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Preliminary Hearing – Eljamel Inquiry
September 10th 2025

MORNING SESSION

(Lord Weir)

Good morning. Please be seated.

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 uh 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, health care provision in this country is of the highest order of 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 11. May I leave it to you to decide when we've reached a suitable point?

(Jamie Dawson KC)

Thank you very much, sir, and good morning. I am Jamie Dawson KC. I appear as Senior Counsel to the inquiry along with my learned junior Miss Alex Price-Marmion an 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 uh 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 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 one of the National Health Service Scotland Act 1978 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 improvement in the physical and mental health of the people of Scotland and and 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 has 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 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 or harmed patients both in the operative sphere and uh within 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 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 care. 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 well-being 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 prior 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, cooperation, 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 by an uh 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 core participants were all invited to make written submissions if they wish to do so. And an opportunity has been extended to those who provided such written submissions to make an oral submission or have one made on their behalf relating to matters which core participants 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 core participants 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 in due course. Some of them are represented at the hearing. Some will make or 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 helpfully 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, sir, on the following matters.

One, core participants and representation on their behalf today.
Two, the commencement and progress of the inquiry.
Three, the independent clinical review.
Four, our approach to evidence and public hearings.
Five, the terms of reference and list of issues.
Six, rule eight requests and section 21 notices.
Seven, disclosure of documents.
Eight, instruction of expert witnesses.
Nine, communication and the inquiry's trauma-informed approach.
10, protection of information.
And 11, future hearing dates before making some concluding remarks.
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 on 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, and 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 we 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 not 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 out with this room and is subject to the inquiry's First Order covering those in attendant 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, this space is used for the hearings of the Scottish Covid 19 inquiry, another public inquiry set up by the Scottish ministers. As that inquiry uh needs to use the space for its work imminently, we are somewhat restricted in the way in which we are 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 currently are 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 wish 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 rows behind the legal teams uh where we have asked legal representatives and their clients from our corporate core participants to sit.

This has been 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 commitment 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 in Edinburgh today will be the home of this inquiry for its public hearings going forward.

The fact that this hearing space is already equipped for the work of a public inquiry has enabled this inquiry to involve the inevitable considerable delays which would normally 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 core participants, 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 as regards public hearings. 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 four of the inquiry Scotland rules 2007. The applications for core participant status have been considered by you sir in accordance with rule four of those rules which provides that you 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. That in deciding whether to designate a person as a core participant, you must have particular regard for the desi 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 during the proceedings of the inquiry, or in any of its reports.

In making determinations, you considered, sir, whether in each case the application fulfilled the criteria set out in rule 4 in relation to the issues which this inquiry will investigate. You exercised your wide discretion, bearing in mind a number of features. You considered the applications in light of your obligation to run the inquiry as thoroughly and as 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 our core participant protocol, you were obliged to assess very carefully whether applicants could legitimately assist the inquiry in its work and whether their designation would actively contribute to the efficient and thorough operation of our work. As that document sets out, the inquiry expects those who have been so designated to be active participants in all we do.
This inquiry will accord to those core participants 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 133 former patients of Mr. Eljamel and 19 representatives of former patients of Mr. Eljamel represented by Levy and McRae solicitors as individual core participants. These patient core participants are represented today by my learned friends Joanna Cherry KC and Claire Connelly. They appear on behalf of this group today have help helpfully provided you with a written submission in advance relating to matters on the agenda.
Miss Cherry will address you after I have spoken.
NHS Tayside they have provided a written submission uh relating primarily to a matter to which I'll 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.
Healthcare Improvement Scotland. They have not provided any written submission and are legally represented at the hearing by Michael Stewart of the Central Legal Office. No oral submission will be made on their behalf today.
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 made will be made on their behalf today.
The Scottish ministers, they have not provided any written submission. They are represented at this hearing by my learned friends Laura Thompson 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 would be will be made on their behalf today.
The University of Dundee, they have not provided any written submission and are not represented at this hearing.
And the Royal College of Surgeons Edinburgh who have provided a written submission and are legally represented at this hearing by Christine O'Neal 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 Steven Wigmore, you have also invited that process to be represented at this hearing, have sent them the same advanced materials as were received by core participants and have 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 on the item on the agenda in due course. The ICR is represented by Ewan McGillivray of Morton Fraser McRoberts solicitors. The ICR has helpfully 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 cooperation 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 uh relating to the inquiry's core participants and the process by which they were designated by you sir in that capacity.

