Thursday, 27 November 2025
(10.30 am)
Housekeeping
LORD WEIR: Good morning, please be seated.
To those who were with us before, welcome back, and to those attending or joining for the first time, welcome also to the second of two days set aside for the Inquiry's opening statements hearing.
I propose to go straight to the agenda from which you will have seen that the first item on that agenda involves opening statements being delivered by Mr Dundas on behalf of Healthcare Improvement Scotland and NHS Education for Scotland and I will invite Mr Dundas to come forward and give those statements now.
Opening statement by MR DUNDAS
MR DUNDAS: Thank you, sir.
My name is Shane Dundas and along with Mr Stewart, Ms McCabe and Ms Davidson of the NHS Central Legal Office, I represent two core participants in this Inquiry: NHS Education for Scotland, NES; and Healthcare Improvement Scotland, HIS.
At the outset, both NES and HIS wish to recognise that many of Mr Eljamel's former patients and their families are participating in this Inquiry or are watching these proceedings remotely. They wish to

acknowledge the harm which has been sustained by them either directly or indirectly due to the actions of Mr Eljamel and they wish to express their deepest sympathies to them in respect of that.
NES and HIS further wish to offer their thanks to the Inquiry for being afforded core participant status and express both their willingness to assist the Inquiry in any way that they can and their commitment to taking forward what lessons may emerge from these proceedings which relate to the work undertaken by them.
NES and HIS are conscious that some people listening to this opening statement may not be familiar with the work which they do and it is important to NES and HIS to explain who they are, what they do and how they can assist the Inquiry this going about its task. I will therefore divide my opening statement into five chapters.
First, I will consider the background to NES. Secondly, I will turn to consider NES's participation in this Inquiry. Thirdly, I will consider the background to HIS. I will then turn to consider HIS' participation in this Inquiry and then finally, I will address other matters relating to the Inquiry's work.
I turn first to address NHS Education for Scotland. NES is a special health board that provides education,

training and workforce development for those in NHS and social care sectors in Scotland. It is responsible for facilitate a skilled, capable and well-supported health and social care workforce by developing and delivering educational programmes, leading national projects and utilising technology-enabled learning and digital services.
NES was established in 2002 under the NHS Education for Scotland order. It brought together three existing bodies: the Scottish Council for Postgraduate Medical and Dental Education, the Post-qualification Education Board for Pharmacists and the National Board for Nursing, Midwifery and Health Visiting for Scotland.
These bodies were originally instituted to meet the growing need for structured postgraduate medical, dental and other healthcare education and to ensure that the quality of educational programmes met the regulatory standards imposed by the relevant regulator, so, for example, the GMC. And upon its institution, NES assumed these overarching responsibilities.
So NES focuses on education and training, whereas other health boards, known as "territorial health boards", are responsible for the delivery and management of local health services to the public.

In April 2014 the Scotland Deanery was established which forms part of NES and its responsibility is to manage the education and training of all resident doctors in training in Scotland, ensuring that their training meets the regulatory standards of the GMC and that they progress appropriately through their training pathway.
And prior to the formation of the Scotland Deanery in 2014, medical education and training was managed by four separate regional deaneries across Scotland and NES combined these deaneries into a single national Scotland Deanery in 2014 to oversee all postgraduate medical education and training programmes across the four regions, and the move to merge the four regional deaneries was undertaken to streamline the management of medical education and training across Scotland.
By creating a single unified deanery the aim was to ensure greater consistency in standards, improve efficiency and facilitate better sharing of resources and best practice across Scotland.
In its capacity, NES is therefore responsible for the recruitment of all resident doctors in training in Scotland and the Scotland Deanery works in partnership with territorial health boards, hospitals and GP surgeries to train resident doctors to be the senior

clinicians that Scotland needs to treat its population in the future. And NES ensures that doctors are given the right training opportunities and experiences to equip them to be effective and capable practitioners.

NES also undertakes annual reviews of resident doctors in training to ensure that they're gaining all competencies required by their training programme at an appropriate rate and through appropriate experience. NES is also responsible for making revalidation recommendations to the GMC and managing procedures related to any performance concerns which arise in relation to resident doctors.

