitably be provided by the patients' lawyers.

As far as that aspect involving the Inquiry of our approach is concerned, that is not dependent on legal funding. Sir, I would urge those representing the patient core participants to judge the inquiry's approach to their involvement on its substantive merits and the plans which I set out this morning. Considerable efforts have been made to seek to make it as easy as possible for patients to be involved in the work of the Inquiry and to be represented.

Significant efforts have been made to allow their active participation consistent with your commitment, sir, to put the patients at the centre of the process. It is the Inquiry's position that the assertions made about funding by my learned friend are baseless and in part based on inaccurate information. We are keen that there is clarity around this matter in case these assertions and their ventilation in public cause patients any concern or undermine their

faith in the Inquiry process. Everything we do and have done seeks to retain that faith and avoid those concerns within the statutory confines of our remit and the need to act in the public interest.

Moving then, sir, to other aspects of uh the points that were raised. I'm very pleased to hear that my learned friend considers that a number of the matters she has raised in her helpful note were covered off by submissions I made earlier today.

And may I reiterate, if there remain issues of concern of this nature falling out with the ambit of what I have said or have to say, we would be very happy to discuss any particular matters with her or her instructing agents on behalf of her clients.

Sir, there were a number of matters that were raised um some of which I think I've covered off already but as I had them noted my learned friend suggested helpfully that it might be useful to seek to have position statements lodged on behalf of participants perhaps in advance of the opening statement hearing. It is not the inquiry's current intention to seek position statements as will become apparent in due course.

A number of corporate statements as I referred to this morning will be sought in connection with section one of our hearings which are to some extent equivalent to what other inquiries cover in position statements. That would deal with the perceived concern about representation if I'm correct. Indeed, sir, I understood her to be suggesting something more broadly from all corporate participants in so far as the matter which she has raised about the extent of NHS Tayside’s representation of their current or former employees is concerned. I think we are both of the same view that that's a matter which will demand further explanation by the board and as I committed to this morning any such response will be made available to core participants.

She raised again the issue of mental health support predominantly in the context of the ICR. That is a matter which falls beyond our remit, sir, although I have made a number of submissions this morning about the importance of our engagement strategy seeking to pursue appropriate ways of patients being supported within the Inquiry which will follow in due course.

As far as the evidential approach and public hearings are concerned, my learned friend has made this the helpful suggestion that in certain cases it might be appropriate for a nominated spokesperson as opposed to a particular patient to be called upon to provide evidence to the Inquiry. As part of our witness management approach, of course it will be

considered as to whether that would be a more appropriate course to take and we will of course be open to suggestions made by her or by those instructing her as regards which cases would be appropriate for that type of approach to be taken. Such an approach would, I would suggest, be consistent with our desire to obtain the best and fullest evidence in as trauma-informed a way as possible.

She made reference to a matter raised in the note about the GMC and health and safety executive. It is not stated in the note that evidence will be given orally necessarily on behalf of either the GMC or the Health and Safety Executive. What's said in in the Counsel to the Inquiry Note and I said this morning is that those bodies will be called upon to provide evidence. Whether it would be of assistance to the Inquiry for that evidence to be ventilated at a public hearing is a matter which will be decided at a later stage and as my learned friend has requested that and other questions around who may be called to give evidence will be matters upon which core participant representatives will be consulted.

There she made a point about what systems exist in order to ascertain whether patients accept the completeness or otherwise the accuracy of their records. As I said this morning, sir, it will be part of our remit to seek evidence relating to term of reference 14 which requires a systemic investigation into potential failures of document retention. So that will be one place in which such matters can be raised. I would anticipate, although I accept that my learned friends have not seen the applicant statement request, that any information which patients already have about issues with their medical records could competently be raised in that statement as well. I would say connected to that as well that the letter of instruction which has been issued for comment to core participants seeks to ask expert neurosurgeons in the ICR process whether their ability to provide an opinion on the case has to any extent been undermined by absent records or other problems. So these are all places in which those issues will be able to be ventilated.

She raised an issue about uh NHS Fife. That's a matter on which I think it may be necessary to get further information. It's very helpful that's been raised on behalf of those of her clients whom that affects. I suspect that information might best come from her instructing agents in order to understand precisely what it is that we think those records might usefully contain, because as I understood it, it may may relate to aftercare received. I think the position this morning went slightly further than the note because the note says it relates to aftercare.

My position as I set out this morning is if it relates to aftercare that's really a matter for the ICR and not a matter for the inquiry. But I took it to be the case that Ms Cherry was suggesting those records may contain other useful information which is the very subject I think we would like to explore.

What she said about the possibility of inappropriate continued referral to Mr Eljamel, off the top of my head, I think could have a relevance to the Inquiry and that's a matter which I think we should we should pursue.

As to how many of those records, in what cases, and at what time, I think that's a matter for further discussion which I'd be very happy to be engaged in.

She made two observations relating to disclosure of documents. As I set out this morning, it would be impossible for an Inquiry to set out in advance um prescribed rules about when documents will be disclosed. It is of course the case that the inquiry will endeavour to disclose documents in sufficient time for them to be reviewed and for useful contributions to hearings to be made on behalf of core participants in particular those whom she represents. She will recall that I have strongly urged those who are in possession of documents to produce them in accordance with the inquiry's timescales which will be constructed with a view to making sure that the documentary product of those processes will be available in accordance with her and other corporate representatives wishes.