Firstly, as regards the patients, consistent with the commitment made by you to put patients at the in at the centre of the inquiry, um 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 core participant group at paragraph 2B. NHS Tayside addressed this matter in its written submission to the effect that NHS Tayside does not represent individual or current employees. 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. It seeks guidance from the inquiry as to the practical support which should it should offer to such witnesses. The submission refers to a circular sent to former employees and states that this includes a section on separate representation i.e. not by NHS Tayside’s lawyers. It suggests that NHS Tayside can offer pastoral support to former and current employees and that NHS Tayside can offer practical support which appears to be limited to offering time off work, arranging secretarial support and a certain level of access to documentation.

The inquiry's processes for seeking and finalising witness statements from corporations and individuals are set out in its protocol on its approach to evidence and written statements which is available on the inquiry's website. In so far as the NHS Tayside written submission

seeks the input of the inquiry on the pro on the approach which it expects NHS Tayside 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 by their employer and their employer's legal representatives in the completion of those statements when the tenor of the 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 Scottish government.

As far as NHS Tayside's request to the inquiry to clarify where whether it should offer practical support 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 issue 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 could not 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 NHS Tayside hard to follow. In particular reconciling the suggestion that NHS Tayside might provide assistance or support with statements or otherwise provide pastoral support but that it does not represent the individuals who worked on its behalf and has signposted and indeed 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 uh who 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 NHS Tayside and its lawyers to corporate employees who are providing corporate statements and not to others. Are they not too 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 over 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 NHS Tayside 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, the Scottish ministers are represented at this hearing by counsel only in their capacity as core participants in the inquiry. I will return to this in the context of my submission about the independent clinical review, but it had been hoped that this hearing

might be used as a means of making progress with the Scottish government in its role as the financial sponsor of the inquiry and indeed of the independent clinical review.
Though that is unlikely to be possible, I'll return to what might be achieved in that 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 with our representatives, 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 the 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 in this regard in early course. Core participants will be kept in informed of progress.
More generally, sir, it should be stressed that it is 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 core participants will have relevant information to provide in relation to matters being examined by the inquiry either to the inquiry directly or indirectly via participation in the independent clinical review. 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 its powers if this proves not to be the case.

The commencement and progress of the inquiry.
By way of update, I will focus today on events since the inquiry's public consultation on its terms of reference which started in October 2024. Though I will also set out broadly what occurred before that time as certain core participants and recognised legal representatives will were not involved in that process or at that time. The inquiry was announced by the then cabinet secretary for NHS recovery health and social care on the 7th of September 2023.
On the 29th of 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 setup, 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 uh in for 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 the 14th of September 2024, you sir

announced the launch of our public consultation process on the inquiry's draft terms of reference so that public concerns and issues could be reflected in the final terms of reference and informed 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 the 7th of October 2024 and online on the 10th of October 2024.

The first event was attended by 134 people; 34 devices were logged in to attend the second event. The texts of the chair and senior counsel's addresses to these meetings were made a made available publicly after the events. Interested parties were asked to make any written submissions they wish to contribute in response to a series of questions about the inquiry's remit. The consultation ran for six weeks until the 24th of 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 his. Two came from legal representatives of groups of former patients and three came from organisations with an in otherwise with an interest in the inquiry's work.

Inquiry Counsel carried out a detailed 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 emerge from the public consultation process and the responses we received. Um, this inquiry has put and continues to put these themes at the heart of its work and planning in so far as the terms of reference and the statutory regime under uh underpinning the inquiry allow. Amongst these themes 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; 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 to provide detailed and helpful suggestions uh 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 the 20th of November 2024, you wrote to the cabinet secretary proposing certain amendments to ensure greater clarity and reach in the inquiry's remit based on based on your 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 process based on proposals which had been made by respondents to the public consultation process including the expansion of term of reference one to include other key positions held by Mr. Eljamel in his professional capacity in Scotland beyond those listed in the draft.
A clarification that term of reference three covered the operation and adequacy of NHS Tayside's clinical governance systems including whistleblowing.
Expansion of term of reference 3 to include whistleblowing uh explicitly and reporting processes related to it and the extent to which any clinical government systems within NHS Tayside were adequately engaged and participated in by those working within that board.
The addition to term of reference six of NHS education for Scotland and its predecessor bodies. The addition in term of reference six of the predecessor bodies of Healthcare Improvement Scotland.
The expansion of the role of the Scottish executive and Scottish government in the investigation by their addition to term of reference six.
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.
Clarity around the statutory limitations of the inquiry to determine any fact determine any fact or make any recommendation uh which was not wholly or partially or primarily concerned with a Scottish matter in terms of section 28 of the 2005 Act.
Clarity around the inquiry's responsibility to analyse and criticise by the insertion into 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 finally expansion of 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 this inquiry's investigation will be NHS Tayside. They are the 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.