And quality management visits are also a key element of the work undertaken by NES. NES's quality management team will visit an institution, so, for example, a GP surgery or a hospital, to assess the quality of the training environment and assess whether it satisfactorily meets the GMC standards for medical education and training.

And these visits assess training environments rather than individual trainees. And the quality of their training is reviewed through surveys, questionnaires and interviews with staff, trainers and trainees to identify strengths and areas for improvement.

And the goal is to promote good practice and enhance

the quality of medical education and training across Scotland. So, in summary, NES is different from other health boards because it is a national health board with statutory functions for providing, coordinating, developing, funding and advising on education, training and workforce development for the NHS rather than the direct delivery of frontline healthcare services.

Finally, looking to the future, the Scottish Government is considering implementing a plan to merge NES with NHS National Services Scotland to create a single organisation which would continue to undertake the responsibilities of NES in conjunction with other statutory functions under a new name: NHS Delivery.

Turning, now, to chapter 2 and NES's participation in the Inquiry. One of the areas of investigation is other bodies which played or could have played a role in the care provided by Mr Eljamel to his former patients. In particular, the roles of the Scottish Council for Postgraduate Medical and Dental Education and NES, relating to the maintenance of standards in the training of doctors and surgeons. This is an area of investigation for the Inquiry which is central to NES and in respect of which NES considers it can contribute considerable knowledge and experience.

The incumbent senior medical team at NES can impart knowledge of the systems currently in place for education and training and how the landscape has developed in recent years.

In addition, previous NES post-holders can provide relevant information relating to the education and training systems in place at the time of Mr Eljamel's practice in order to understand the environment in which he operated, and NES has provided the Inquiry with a list of relevant witnesses separately.

Another area for investigation is the identification of any lessons and implications for the future and the making of recommendations if the Inquiry considers them to be appropriate. And the participation of NES in this Inquiry is not only about explaining historical processes but also about ensuring that the education, supervision and quality systems operated today are safe, connected and responsive.

And as the special health board responsible for the provision of education and training in Scotland, this is an aspect of the Inquiry which NES considers to be of vital importance so as to learn from the past to strengthen Scotland's system of training and governance for the future.

And NES considers that it can assist the Inquiry in

identifying any areas of learning which emerge and recommendations which face the future. For example, one broad area which the Inquiry could consider is how further integration between education and safety systems across NHS Scotland could improve the early detection of and response to clinical risk. And by drawing on the knowledge and experience it possesses, NES can contribute constructively to the Inquiry's objective of fostering a culture of continuous improvement, ensuring that lessons learned are both evidence-based and relevant to the evolving needs of the health service in relation to the training of future doctors.

Turning, now, to considering Healthcare Improvement Scotland. HIS is a health body which was constituted by legislation in 2011. HIS is a unique combination of a range of statutory duties and other functions including quality assurance, improvement, service redesign and strategic planning. It also provides evidence-based advice, guidelines and standards for health and care professionals and resources for NHS boards to conduct community engagement for service change.

HIS is also responsible for the registration and regulation of independent healthcare, which was conducted by the Care Commission until HIS was

established. And HIS' key duties, as set out in legislation, are as follows: a general duty of furthering improvement in the quality of healthcare; a duty to provide information to the public about the availability and quality of services provided under the health service; and when requested by the Scottish Ministers, a duty to provide to the Scottish Ministers advice about any matter relevant to the health service functions of HIS.

And to fulfil its functions, certain statutory duties are conferred upon HIS. For example, powers of access and entry for the purposes of inspection.

HIS works with over 100 partner health and social care organisations taking a quality management systems approach in a range of different ways to strategically redesign and continually improve services. It provides advice and shares knowledge that enables people to get the best out of the services they use and to help services improve, making the best use of resources.