She made reference to the need to have documents in order to make meaningful rule nine applications. I make a slightly tangential though I hope useful point about that. In the public hearings protocol there is set out albeit at an early stage the process which this Inquiry intends to follow with regard to contributions from legal representatives about possible questions being asked of witnesses at oral hearings. It is that that her reference to rule 9 applications relates to that area. The position in that regard is that we are we are going to take a more informal approach than other inquiries in order to try to maximise efficiency. And I no doubt I know that my learned friends have read the Protocol, but for the benefit of others, it is our intention that proposed questions would be shared between Counsel and that decisions would be made and that as regards which questions would be asked that there would normally be the opportunity for further discussion about questions on the day with a formal rule 9 application coming after that process and very much in the hope that that process amongst counsel will result in a more meaningful contribution and discussion about which questions should be addressed. So that's rather tangential to the point she was

making but I make it in the hope that it's of assistance. As regards the protection of information and data protection, as I said this morning, Ms Cherry's reassertion that this is a matter of considerable importance to her clients is a matter which is well known to the Inquiry already.

It has been represented to us through various media that that is the case. She's asked the very legitimate question as to in what circumstances it would be likely that anonymity would not be granted to an individual who made an application for it. I concede that it would be difficult to envisage a situation in which it would not, given the stipulations that have been made in our existing documents. The need for there to be a process arises from the statutory rules which underpin the inquiry and the documents which we have issued have tried to make it clear that that would be the normal course in cases where applications for anonymity were made on behalf of patients. As I said this morning that presumption as I put it would not apply to applications for anonymity in other cases although, sir, you as I know would entertain such applications.

Sir, those are all of the points that I was able to note down in the time. It may be that there are other matters uh which are left over but as I said at the beginning I'd be very happy to discuss those.

May I thank also Mr. McGillivray for his submissions in particular his update as regards the position on the numbers registered. It's very encouraging to see as I said this morning that the completion of the documents which have been discussed between the Inquiry and the ICR have resulted in privacy notices and consent forms being sent out and indeed for individuals already having indicated both that they would wish to proceed to the next stage of the process namely the taking of an applicant statement and also that they would be prepared to have their material shared with the Inquiry. Beyond that, sir, I have nothing to add. Thank you very much.

(Joanna Cherry KC):

I'm sorry, Mr. Chair. Clarify.

(Lord Weir):

Well, if it's a point of clarification and brief because it's off the agenda and clearly there are a number of matters that have been raised that will be the subject of discussion. I've not of

course been asked to make any ruling today in anybody's submissions and wasn't proposing to do so.

(Joanna Cherry KC):

I promise to be brief. Yes, just very brief briefly, sir.

Just uh to be clear and Counsel to the Inquiry said he was keen for clarity. I did not certainly mean to suggest that those instructing me represent all patients affected by Mr. Eljamel. What I meant to convey was that one law firm represents all the individuals within the core participant group and I that I hoped was clear from what I said.

Second point on the issue of funding for those instructing me. I was very careful in my oral submission to address the issue of flexibility of funding and you will be aware, sir, that that is the matter about which those instructing me have corresponded with you in their letter of 27th August, not the amount of funding - the flexibility of funding. So it is perhaps unfortunate that we had to have such a long exogenous there on the issue of what had gone before that I was raising the issue of flexibility of funding on my responsibility as Counsel.

Likewise, in relation to the issue of consulting with the patients, I read directly from a letter that was received from the solicitor to the inquiry and I will provide the chair with that.

So I can be quite clear that I was raising a legitimate concern there about the issue of consulting not about being paid in advance. If I may jest it's a long time since I've been paid in advance for anything, Chair. It was about being able to consult with the patients and it was being suggested that it wasn't necessary for counsel to consult and that we could just merely take instructions from our solicitor. I hope we're over that hurdle now. But again, in the interest of clarity, I wish to make that point.

And finally, just to correct something that my learned friend said, the issue of equality of arms does in fact apply to inquisitorial processes. There's quite a lot of jurisprudence on that issue particularly in light of the Hillsborough saga. So equality of arms is something which must be taken into account at public inquiries just as in other situations. The patients have article six rights there in the way that any other litigant or core participant at a public inquiry would have.

And I'll leave it at that. Thank you very much.

(Jamie Dawson):

I just want to say something briefly at the conclusion of the hearing, sir… Could I just say, sir, that I hope that today's preliminary hearing has been regarded by those who have attended, whether in person or remotely, as informative, comforting, and hopeful. I and the rest of the inquiry team look forward to advancing the inquiry's investigations in the coming months and to working with core participants in the clear, open-minded, collaborative, and trauma-informed spirit which our stated principles demand. Thank you.

Lord Weir:

Thank you very much. May I also address myself to all who have attended in person at today's hearing or indeed from a remote location and reiterate my thanks for your interest and for your attendance today. I do hope that you found the discussion helpful even illuminating as might have been apparent from Mr. Dawson's contribution.

I personally am very anxious to build and maintain momentum. Now that we advance into the inquiry's uh evidential investigations, I do ask you please to bear in mind what was said by both myself and Mr. Dawson about engagement with the List of Issues which I conceive to be a very important document which is available to you on the website. Please expect to hear regularly from the Inquiry and we will of course meet again as has been previously stated in the month of November. Finally, can I also reiterate my thanks for the written contributions and to Mr Dawson, to Ms Cherry and to Mr. McGillivray for their submissions this morning and this afternoon. To those of you who have travelled, I wish you a safe journey home and the hearing is now adjourned. Thank you.

ENDS