You provided an update on developments in the inquiry's work to those who had registered an interest in our work on the 27th of November 2024, informing them amongst other things um of your 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 setup.

You provided a further update on our progress to the same recipients on the 27th of 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, similarly being fixed by the cabinet secretary; progressed 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 setup date of the inquiry was confirmed to be the 3rd of 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 an interest in the inquiry's public consultation exercise were informed of this in advance on the 2nd of April.
The inquiry's website was also launched on the 3rd of 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.
The inquiry has also published a number of pro 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 comp a comprehensive evidence-based report.
On the 3rd of April, the inquiry published a statement on protocols and principles. These principles to which I have referred emerged in part from representations made to the inquiry during its public consultation exercise. The protocols themselves which can be accessed on the inquiry's website currently comprise a core participant protocol, legal expenses protocol, a protocol on the production handling and retention of documents, a protocol on disclosure, publication restriction and anonymity, a protocol on restriction order applications, a protocol on the approach to evidence and written statements, and a public hearings protocol.
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 uh tailor the work of this inquiry to its particular background, its particular remit, its particular stakeholders and its particular ambitions. In particular, they seek to take account of matters raised with the inquiry about its structure and its approach as part of our public engagement with interested parties.
In accordance with the principles of open-mindedness and collaboration, uh 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. The inquiry encourages those with an interest in its work to read these protocols 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 which will be of more relevance to later stages

in the process. This approach is intended to show those with an interest in our work the direction of travel and to seek to promote a cohesive structure to our 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 uh in our work in June 2025 relating amongst other things to the launch of the inquiry's invitation for applications 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 our 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 when one was where one was wanted. When the inquiry was announced, the then Cabinet Secretary said on the 7th of 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 way that an inquiry will not offer”.
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 uh set out what went wrong 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 our fundamental principle of clarity, the inquiry hopes that this 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 core participants 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. 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 the 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 our work. Given the importance of the two processes working together, the terms of reference of each process require each to set out publicly how they intend to work together operationally. This has been done already in a memorandum of understanding which was entered into between the chairs of the two processes dated the 3rd of April of this year.

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. The material which will be made available to the experts in each case will comprise full available hospital records from NHS Tayside, full available GP records, full available private hospital records in appropriate cases and a statement provided to the ICR by the applicant known as the applicant statement. 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 with us by a number of patients, the aspiration is that the contents of the GP records and/or the applicant statement will supplement and at times fill the factual picture. 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 substandard care on Mr. Eljamel's part or on the part of those working under him. As the evidence uh 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 that the material available to the ICR experts is provided in a timely, orderly, informative manner and form and that the ultimate neurosurgical reports are produced in an independent, comprehensive, evidence-based and well-reasoned way.

Thus through the ICR though the ICR's clinical independence is enshrined in the memorandum of understanding, 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 and also the standard form letter of instruction which will be sent to the neurosurgeons. 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 and each neurological report 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 the two processes is streamlined for the mutual benefit of each.

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 ICR where the use of such powers is deemed appropriate. Though the inquiry hopes that applicants to the ICR will consent to any such 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, 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, uh the 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. 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 any patient in such cases to offer the opportunity of making an application to the ICR within a reasonable time frame. If that does not happen, the case will proceed to neurosurgical review.

In any event, 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. 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.

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 material and expert analysis. This will include clinical evidence which emerges from later cases which go through the ICR process which will be available to the inquiry where there is consent or request by the inquiry and which will be factored into its analysis and decision-making at a later stage.

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 inquiries and systemic investigation. Ultimately, reports compiled by the expert neurosurgeons will be made available to the applicant as well as to the inquiry. The ICR will also provide the inquiry with a summary report or reports relating to key clinical themes which have emerged from

the ICR's work. Operational documents have now been agreed as between the two processes with particular regard to the incomplexities and sensitivities relating to data protection in light of the nature of the medical information which will be 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 consent form to sign which will allow information to be passed for 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 statement which will be completed after the inquiry has provided what are hope 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 receive a letter of instruction on a case-by-case basis in a standard form. Entirely understandable concerns have been expressed to this 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 the right to apply to the inquiry for an anonymity before the applicant statement is disclosed to others or published. I will return in due course to the process involved in that regard.