HIS is not a healthcare provider and it is not responsible for the performance management of any NHS or social care body or individual practitioner which does provide care. HIS scrutinies the safety and quality of NHS services in Scotland, but it does not act as regulator. In Scotland, health boards are ultimately

accountable to the Scottish Government Cabinet Secretary for health and social care through well-established and rigorous performance management and escalation processes.

Now, as I have already said, HIS was established as a health body in 2011 and the Inquiry's investigations will consider events prior to then, and for that reason, HIS thought it may be of assistance to make brief comments about two predecessor bodies. In particular, the Clinical Standards Board for Scotland and NHS Quality Improvement Scotland.

The Clinical Standards Board for Scotland was a special health board established in 1999 and its objectives related to quality assurance and accreditation. It had two overarching statutory functions: promoting public confidence that the services provided by the NHS were safe and that they met nationally agreed standards, and demonstrating that the NHS was delivering the highest possible standards of care based on the resources available.

And to do so, the Clinical Standards Board developed a standard setting and purview process in partnership with healthcare professionals and the public. And this process complemented the legal duty of each NHS body to monitor and improve the quality of healthcare which it

provided to individuals, which is a process known as clinical governance.

The Clinical Standards Board for Scotland was dissolved in 2003 and NHS Quality Improvement Scotland was thereafter established. And it was constituted as a special health board with a remit to improve the quality of healthcare in Scotland. NHS Quality Improvement Scotland was tasked with improving the quality of healthcare by delivering on six key functions:

Providing advice and guidance on effective clinical practice; setting clinical and non-clinical standards of care; reviewing and monitoring NHS services; supporting staff in improving services; promoting patient safety; and the implication of clinical governance.

NHS Quality Improvement Scotland was dissolved in 2011 and replaced by HIS. HIS and NHS Quality Improvement Scotland are separate bodies. However, HIS has taken over some of the functions which NHS Quality Improvement Scotland previously delivered.

Turning, now, to consider HIS' participation in this Inquiry. One of the areas of investigation is the role other bodies played or could have played in the care provided by Mr Eljamel to former NHS patients and, in particular, the roles of the Clinical Standards Board

for Scotland, NHS Quality Improvement Scotland and HIS in relation to the maintenance of healthcare standards over the relevant period.

Now, this is a matter central to HIS' participation in this Inquiry because it relates to the statutory duty which it fulfils. And there are several functions of HIS where HIS considers it can contribute considerable knowledge, experience and expertise to assist the Inquiry with its investigation of the matters which fall for consideration.

For example, it provides the expertise and resources to coproduce standards which are developed, informed and shaped by people who commission, deliver and use health and/or social care services, and it uses well-established, robust methodology to underpin standards development.

NHS Scotland has a statutory duty to ensure that the quality of care that it delivers is improved continuously and HIS will undertake inspections against standards or appropriate framework for assuring the quality of service provision. And this is one of the key areas where HIS can assist the Inquiry, because it can provide evidence about how healthcare standards are devised, how they are communicated and how they're ultimately fulfilled.

The conditions in place now can be compared to the conditions in place over the relevant period to understand the environment in which Mr Eljamel was operating.

HIS has also provided a separate list of witnesses to the Inquiry detailing individuals who may be able to speak to the historical processes implemented under predecessor bodies as well as the systems now in place under HIS.

Another core issue for this Inquiry is to identify any lessons and implications for the future arising out of its investigations and the making of recommendations. HIS considers this to be an important part of the Inquiry process and will provide such assistance that it can, based on the evidence heard, as to how matters of clinical governance may be capable of being improved upon in the future.

HIS occupies an important statutory function in maintaining and improving quality and health services and it considers that it is well placed to assist the Inquiry in looking to the future by providing evidence about the underlying purpose and aims of healthcare standards and how these may be best fulfilled.

Finally, turning to chapter 5, NES and HIS consider

that the terms of reference and list of issues are thorough. They have not identified any areas beyond those already identified which they consider should be investigated relative to their involvement in these proceedings. NES and HIS have both received rule 8 requests from the Inquiry and are in the process of responding to them and NES and HIS have undertaken a considerable amount of work in that regard.

