THE ELJAMEL INQUIRY

Opening Statement on behalf of NHS Tayside

Introduction

1. NHS Tayside welcomes this Inquiry which has been established to investigate the professional practice of Mr Eljamel, a consultant neurosurgeon, who was working in NHS Tayside between 1995 and 2014, and the adequacy of governance systems that were in place to protect his NHS patients.

2. NHS Tayside recognises the importance of this Inquiry for many patients of Mr Eljamel and their families. It understands that the Inquiry will be a difficult time for many people. NHS Tayside wishes to extend its sincerest apologies to all patients who have suffered because of the treatment they received from Mr Eljamel.

3. Many patients of Mr Eljamel have experienced injury and distress and have been left with an enduring distrust of healthcare professionals and the NHS. At a time when many patients were faced with frightening diagnoses and had the reasonable belief and trust in NHS Tayside to keep them safe, they were let down. NHS Tayside is very sorry for the events that happened and fully acknowledges that, in many cases, this was exacerbated by the way in which it managed patients' complaints and concerns.

4. NHS Tayside knows that it failed to react appropriately and at an adequate pace when there were concerns raised about Mr Eljamel's clinical practice. Again, in this regard, it let down its patients. NHS Tayside understands that patient trust and confidence has been eroded because of the actions of Mr Eljamel and its own failures to ensure its systems of oversight and supervision of Mr Eljamel were adequate.

5. NHS Tayside regards it as fundamentally important that its patients have confidence in the quality of care and treatment that they receive. It has made many changes in the intervening years since Mr Eljamel worked in NHS Tayside to strengthen clinical and professional governance. Changes have been made to

systems and processes to ensure that NHS Tayside is alerted at an early stage when there are escalating concerns relating to clinical practice. It has also ensured that there are many ways in which people can speak up about any concerns they have, and that when complaints and concerns are raised, they are managed in a consistent and timely way with openness and transparency.

6. All of these changes have been made with the intent of avoiding a similar situation occurring. NHS Tayside recognises that openness and transparency is fundamental in order to rebuild the trust of patients and the wider public.

7. NHS Tayside very much views this Inquiry as an opportunity for an independent assessment of what went wrong and why. It welcomes recommendations from this Inquiry as to further changes which should be made. The Inquiry's conclusions will be of great importance to NHS Tayside as the safety, wellbeing and trust of patients is at the heart of its work. As a learning organisation, it wants to hear from patients and families - those best placed to advise and share their experiences – as to how it can consistently improve and build confidence in the services it delivers.

8. NHS Tayside is fully committed to assisting the Inquiry and will work collaboratively with the Inquiry team. It welcomes the Inquiry's trauma-informed approach and is keen to ensure that this is adhered to. NHS Tayside recognises that its systems and processes are a significant focus of the Inquiry's investigations. It will closely review relevant materials and will listen carefully to the evidence to understand the perspectives of those directly affected, all with an openness and a willingness to get things right for its patients.

9. This opening statement addresses the following areas:

    A. The role of NHS Tayside as a health board
    B. NHS Tayside's Due Diligence Review 2023: findings, recommendations and actions
    C. Support to those directly impacted by the Inquiry
    D. Assistance to the Independent Clinical Review ('ICR')
    E. Data protection breaches
    F. Preliminary comments on the Inquiry's approach

G. Time bar for civil claims by patients of Mr Eljamel

A. The role of NHS Tayside as a health board

10. Tayside Health Board, commonly known as NHS Tayside, is one of fourteen territorial health boards in Scotland and was established in 1974.[1] Health services in Tayside have operated under different legal and governance arrangements from the period 1974 to date. A health board is a public body constituted by the Secretary of State.[2] Each health board is responsible for its respective region. NHS Tayside is responsible for health services in Angus, Dundee City and Perth and Kinross.[3] It provides health services to those in its geographical area and may also do so for patients from other health board areas.[4]

11. NHS Tayside is required under legislation to fulfil certain duties and functions.[5] It plans, commissions and delivers NHS services to its local population. This involves the delivery of frontline NHS services, including primary care, secondary care and tertiary care in hospitals within its geographical area.