Sir, I have recognised that patients and patient representatives has have expressed significant concerns about the ICR and its process. There is a good deal of misunderstanding about these matters. The submission made on behalf of the patient core participants in writing has set out some of these concerns and more. What I have set what I've set out to do today 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. The ICR is a creation of Scottish government. It chose to put it in place. It continues to require to support the ICR 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 time scales. 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. It needed to be set up from scratch. A process which has been largely left to Professor Wigmore with assistance for the inquiry team. This 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 its 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 the operation of the systems are not matters within the inquiry's control. 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. However, this does not mean that the concerns and misgivings of patients about the process are not genuine or reasonable. They are. I have recognised that they are, and I'm sure Professor Wigmore does so also. As a result of the considerable concerns about the ICR, the legal representatives of the patient core participants helpfully proposed a meeting take place last Friday to discuss and hopefully resolve these concerns in particular uh an apparent impasse relating to aspects of the process within the Scottish government's control and beyond Professor Wigmore's or the inquiry's.

That meeting was attended by both representatives of the inquiry, including myself, and by Professor Wigmore and his team, as both recognised the importance of listening to patient concerns, working cooperatively, we hope in a and we hope in a reassuring and productive manner. It is a matter of regret to the inquiry that the meeting was not attended by representatives of the Scottish government who were invited, holding, as they do, the power to resolve patient concerns and to resolve them quickly.

I understand that my learned friend Miss Thompson is not instructed to speak on behalf of her clients, the Scottish ministers, in their sponsorship capacity this morning, meaning that these matters will also not be resolved today. 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 chair of 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 no staff to assist with the taking of applicant statements in any meaningful sense. Further, there is a clear need in the inquiry's view for advocacy support by patient representatives in providing their statements 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 interest of achieving the progress which so many of their clients told us they reasonably expected. This is particularly pressing. 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 expert reviews. The inquiry has already compiled a list of priority cases which as per the provisions of the memorandum of understanding. 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 time scale 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 the 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 to 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 core participant co cohort and the Scottish government 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 core participant representatives on Friday, Professor Wigmore and I were able to explain aspects of the plan processes which we were told uh were both reassuring to the patients' representatives and as I understood it, clear. The matters raised at paragraph 2C of the written submission provided on behalf of the patient CP group were covered as I understand to their representatives' satisfaction in so far as was possible in the absence of a representative of the Scottish government

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 fulfilment of our 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 deduced formally. That you have determined that such formality would be inconsistent with the inquisitorial nature of the inquiry and likely to involve unnecessary cost.
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.

Section one of the inquiry's investigations is and will be 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 hearing sections to follow including a) general background structures and roles of the various key organisations key people and key policies; b) evidence relating to term of reference one 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 under terms of reference four and five; c) evidence relating to the systems underpinning term of reference 14 relating to document management systems within NHS Tayside; d) the broad ambit and findings of the investigations to be looked at under term of reference 12, and e) independent expert evidence instructed by the inquiry on rules and systems relating to key areas covered by the terms of reference to which I will return.

A fuller provisional scope for section one of the hearings will be released to core participants and published in due course. It should be emphasised that as section one 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 one. It is intended that a fuller exploration of the details issues of controversy which arise from the analysis of the full range of evidence available to the inquiry will be able to be undertaken in later sections of the inquiry's plan. The inquiry will be willing to consider having witnesses return to provide over 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 two 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 two, the inquiry will hear evidence from a selection of patients and if necessary, their representatives relating to 1) the key clinical themes of substandard 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; 2) 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 four and five, campaigning for a public inquiry and the experience of other investigations, term of reference 12, and lack of candour, term of reference 7 and 13; and 3) issues with document management and access under term of reference 14. At paragraph 2A of the written submission provided on behalf of the patient core participant 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 evidence in section two 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 of the accuracy of medical records that being part of the inquiry's remit under term of reference 14 about which they will be able to provide their position as part of the general opportunity to comment, as well as within the ICR applicant statement process.

At paragraph 2D of the written submission provided on behalf of the patient core participant group, it is asked what the inquiry were 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 terms of reference. Any such discovery would be most likely to arise in the context of the ICR neurological review, though the question, I think, arises from the genuine need for there to be consideration of how such news would be broken to a 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 as handled as sensitively as possible and therefore to involve the patients' legal representatives if they have one.

One further point of clarification, the per the inquiry's ability inability to make findings of criminal liability under section 21 of the 2005 Act does not limit its ability under section 22 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 to report suspected criminality to the to the appropriate authorities.

In section two of the hearings, the inquiry will also hear evidence from the independent clinical review about its findings of substandard clinical practice on the part of Mr. Eljamel or those working under his supervision uh from that process uh under terms of reference 15 and 16.

In section three, the inquiry will hear evidence from medically 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 three, 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 from the General Medical Counsel relating to their involvement in relevant matters with a focus on terms of reference 8 11 and 13.