They understand the importance of producing statements which are comprehensive, clear and which will be of assistance to the Inquiry. With a view to producing those, both NES and HIS anticipate seeking a short extension from the Inquiry to allow them to complete the work which has already been undertaken, ingather the relevant documentation which they hold and thereafter, respond in full to the rule 8 requests in such a way that will assist the Inquiry in effectively fulfilling its terms of reference.

Finally, sir, turning to the trauma-informed approach. NES and HIS recognise that the subject matter of this Inquiry is likely to be traumatic for those who have been directly and indirectly affected by Mr Eljamel's actions and the Inquiry has indicated that it intends to adopt a trauma-informed approach to the matters that it will examine and that is an approach

which NES and HIS not only support but one which they are committed to participating in.

And due to the nature of the work undertaken by them, NES and HIS are both familiar with the principles upon which a trauma-informed approach operates. The National Trauma Transformation Programme is funded by the Scottish Government and delivered in partnership with NES and other bodies. So NES plays a key role in the development of a wide range of learning resources, guidance and implication support for all sectors of the workforce to up-skill staff to the appropriate level of trauma-informed and responsive practice and, critically, to embed and sustain this model of working.

NES can bring this knowledge and experience to the Inquiry.

HIS also recognises the prevalence and impact of trauma and is familiar with the principles which underpin a trauma-informed approach, prioritising safety, trustworthiness, choice, collaboration and empowerment through its work.

In line with the Scottish trauma-informed practice framework, all members of staff at HIS must complete, as a minimum, foundation level mandatory trauma-informed practice training on induction and they must refresh and renew that training every two years, and it is designed

to increase the understanding of what psychological trauma is, how it can affect individuals and how people can be supported to recover.

HIS can bring this knowledge and approach to the Inquiry with the aim and intention of creating physically and emotionally safe environments and actively involving people with lived experience. And this approach demonstrates sensitivity to the risk of re-traumatisation, reflecting HIS' commitment to a trauma-informed culture that values dignity, respect and recovery, ensuring that engagement with the Inquiry is not only procedurally fair but also psychologically safe and inclusive.

Both NES and HIS are carefully considering the trauma-informed approach proposed by the Inquiry. Whilst they have no specific comments to make at present beyond an indication of general support for that which has been proposed, they wish to emphasise that such assistance as is provided by them to this Inquiry will be done so through this important lens.

NES and HIS look forward to working with and assisting the Inquiry in fulfilling its terms of reference. They will share any relevant knowledge and experience they have in relation to the Inquiry's areas of investigation and they conclude by renewing their

commitment to supporting the Inquiry with its work.
Thank you, sir.
LORD WEIR: Thank you very much indeed.
It may be that although the agenda makes for a break at this time, we can perhaps proceed directly to the next item on the agenda in which I'm going to invite Mr McGillivray to address the hearing on behalf of the Independent Clinical Review.
Mr McGillivray.
Oral submission by MR MCGILLIVRAY
MR MCGILLIVRAY: Thank you, sir, and good morning. My name is Ewan McGillivray and I'm appearing for Professor Wigmore, who is the Chair of the ICR, the Independent Clinical Review. Professor Wigmore is grateful for this further opportunity to address the Inquiry and provide an update.
I would, sir, adopt the written submissions which were lodged on Monday of this week, subject to some change to the figures which I will come on to very shortly.
There are three brief chapters to my submissions this morning. First of all, registrations with the ICR. Secondly, support for patients and, thirdly, future procedure.
So, first of all, regarding the figures about

registrations and consent forms, the position, as at close of business on Tuesday of this week, is that there have been 474 registrations. This has led to 354 consent forms being completed and of those 354 consent forms, all of them except for three have authorised the sharing of the information with this Inquiry.
The ICR is very grateful to all those who have participated so far. The ICR is still receiving registrations, although in the past month or so the volume has decreased, no more than a handful each week.
The closing date for ICR registrations is 1 December this year and that date was made public on 27 October this year. However, in the event there are any extenuating or unforeseen circumstances which lead to a delay in registration taking place until after 1 December, sympathetic consideration will, of course, be given to enable such late registrations to be received and a review to be given there as well.
I turn, now, to the second of my three chapters: support for patients. Professor Wigmore is pleased to note the assurances given by the Cabinet Secretary in the recent letter to you, sir, which senior counsel to the Inquiry spoke about yesterday.
Professor Wigmore shares Mr Dawson's view that next