12. Like other health boards, NHS Tayside is funded by and reports directly to the Scottish Government. It is accountable to the Scottish Ministers, who in turn are accountable to the Scottish Parliament.

B. NHS Tayside's Due Diligence Review 2023: findings, recommendations and actions

13. Since 2013, multiple internal and external reviews have been undertaken in relation to Mr Eljamel's practice. These identified and addressed systemic issues within

[1] National Health Service (Scotland) Act 1972, as set out in the National Health Service (Constitution of Health Boards) (Scotland) Order 1974 which was repealed by the National Health Service (Variation of Areas of Health Boards) (Scotland) Order 2013 ('the 2013 Order').
[2] Section 2 of the National Health Service (Scotland) Act 1978 (as amended) ('the 1978 Act').
[3] Schedule 1 to the 2013 Order.
[4] Section 2C of the 1978 Act.
[5] As set out in the 1978 Act.

NHS Tayside. The reviews highlighted important points for NHS Tayside to address relating to professional governance, creating a culture for staff and patients to speak up about safety concerns, and the importance of clinical effectiveness.

14. As the Inquiry will consider the reviews undertaken under Term of Reference 12, this opening statement focuses on the most recent review which was the 'NHS Tayside Due Diligence Review of Documentation Held Relating to Professor Eljamel' dated 25 August 2023 ('the Review'). This is mentioned to emphasise NHS Tayside's commitment to learning what had gone wrong and what it has done to try to strengthen its systems and processes.

15. The Review was undertaken following the publication of the Scottish Government's review in 2022[6] and the subsequent meeting and ongoing engagement with two patients involved in that 2022 review. This prompted NHS Tayside's Chief Executive and the Executive Medical Director in 2023 to commission work to try gain a better organisational understanding of NHS Tayside's actions in relation to Mr Eljamel, including its responses to previous external reviews to address unresolved ongoing concerns by former patients.

16. This initial work identified that there was no single, comprehensive archive or document store recording events and decisions relating to Mr Eljamel. An information log was therefore created to record all documentation held by NHS Tayside.

17. Following this, the Executive Medical Director commissioned a due diligence review of all documentation held by NHS Tayside relating to Mr Eljamel. This was intended to produce an accurate account of matters relating to Mr Eljamel from the documentation available to NHS Tayside at that time.

18. The aim of the Review was to provide NHS Tayside with a fresh assessment of the professional, clinical and corporate governance position relating to Mr Eljamel's tenure. This included associated recommendations and actions for NHS Tayside.

[6] 'Review of Unresolved and Outstanding Concerns regarding Professor Eljamel, Former Consultant Neurosurgeon at NHS Tayside', Scottish Government, May 2022.

19. The Review was undertaken by a team led by the Associate Medical Director of Clinical Governance, and considered the following areas:

    1. The appointment process followed for Mr Eljamel.
    2. Organisational systems and processes in place to identify concerns in clinical practice in NHS Tayside up to 2014.
    3. Internal signals in NHS Tayside of concerns in clinical practice.
    4. The effectiveness of NHS Tayside in recognising and reacting to internal signals of concern.
    5. The actions taken by NHS Tayside to learn from external scrutiny.
    6. Current clinical and professional governance arrangements in NHS Tayside.

a. <u>Due Diligence Review Findings</u>

20. The findings of the Review were reported by the Executive Medical Director to NHS Tayside on 31 August 2023. These included conclusions as to past events, and considered the clinical and professional governance arrangements in place in 2023. A non-exhaustive summary of the findings includes:

    - The behaviour of individual doctors
      Mr Eljamel was not open and honest with patients and colleagues. Whilst such behaviours are rare within the medical profession, there is a need to have systems in place to detect and act on these if they occur.
      Since Mr Eljamel practised in Tayside, NHS Tayside has overhauled the governance and alert systems in place for professional governance.