In section four, the inquiry will hear evidence from other organisations which could or should have had a role in the oversight in oversight in the interest of Mr. Eljamel's patients on a wide variety of aspects of the terms of reference with a focus on term of reference six relating to the role of these organisations.

In section five, 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 three, corporate clinical oversight. Terms of reference four and five, complaints, etc. Term of reference six in so far as it relates to the actions of the 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 six.
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 um 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 focusing on a witness-based as opposed to a 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 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…

(inaudible)

It would indeed. Thank you, sir.

(Lord Weir)

Thank you. Thank you everyone. We'll break now for half an hour and resume again at uh 5 to 12.

BREAK

(Lord Weir)

Thank you, Mr. Farthing. Please stand. Yes. Have a seat everybody. Thank you.
Mr. Dawson, when you're ready.

(Jamie Dawson KC)

Thank you, sir. Um, in my submission, sir, I've reached number five, the terms of reference and list of issues. I've already set out the process.

(Lord Weir)

Sorry, I've lost uh in my uh notes what page you're speaking from. Could you perhaps give me that?

(Jamie Dawson KC)
33

(Lord Weir)
33. Okay. Yeah. The terms of reference and list of issues.

(Jamie Dawson KC)
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.
The inquiry has become aware of issues which have been raised relating to the role of the general medical counsel and the health and safety executive in this inquiry. 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 those terms of reference that the role played by those 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 needs to be paid in that regard to paragraph B of the explanatory notes to the terms of reference to which I've already uh made me of which I've already made mention. It is our interpretation that was deemed by the cabinet secretary to be the position that the inquiry could not investigate the roles of these bodies as they fall out with the legislative competence of the Scottish Parliament and are thus beyond the ambit of a Scottish inquiry as defined by sections 277 and 28 of the 2005 Act.
For the sake of clarity, evidence will be sought by the inquiry from the HSE and the GMC which will be considered but only in so far 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 upon to produce evidence relating to the role of NHS Tayside under term of reference 11 relating to the uh the removal voluntarily by Mr. Eljamel of his name from the medical register. It is also worthy of note that the inquiry has the empower 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 six. 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.
So I would like to make mention of term of reference 12. This term of reference requires us to investigate the adequacy and timeliness of previous investigations into issues surround 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 independent clinical review was offered as an alternative.
This term of reference allows a degree of introspection on the purpose and existence of Scottish public inquiries in the broader sense. Though, as I've said, the role and actions of the GMC and HSE are not included in our terms of reference, this term of reference 12 will allow investigation of what consideration was given to what this inquiry would be about, its plan scope, and the potential jurisdictional limitations of a Scottish inquiry to answer legitimate questions which arise. 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 HSE or the GMC, but we can investigate what consideration was given to the limitations relating to the investigation of those bodies when the inquiry was in contemplation and when it was announced.
I would also like to make a point of clarification about our current interpretation of the remit in so far as it applies to private cases. The terms of reference do not require us or enable us to look at cases undertaken by Mr. Eljamel in his private practice or systems which existed to minimise harm for patients treated in private care. 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 terms of reference do however require the inquiry under term of reference three 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. The terms of reference also require under term of reference 2A that we 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 allows it to provide clinical reviews of private cases. Evidence of substandard 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 referred.
During the public consultation on the terms of reference, a number of very helpful suggestions were made by participants, predominantly patients 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 consider a considerable number of these have been incorporated into the inquiry's provisional list of

issues, which was finalised in June 2025. It is a living document setting out in greater detail the matter 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 our commitment 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 in um the list of issue issues to be addressed and in indeed those to be addressed in 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 core participants would additionally wish the inquiry to consider uh as part of the provisional scope of its or 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 already 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 the ICR's neurosurgical experts. 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. For uh I I'll return to the opening statement hearing in due course.

For the sake of clarity, you have indicated that you will be prepared to construe the ref 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 matters beyond a reasonable construction of its terms of reference. However, the inquiry is open to the consideration of proposed issues which core participants 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 eight requests and 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, the Scottish Ministers, NHS Education for Scotland, Health Care Improvement Scotland, Circle Healthcare, the General Medical Counsel, the Health and Safety Executive, Police Scotland, the British Medical Association, the Royal College of Surgeons in of Edinburgh, the Royal College of Surgeons based in London, NHS Lothian, and the BBC.