week the applicant statements might be sent out to the first 50 patients or their representatives which have been identified by the Inquiry as being an immediate priority.
Other than completing the work on the data sharing agreement and the data protection impact assessment between the ICR and the Inquiry which Mr Dawson referred to, there is one small hurdle to be overcome on the ICR side before those applicant statements can be sent out.
The ICR awaits feedback from a small group of patients whom it's asked to check over the terms of the questionnaire to be completed by participants in the ICR who are seeking support from the Association of Clinical Psychologists.
I would submit, sir, that seeking this feedback from patients is consistent with the trauma-informed approach which the ICR's own terms of reference mandates.
The closing date for this feedback is tomorrow. Once it has been received and due consideration has been given to it, the final versions of the questionnaire will then be posted on the website and those applicant statements can be sent out.
I will turn now briefly, sir, to further procedure. I would start by saying that Professor Wigmore shares the frustration at the destruction of the surgical log

books which were discussed yesterday. He does regard this as quite a loss.
I turn, now, to the instruction of the neurosurgeons who will be assisting the ICR. This week Professor Wigmore will be writing to 450 consultant neurosurgeons who have been identified by the Society of British Neurological Surgeons as suitable experts for ICR purposes, so it will contain information and a request that they consider preparing a report and becoming involved in the ICR.
I would take this opportunity, now, to add that Professor Wigmore has been grateful for the support provided by the Inquiry's legal team in finalising the terms of the letter of instructions to be sent to the neurosurgeons and indeed also for the help in finalising the terms of the applicant statements. The terms of both those documents were agreed on 28 October.
Sir, I think it was NHS Tayside who raised the question of core participants being advised of the identity of the neurosurgeons who are helping the ICR. Professor Wigmore's instinct is to publish the identity of all those neurosurgeons on the ICR's website in the interests of transparency.
However, the position about that will be confirmed once the neurosurgeons have been identified and they

have been given notice of this matter.
I conclude, sir, by reiterating that Professor Wigmore and the ICR staff will continue to seek to assist the Inquiry in any way it can and they all look forward to continuing to work with you and your team.
So, sir, those conclude today's submissions, unless, of course, you have any questions about these matters and I will be happy to do my best to address them.
LORD WEIR: Thank you very much.
Ladies and gentlemen, the next stage in today's proceedings involves a response from counsel to the Inquiry to various statements that have already been made and which you have heard. And against the possibility that he may wish to respond to any matters that have been raised this morning, it might be a convenient moment for to us take the promised break at this time and let's aim to start again in half an hour's time. Thank you.
(11.11 am)
(A short break)
(11.41 am)
LORD WEIR: Thank you, please be seated.
The final item of the agenda requires me to invite Mr Dawson to address the hearing in response to the

submissions and statements that have been made.
Mr Dawson.
Response statement by MR DAWSON
MR DAWSON: Thank you very much, sir. The Inquiry team is very grateful to our colleagues who have made oral opening statements at the hearing and to those who have provided written opening statements and submissions on the counsel to the Inquiry note.
We are also very grateful to the clients who have clearly taken the time to provide detailed instruction to enable these statements to be made. The contributions have been very valuable. Your efforts and those of the clients whom you represent are greatly appreciated.
In the outline for these hearings set out some months ago, in the Inquiry's public hearings protocol, we said that we wished to have a separate hearing slot at this point in our procedural planning so as to allow our core participants to make active contributions to our work, both on matters of substance and process, consistent with the Inquiry's principles of collaboration and listening.
The detail of much of what has been said and written is undoubtedly valuable and informative and the Inquiry will require to take time to reflect on how aspects of