    - Monitoring signals of poor practice or harm
      Whilst there were multiple ways in which signs of poor practice could appear, the way in which some of those signs were joined up was lacking, and feedback from trainees was not always seen by line managers.
      Since Mr Eljamel practised in NHS Tayside, joining up of potential alerts is achieved through an Executive Director-led Safety Oversight Group which responds to emerging potential issues.

- Guidance to ensure consistency in governance processes

  There was variability in the organisational response to signs of poor practice within the system. Some complaints did not lead to formal investigation using governance processes, and there was a variation in response times. Once multiple signs of poor practice were considered together in 2013, decision-making related to Mr Eljamel's practice was delegated too far down the organisation. Restrictions placed on Mr Eljamel's practice in 2013 were not adequate and decision-making was not sufficiently well documented. The level of supervision decided upon was not proportionate to the concerns being raised at the time and once implemented was not monitored effectively. During the period of Mr Eljamel's employment, there was an absence of an advanced process of professional governance from concerns being raised to their being acted upon, and in ensuring clear documentation of decisions made.

  However, there is now a process in place through the establishment of the Responsible Officer Advisory Group ('ROAG').

- Assurance that learning occurred and would be spread

  Reliable documentation of actions arising from recommendations from previous reviews from 2013 to 2022 was not consistently present, and monitoring and assurance routes for those actions were variable.

  However, revised systems have greatly improved the opportunities to connect signs of poor practice and adopt whole system learning from events.

- Communication with patients affected by Mr Eljamel's practice

  The communication with patients throughout the process was of variable quality, fragmented, and generally poor. There had been no central coordination to ensure a truly person-centred approach. Where concerns were raised by patients, the issue was managed through a small subset of the Acute Management Team. There was a lack of visibility within NHS

Tayside, no governance routes to assure and scrutinise, and no indications or reporting of improvement through action plans.

Since the establishment of the Patient Liaison Response Team ('PLRT') in early 2023, patients with long-running concerns have a single point of contact to build improved relationships and understanding of concerns, to achieve a more consistent and person-centred approach.

b. Due Diligence Review Recommendations

21. The Executive Medical Director made nine recommendations arising from the Review - in relation to professional governance, clinical governance, and corporate governance - which were presented to NHS Tayside.

22. NHS Tayside fully accepted the Review's recommendations and developed an Action Plan to address them.

c. Due Diligence Review Action Plan

23. The Action Plan considered the following themes:

- Professional Governance
- Training and Education
- Establishment of the PLRT
- Patient Reported Outcomes/Clinical Effectiveness
- Corporate Governance processes for external to Board reviews

The Action Plan has been reported and monitored through NHS Tayside's Clinical Governance Committee - a public committee - from October 2023 to date.

Two key areas in the 2023 Action Plan related to:

(i) the strengthening of the then-recently established ROAG, and

(ii) the next steps needed to embed the new PLRT ensuring it was resourced adequately.

(i) NHS Tayside's Executive Medical Director is the Responsible Officer ('RO'). The ROAG continues to meet regularly, and at short notice if required, to raise professional governance concerns relating to doctors with the RO. A matrix is used to give a consistent, systematic response regarding the nature of any concern raised, and what action to take to ensure patient safety and to support doctors in difficulty. Decisions made by the ROAG are supported by the NHS Tayside Human Resources team and cascaded through the medical managerial line within the services. The Executive Medical Director as RO then uses this information to take any necessary action to restrict a doctor's practice in the interests of patient safety. This protects against further difficulties and, if necessary, the General Medical Council ('GMC') is informed. The ROAG and professional governance processes are now included in the annual induction for trainee doctors. The consultant handbook includes information on these professional governance arrangements. The ROAG presents an annual report for assurance to the Staff Governance Committee, a standing committee of NHS Tayside.