Before outlining the planning in more detail, it's 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. 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 this morning, sir, will not hesitate to use its powers of compulsion if and as soon as it requires to 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 for section one of the hearings will be served on particular individuals whose evidence is considered to be relevant uh 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 one 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 for particular individuals, the inquiry will issue rule eight requests to them in the usual way. Rule eight requests for a wider range of 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 eight requests are being issued on an iterative basis uh as part of which further requests will be made of recipients focusing on particular issues or topics which arise later in the inquiries process. Further rule eight requests will be issued on a rolling basis to organisations and witnesses as issues come into greater focus. In so far 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 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 side using its statutory powers of 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 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 2F of the written submission provided on behalf of the patient core participant group it is suggested that some patients resident in Fife received aftercare 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 remit. This is a matter on which further discussion with the ICR is likely to be necessary, though the inquiry will be happy to consider what steps it could legitimately take

to assist in that process. Measures which will be routinely be taken to restrict access to certain general types of information are set out in the inquiry's general restriction order. The inquiry intends to apply ciphers over material redacted from recovered documents as per the categories set out in that general restriction order so that recipients of materials know why redactions have been applied and that thought has gone into why information requires to be restricted from publication.

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 consider consideration of their inquiry's obligations to serve warning letters under rule 12 and following of the 2007 rules. In light of these considerations, the inquiry has already made efforts to locate Mr. Eljamel since it was set up and acquired statutory powers to recover and consider evidence. The steps the steps which have been taken to this point have comprised the inquiry comprise 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 Mes Medical Centre, and contacted it by email in April and again in May of this year, seeking information about how to get in contact with them without success or reply. Further information received by the inquiry suggested that Mr. El Jamal may be working in a hospital called Al- Nada Hospital. Further investigation suggested that there was a hospital of that name in Misrata, Libya, which claimed to specialize, amongst other things, in neurosurgery, spine surgery, and chronic pain. A letter was sent to Mr. Eljamel at this address on the 28th of May, 2025, intimating the inquiry's process for applying to be a core participant and seeking details of Mr. for Eljamel's contact information and any legal representation via various tracked methods. No reply has been received. Additionally, an email was sent to the hospital on the 2nd of July to which no response was received either. The inquiry had information available to it which suggested that two major medical defense organisations may have represented Mr. Eljamel in Scotland at some point in the past at least. We have written to both and both have confirmed to the inquiry that they that 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. 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 sizable 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 the 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 material providers will be expected when the rule 8's 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 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 their inquiry. Disclosure to 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 eight 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 progress of rule 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 eight requests have been made. For the purpose of the introductory material which will be elicited and examined in the inquiry section one, 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 one of the hearings. Where it is deemed necessary and in light of the introductory nature of that section, individual rule eight requests for written statements will be issued. As I have mentioned, these rule eights will be prioritised so that progress towards disclosure material can be made to allow core participants to prepare uh for section one of the 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 on the inquiry's website. Shortly after the rule 8 requests for corporate and possibly individual written statements and documents for section one, the inquiry will issue wider documentary rule eights seeking documents more generally relating to the full ambit of the inquiry as appropriate to their involvement in the subject matter of our work.

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 sold. The inquiry anticipates that disclosure of the documents received in response to rule eight requests will be done in an order which is appropriate to the way in which the inquiries hearing sections are structured.

Given that the inquiry will in section two focus on the evidence of patients and the 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 from the ICR, neurological reports and their exhibits, neurosurgical reports and their 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 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 set 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 recognise legal representatives of core participants shortly before disclosure commences. Only those who have provided assigned undertaking to the chair will be permitted access to the material that the inquiry discloses to its 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 as I have already set out and focus on preparing and delivering an opening statement to the choir 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 and connected to section one of the hearings will begin before the end of the year and as soon as possible.