(ii) The PLRT was established in direct response to recommendations made by the Scottish Government in its 2022 review. Its role is to respond to patient and family enquiries and act as a central point of contact for information. It provides an oversight function to ensure a coordinated, person-centred response to events and incidents involving multiple patients. Members of the PLRT have completed Trauma Risk Management (TRiM) training to support those affected by potentially traumatic medical events. The PLRT is now well established and continues to assist patients and families who have requested support in both the ICR and this Inquiry, helping to ensure communication is clear and support is trauma informed.

24. In actioning the recommendations arising from the Review, NHS Tayside has sought to achieve improvements in patient safety and the quality of patient care. NHS Tayside considers that its systems are now better placed to respond to any future clinical concerns and potential harm to patients from the practices of individual clinicians. The aim is that the positive changes which have been made will reduce the risk of, and prevent, events such as those being considered in this Inquiry arising in future.

25. Whilst the systems and processes now in place are very different to those which existed at the time of Mr Eljamel's employment at Tayside, NHS Tayside recognises that there will always be more to learn. It is keen to learn lessons from this Inquiry, to enable it to do what more it can to ensure the safety of its patients.

C. Support to those directly impacted by the Inquiry

a. Former patients of Mr Eljamel

26. NHS Tayside wishes to offer its support to those who are directly impacted by the Inquiry. On 3 October 2025, the Executive Medical Director of NHS Tayside, Dr James Cotton, sent a letter to the ICR setting out the support options offered to former patients participating in the ICR. Patients are being offered the opportunity of independent, confidential and trauma-informed psychological support and care. Patients participating in the ICR will self-refer to this service via the ICR website. NHS Tayside is making the same offer to all former patients of Mr Eljamel, regardless of their participation in the ICR, and this can be accessed through the PLRT.

b. Current and former employees of NHS Tayside

27. In advance of the Preliminary Hearing on 10 September 2025, Counsel to the Inquiry asked NHS Tayside to confirm its position in relation to the provision of representation and support to its current and former employees in connection to the Inquiry. NHS Tayside's position was set out in written submissions dated 4

September 2025 and have been clarified in its submissions dated 13 November 2025.

28. NHS Tayside wishes to reinforce that it is keen to fully support all of its current and former employees throughout the Inquiry. There is, however, an important distinction between representation and support. NHS Tayside's legal team are not the legal representatives of any individual in this Inquiry. They are instructed by and represent the public body NHS Tayside. This does not mean that NHS Tayside will not provide *support* to current and former employees of NHS Tayside. Its intention has always been to provide as much support to individual employees as is considered acceptable by the Inquiry.

29. Steps have already been taken by NHS Tayside to provide a range of pastoral and practical support to its current and former employees, as set out in its written submissions dated 4 September 2025. In those submissions, NHS Tayside sought guidance from the Inquiry in relation to the nature of legal support which it ought to offer its current and former employees. This guidance was sought because NHS Tayside fully appreciated the distrust felt by some of the former patients of Mr Eljamel towards it. Considering this, the concern was that issue may be taken with NHS Tayside and its legal team being too closely involved in the provision of written and oral evidence by its current or former employees. NHS Tayside does not want to cause any further trauma or distress to the patient group. It is also important that current or former employees of NHS Tayside feel able to provide their best evidence. Those individuals may not feel comfortable with NHS Tayside's legal team being involved in the provision of their evidence to the Inquiry.

30. NHS Tayside also considers that it would not be appropriate for its legal team to have any involvement the preparation of an individual current or former employee's evidence in circumstances where the individual's position diverges from that of NHS Tayside. It is anticipated that a conflict of interest will not likely occur in most cases, but such a situation could nevertheless arise.

31. At the Preliminary Hearing, oral submissions by both Counsel to the Inquiry and Counsel for the patient group indicated that the expectation is for NHS Tayside to provide legal support to individual current and former employees in connection with

the preparation of their evidence. NHS Tayside is grateful for this confirmation and has set out in its submissions dated 13 November 2025 a proposed approach to the provision of legal support for current and former employees in connection with their evidence to the Inquiry. It is hoped that the suggested approach will be acceptable to the Inquiry and to Core Participants.

D. Assistance to the Independent Clinical Review ('ICR')

32. NHS Tayside wishes to offer its assistance and support to the work of the ICR. It has previously provided assistance to the ICR by contacting those patients who had advised NHS Tayside's PLRT that they would like to be engaged with the ICR. This communication was to advise them of the online public engagement session to be held by Professor Wigmore of the ICR on 26 February 2025. NHS Tayside's intention in assisting in this way was simply to allow the ICR to make progress with its important work. The ICR also sought assistance from NHS Tayside to write out to the whole Eljamel patient cohort to advise of its work. As the Inquiry had not yet been formally set up when this assistance was sought, the ICR had no means of compelling NHS Tayside to provide the required information. NHS Tayside was the only organisation with access to the necessary information of patient names and addresses. To help the ICR progress its investigations without unnecessary delay, NHS Tayside therefore wrote out to the Eljamel patient cohort as requested.

E. Data protection breaches

33. Regrettably, there have been some data breach incidents. These have been dealt with by NHS Tayside and reported appropriately to the Information Commissioner's Office ('ICO') which is the regulatory body for data protection. NHS Tayside also sent letters to the individuals affected to inform them of this error relating to their personal data, explaining what had happened, and to offer its sincere apologies. NHS Tayside would like to sincerely apologise again to those affected. It recognises that these incidents may have compounded patients' distress and further eroded confidence in NHS Tayside.

34. Following the data breaches, the Chief Executive commissioned a Learning Review. This sought to evaluate the systems and processes in place in relation to information governance, identify improvements required to data security across NHS Tayside, and make recommendations for organisation-wide learning.

35. The Learning Review has identified areas for improvement relating to organisational data protection awareness and its consistent application in practice, and the requirement to strengthen information governance structures. An Improvement Plan will now be developed and will report for scrutiny and assurance to NHS Tayside's Clinical Governance Committee.

F. Preliminary comments on the Inquiry's approach

36. Counsel to the Inquiry has produced a very detailed and comprehensive List of Issues. NHS Tayside is grateful to have been afforded the opportunity to input into this document. It welcomes the close assessment by the Inquiry of the matters contained within the List of Issues. It considers that all the listed issues are important and merit detailed attention in the Inquiry's investigations.

37. There are a number of comments which NHS Tayside makes, in an attempt to assist the Inquiry at this stage. These are addressed in the following paragraphs within this section.

a. The scope of Mr Eljamel's practice within the NHS in Scotland

38. NHS Tayside supports a broad and thorough investigation by the Inquiry into Mr Eljamel's practice within the NHS in Scotland.

39. Neurosurgery within NHS Tayside was originally established as a purpose-built unit in Dundee Royal Infirmary in 1966. Whilst Ninewells Hospital officially opened in 1974, neurosurgery services remained at Dundee Royal Infirmary until its closure in 1998. Mr Eljamel will, therefore, have worked at Dundee Royal Infirmary for a

period. The Inquiry may therefore wish to investigate Mr Eljamel's practice at Dundee Royal Infirmary.

40. As far as NHS Tayside is aware, Mr Eljamel did not practise in any other health board in Scotland. It is noted that Counsel for the patient group raises the point that some patients of Mr Eljamel were from the NHS Fife area. As NHS Fife does not have its own neurosurgery unit, patients from that health board area may be referred to NHS Tayside for neurosurgery treatment. It is not uncommon for patients from other health boards to receive treatment within NHS Tayside. NHS Tayside considers that any NHS patients treated by Mr Eljamel during his employment with NHS Tayside should come within the scope of the Inquiry.