Instruction of expert witnesses.
The inquiry will benefit from the end the evidence of 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 hearings. As per paragraph 2H of the written submission provided on behalf of the patient core participant group, the inquiry will ensure that its experts are truly independent of NHS tide. Professor Wigmore has also taken 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 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 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 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 whether they 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 one. 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 the background to the types of surgery performed by Mr. Eljamel responsibilities of consultant neurosurgeons issues raised about problems with surgery or care relating to terms of reference four and five management of surgical lists workloads under term of reference two and training of junior staff. Medical ethics including the instruction of ex an expert or experts in medical ethics will include the peculiarities of surgery and neurosurgery as regards ethics. Consent issues, duties of candour arising from term of reference 7 and term of reference 13. The pressures of private practice arising from term of reference 2. Obligations relating to research, the training of junior staff and associated obligations, clinical supervision and suspension, duties when things go wrong, and obligations with regard to making and retaining notes and records.
Health administration.
This instruction will include the responsibility of health boards or other health bodies with regard to appointments and induction and training, the management of workloads, clinical governance, the separation between professional and corporate clinical governance, private hospital coordination, requirements relating to complaints and feedback systems, investigative responsibilities, duties of reporting to other bodies and document management and associated obligations. In addition to the important background evidence to be sought by the inquiry in connection with section one, it is anticipated experts will be recontacted for further input as necessary as the inquiry's investigations as the inquiry's investigations progress including but not limited to its considerations of lesson lessons learned and recommendations in section six communication and the inquiry's trauma-informed approach. 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 with an interest in its work via a) contact list which was generated from those who were involved in the inquiry's public consultation exercise and who wish to be kept appraised of the inquiry's process and b) a temporary website which was used until the inquiry's proper website was set up and went live on the 3rd of April this year. 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 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 core participants recognise 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 its most it most efficiently to comply with its commitments to the principles of cooperation, clarity, and listening. As a result of this transitional position, the inquiry has 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 upon which they might come into contact with our work. This is part of the inquiry's commitment to listening to those with an interest in our work as to how they wish it how how they wish it to operate. No such suggestions have as yet been received, though the inquiry remains open to any suggestions in this regard. In order to seek to improve the ways that the inquiry engages with those with an interest in its work, including its core participants, the inquiry intends to launch the following initiatives.

Firstly, 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 staff have been engaged in it based on their experience of trauma-informed work in the charitable and legal 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 who how core participants would like to receive and undertake communication with the inquiry which it is hoped will be a product will be the product of the this preliminary hearing and its associated work. Those details will include plans for engagement with the inquiry stakeholders about the initiatives as a means of seeking to promote collaboration, listening and clarity. In their written submission, counsel for the patient core participants point to the lack of uh 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 supports its patients who wish to participate will form an important 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, nor indeed part of our remit to provide treatment or resolution of these, this does not mean that we will that we will not continue to provide support for those who have difficulty engaging with our process. In part in part that is a part of the function of the patient legal representatives whose involvement in the inquiry is funded by it. However, 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 the 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 such in place such systems 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 as well as 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 recognizing 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 statement or statements or the ICR's neurosurgical reports or is otherwise necessary for the purposes of the inquiry's oral hearings. It will not be published if not relevant to matters falling within the inquiry's terms of reference where material following falling within this category the category of potentially relevant evidence comes to

be considered for disclosure and publication. Individuals to whom medical information will relates will have the opportunity to apply for anonymity. 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. Though open to all, you have indicated that you would be minded to grant such applications in cases of former patients of Mr. Eljamel. In addition, a restriction order otherwise limiting the nature of material which can be disclosed or published can also be 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 2J of the written submission provided on behalf of the patient core participant 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 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 to require to publish 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 our process. Steps will be taken to redact adequate information from documents to protect a person's identity who has been granted anonymity and still allow their evidence to have meaning. It should 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 reasonable 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 are and processes are with regard to the ultimate publication of the material with which the ICR 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 which will operate but each will operate its own system. Both the inquiry and the ICR have a management system which will be accessible only to 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 at this stage of introducing the secretary whom you met this morning, Dan Farthing, who has many years of experience of working for the benefit of vulnerable individuals in the charitable sector. In addition, uh, relatively recently appointed a solicitor the inquiry is Lynn Carey, who has many years of experience of dealing with harmed individuals in their former role as a solicitor in p private practice. They will be central to the role of the inquiry in informing and adhering to its trauma-informed policy, its engagement strategy, and its engagement strategy, consultation about which will begin in early course. They will be primarily responsible for overseeing the system relating to the confidentiality of documents which I have outlined.
Future hearing dates.
The public hearings of the inquiry will be livestreamed. Transcripts of evidential hearings will be published on the inquiry's website. 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 in late November at the inquiry's hearings venue in Edinburgh. The principal purpose of this hearing will be to allow the inquiry's core 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 recognizing recognised legal representatives require sufficient time to be able 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 of this year. This is because the inquiry will require to gauge the wishes of core participants as regards to whether they would 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 like to be necessary and sufficient for this purpose. At paragraph 2A of the written submission provided on behalf of the patient core participant group.
It is suggested that a provisional timetable would be of comfort to the patient group for the evidential hearings. 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 3-week slot from the 9th of February has been allocated to us. Holding hearings in February 2026, we anticipate will allow sufficient time for preparation for them. It is likely that the first set of evidential hearings in section two 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 2A of the written submission provided on behalf of the patient core participant 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 but that it does not require to be for those hearings to proceed. As I have set out, the inquiry has identified a set of 50 priority cases and a timetable for their completion within the ICR process. These cases have already been triaged as being of particular clinical significance to the inquiry's remit. This this timetabling aims to have these cases completed within the ICR process 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 ICR and so that further patient and ICR evidence can be heard at that time. Information about the conduct of evidential hearings and the broad outline of the process which will be followed in advance of them is set out in the inquiry's public hearings protocol.