41. It is noted that if another health board is identified as being of relevance to the Inquiry's investigations, this may require that board to become a core participant in the Inquiry, which could result in some delay to proceedings.

b. Mr Eljamel's involvement in research projects (ToR 2(e))

42. NHS Tayside recognises that Mr Eljamel held concurrently a research position with the University of Dundee alongside his patient practice at NHS Tayside. It is understood that given his academic position, research projects were a component of Mr Eljamel's workload. As such, this area will likely be of interest to the Inquiry. NHS Tayside does not have access to information about Mr Eljamel's research. Accordingly, this area did not form part of NHS Tayside's internal investigations in relation to Mr Eljamel's practice. NHS Tayside therefore welcomes the Inquiry's investigation in this area as part of Term of Reference 2(e).

c. Complaints or concerns regarding Mr Eljamel's practice prior to 2012 (ToRs 4 & 5)

43. NHS Tayside's knowledge regarding any complaints made prior to 2012 is limited. This is because its complaints systems were changed in 2012, and the information contained electronically on its old systems was not retained.

44. Notwithstanding the limited information available to it, NHS Tayside would welcome investigation by the Inquiry into any complaints or concerns raised about Mr Eljamel's practice prior to 2012 in Terms of Reference 4 and 5, some of which will no doubt be informed by the work of the ICR.

d. Previous investigations and reviews relating to Mr Eljamel's practice within NHS Tayside (ToR 12)

45. NHS Tayside recognises that there are some very detailed questions in the List of Issues about how the investigations listed under Term of Reference 12 were conducted and the outcomes.

46. The Due Diligence Review, discussed above, was conducted because of the recognition that previous investigations and reports into Mr Eljamel's practice did not sufficiently address the full range of issues. It is acknowledged by NHS Tayside that there was previously a lack of oversight around the timing and nature of reviews, and the actions taken to address review findings.

47. The focus of the Due Diligence Review was to assess the governance position, with recommendations and actions. The Review looked at the systems in place, and improvements that could be made going forward, rather than individual actions by former employees. NHS Tayside therefore considers that the Inquiry's investigation into previous reviews would benefit from detailed consideration of the rationale behind individual decision-making within NHS Tayside at the relevant time, which was outwith the scope of the Due Diligence Review, as this may give rise to further learning points.

e. Possession of documents relevant to the Inquiry

48. NHS Tayside holds many documents which will likely be of assistance to the Inquiry and is working hard to respond to any requests for evidence it receives from the Inquiry.

49. Given the passage of time, however, some documents have been destroyed in accordance with the contemporaneous NHS Tayside's Health Records Strategy

and Management Policy, its Health Records Operational Guidance & Service Operating Procedures, and Scottish Government guidance. These indicate a minimum number of years in which documents ought to be retained, after which they are eligible for destruction. Some documents were therefore destroyed long before the setting up of this Inquiry.

50. More recently, however, NHS Tayside has discovered that around 40 hard copy theatre logbooks, which would have contained information relating to Mr Eljamel's surgeries during the period 1995-2013, were unfortunately destroyed on around 24 July 2025.

51. NHS Tayside understands that these logbooks may have contained information of potential assistance to the Inquiry's investigations. It also recognises that the destruction occurred following a formal 'Do Not Destroy' Notice, for information that may be of relevance to the work of the Inquiry, issued on behalf of the Chair on 11 October 2024.

52. As soon as the incident became apparent, the matter was escalated immediately within NHS Tayside. An internal investigation has taken place. It has been ascertained that the theatre logbooks were destroyed by members of the department in which they were held. The individuals involved were not aware of the connection between the theatre logbooks and Mr Eljamel. The destruction was carried out in accordance with the NHS and Scottish Government guidance and policies mentioned above. The destroyed theatre logbooks related to surgeries undertaken by Mr Eljamel and other members of staff.

53. Given the importance of this matter, it has been raised at a senior level within NHS Tayside. Renewed instructions have been communicated to staff in relation to identification, logging and retention of documentation relevant to Mr Eljamel, to try to ensure that there is no further destruction of documents in error.

54. NHS Tayside has ascertained that much of the information normally contained within the destroyed logbooks should be contained in patient records, if those still exist. It is hoped that much of the information will still be available to the Inquiry, albeit in a different format.

55. NHS Tayside deeply regrets this error and is committed to ensuring that this does not happen again.

f. Identification of witnesses to the Inquiry

56. NHS Tayside previously provided the Inquiry with a list of individuals it employed in management roles at the relevant time. It is considered that these individuals may be able to assist the Inquiry with the provision of written and/or oral evidence.

57. NHS Tayside does not, however, have witness statements from any individual. Mr Eljamel worked in various wards and clinics for a period of almost twenty years. NHS Tayside is providing to the Inquiry medical records sought by Section 21 notice, which contain information about clinical personnel involved in patient care. This information may be of assistance to the Inquiry's identification of individuals whose evidence may be relevant to its investigations. NHS Tayside offers to further assist the Inquiry as far as it is able to do so.

g. Expert evidence

58. NHS Tayside is grateful to the Inquiry for allowing it the opportunity to review and input into the draft ICR letter of instruction to expert neurosurgeons. It would welcome this same opportunity in respect of any further experts instructed by the Inquiry.

G. Time bar for civil claims by patients of Mr Eljamel

59. Under Section 17 of the Prescription and Limitation (Scotland) Act 1973, a claim for damages for personal injuries must be brought within three years (often described as time bar), unless the court exercises its discretion in terms of Section 19A to allow an action to proceed outwith that timeframe. NHS Tayside is aware of a view, reported in the press, that patients of Mr Eljamel ought to be exempt from the three-year limitation period.

60. In claims for damages for personal injuries by former patients of Mr Eljamel raised outwith the three-year limitation period, NHS Tayside has committed to actively reviewing the facts and circumstances on a case-by-case basis when considering whether to plead that the claim is time barred. NHS Tayside believes this approach accords with the expectation of the Scottish Government, as stated by the First Minister on 2 October 2025 at First Minister's Questions.

Conclusion

61. NHS Tayside remains sincerely sorry for the distress experienced by patients of Mr Eljamel. It is acknowledged that NHS Tayside failed to put in place sufficient measures to safeguard patients once concerns were raised about Mr Eljamel and this placed the safety and wellbeing of patients at risk.

62. NHS Tayside recognises that in many cases it has added to the distress and trauma experienced by patients in the way it has handled ongoing complaints and concerns. It is also sincerely sorry for this.

63. As already noted, the Due Diligence Review in 2023 found that NHS Tayside's communication with Mr Eljamel's former patients was poor. This was not appropriate nor acceptable.

64. NHS Tayside understands that all of these factors have undermined the trust and confidence of patients, families and staff, and has been working hard to rebuild that trust. It has sought to understand and learn lessons from the events surrounding Mr Eljamel. It has taken seriously and acted upon the findings and recommendations arising from internal and external reviews.

65. The clinical and professional governance processes within which NHS Tayside's teams operate today are demonstrably different to those which were in place more than a decade ago. Positive changes have been made to systems and processes within the organisation to seek to safeguard against the possibility of any such incidents arising again in future.

66. Nonetheless, it is recognised that there is always room for further learning and improvement. NHS Tayside is keen to continue to learn lessons for the future. It is hoped that any recommendations arising from this Inquiry will lead to further organisational improvement which will positively impact on the quality of patient care.

67. NHS Tayside wishes all the former patients of Mr Eljamel and their families to know that it is entering this Inquiry with openness and transparency at the forefront of its participation. NHS Tayside will contribute openly to this Inquiry. It will be accountable for the decision-making and actions taken while Mr Eljamel was working in NHS Tayside, and for its handling of complaints and investigations thereafter.

68. As a learning organisation, NHS Tayside is committed to improving services. It wishes to take whatever steps are necessary to ensure that its systems and processes are the best that they can be to provide safe, effective and patient-centred care for the population of Tayside.

Una Doherty KC
Cat MacQueen, Advocate

Counsel for NHS Tayside

19 November 2025