I have set out the planning for the opening two sets of hearing sections which will take place on current projections in February and the spring of 2026 and have pointed out that for a period we will require to work around the windows of availability in our shared hearing 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 those future hearing sections. We do however recognise the need for patients and others to have a broad picture of our plans and will keep our core participants 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 hearing space is generally more available for this inquiry's use. This will enable the inquiry to plan hearings with a degree of flexibility. Details of the timing of and arrangements for those hearings will be announced to core participants as soon as possible.

Sir, by way of conclusion, 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 and is certainly not the case in this inquiry. 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 in our work of 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 it adheres to its principles. It has done so in light of the general context of all public inquiries

and the particular context of this one. The general context of which those with an interest in our work should be aware is despite having considerable powers to seek to compel evidence with its requirements in an effort to meet its objectives, a public inquiry is reliant on me in 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 request by the set deadlines and that those deadlines will be met and met fully. Witnesses who are called upon to provide written statements will be expected to do so as requested. Necessary resources require to be allocated or put in place in advance to meet them. The ICR and its and will be expected to make progress with its work as per our timetable uh and as the memorandum of understanding requires it to do. This will include efforts being made by those who sponsor it as well as those who participate in it. The inquiry relies on these part parties to perform its role in the way and within the time they have been required to do it. Although the need to do so may at times be an irritant to some, costly for others, or even at times painful. Parties upon whom the inquiries include not only its core participants, witnesses and material providers, but also the Scottish government, which provide 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 Scottish government performs its supporting role in accordance with the legitimate expectations of our participants and that 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 the delay is intolerable. The delays have been experienced since 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 with our work will be expected to bear in mind the historic nature of this inquiry. The length of time patients, other stakeholders and the general public have waited to get answers to their reasonable questions. These and all organisations and individuals who have deadlines within 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 it has had with meeting its reasonable targets and to identify those who have contributed to any delay. The specific context to which I have referred is one of cons 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 inquiries by which I mean Scottish government sponsored ones. 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 agreement and the public more generally for this inquiry to proceed efficiently though consistently with its 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 design 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 expectation expectations and the inquiries ambitions uh are frustrated by others, we will make every effort and take every step to to seek to put a stop to that. In particular, it is important to recognise that the inquiry has devised systems and processes to allow significant participation by the patient body to whom you have committed, sir, to putting at the centre of your inquiry. The opportunities for participation also apply to other core participants 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 by the measures the inquiry has put in place so far or will put in place to maximize such engagement which are not mandatory in terms of the statutory rules which govern us but which have been adopted by this in 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 and as individuals. You have designated over 150 such individuals in that capacity. Those rules do not require the designation of core participants from a wide range of organisational interests in the inquiry's work. You have designated core participants representing the health board, the government governmental interest in our work as 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. Those rules do not require similar contributions to letters of instruction for individuals providing in 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. As I have said, this inquiry will have such a hearing. Those rules normally require uh those rules normally require funding awards to patients to be made subject to means assessments. This inquiry does not. 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 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 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.
It means the conduct of a comprehensive investigation into all of the issues arising from the terms of reference with access to relevant evidence from all available sources. It involves an investigation which is efficient, balancing the need for speed of progress which our stakeholders demand and reasonable thoroughness in our work. It means actual real participation by our core participants in the setting of our remit and the guidance of our investigation. It involves a process in which stakeholders in our work are actively engaged in a process they can trust. It means conducting ourselves in accordance with our stated principles in a trauma-informed way. It involves assessing and challenging the evidence we receive in a way which is informed, fair and truly independent of the state. 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 upon which they can rely. The findings and recommendation of which report or reports are accepted and implemented by government for the best 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 who are watching online. Thank you, sir. We will now take a break.

(Lord Weir)
Thank you very much indeed. Um Mr. Cherry, I think we're going to hear from you next. 2pm convenient? Thank you everybody. We'll uh stop now for lunch and uh uh if we can aim to resume again at uh 2pm, we'll hear from uh Miss Cherry at that point.

AFTERNOON SESSION

(Lord Weir)

Yes. Have a seat everybody. Good afternoon. Now I'm going to invite Miss Cherry KC to make submissions on behalf of the core participants represented by Levy & McRae. Thank you.

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 66 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 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 fulltime 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