what has been said can and ought to be incorporated into our planning as we move further into the evidential phase of our work.
We will certainly do so carefully as we have undertaken that we will. For the avoidance of doubt, aspects of what colleagues have mentioned in their statements may give rise to us considering a further update on to the list of issues which the Inquiry is willing to entertain and will review.
It has also been beneficial to be able to use the public nature of these important hearings as a means of ventilating, in public, certain areas of concern. In some areas, this has allowed progress to be achieved which is a positive development.
At this stage, there are a number of areas on which I feel I can usefully make further submissions to you, sir, as follows: first of all, aspects of the terms of reference. Secondly, NHS Tayside log books. Thirdly, documentary production times. Four, the NHS Tayside admissions. Five, matters relating to civil litigation. Six, procedural planning. Seven, Inquiry experts. Eight, the search for Mr Eljamel, before closing.
I turn, then, to aspects of the terms of reference. I think it is important to reiterate at this stage that the terms of reference of an Inquiry are an important

document. They define not only what the Inquiry has to look at, but what it is empowered to look at. The Inquiry's powers of investigation and compulsion, the Chair's right to hold hearings and spend public money, are all only permitted if they relate to matters covered by the terms of reference.
We are not only required to look at things that are reasonably deemed to be covered in them, we are not allowed to look any further. It would be wrong for to us give the impression that there are matters which individuals want us to look at into which we do not think are reasonably covered by the terms of reference which define our duty to investigate and our right to do so in this way.
Even inadvertently to create a misleading impression in that regard would not be consistent with our principles of clarity and openness. It would certainly not be trauma-informed. It is in that spirit and with those principles in mind that I feel I must make some observations about the Inquiry's terms of reference and the remit which they create for us.
In that context, I observe that it is a consistent, though not universal, feature of the patient group's opening statement insofar as it related to the terms of reference that it seeks to assert that matters should be

included within the Inquiry's investigation which would be necessary so that the Inquiry represents an investigation of, to quote "the full extent of Mr Eljamel's actions."

That aspiration, however valid in general terms, is not, I'm afraid, the touchstone by which our remit and your powers, sir, must be determined; the terms of reference are.

This is why I said at the public consultation event in October 2024 that it is important that the terms of reference are clear. I said that we and those who are listening at the time needed to know what we are looking at and what we are not.

I said that this would allow the work of the Inquiry to proceed with a clear purpose and its work to be focused on achieving it, as well as allowing all those who participate to know what we are here to achieve. A major part of the preliminary hearing was devoted to providing an explanation of what we interpreted the final terms of reference to mean, what was included but also what was not.

The patient group states at paragraph 3 of its written opening statement that the voice of the patients must be heard. That is absolutely accepted. Means by which those voices can and will be heard are to be found

throughout the planning for this Inquiry. What cannot be said, however, is that the undeniable requirement that the voices of patients be heard and that the Inquiry should serve as a form of learning, and hopefully of catharsis, can be accepted by the Inquiry as a means of defining its remit when that is the function of the terms of reference.

To do so would, as a matter of law, constitute a violation of the Inquiry's legal powers and limitations. What the Inquiry is and will remain committed to is allowing the patient voice to be put at the centre of the Inquiry in relation to the matters which are within its remit.

As you, sir, have consistently said in your public statements about the Inquiry, we have an already wide remit and a consequently considerable task ahead of us. The breadth of that task was informed by opportunities afforded to patients and others to help to fix our remit in our public consultation exercise. We will set about that task with tenacity and enthusiasm for what we are empowered to investigate. We will do so in the hope that patients will join us in that endeavour, focused on what we are empowered to do, as opposed to what we are not.

We have every faith that they will do so based in no

small part on their thoughtful, evidence-based and ultimately very helpful contributions to date. The patient opening statement consistently identifies the importance of listening to patients and patient evidence in the Inquiry's work. We agree. This is part of the reason why, as I explained yesterday, the timetable for the Inquiry has been postponed, resulting from delays in the ICR, to seek to ensure that all manifestations of that evidence called for is gathered sensitively and carefully.

The result of this important context is that there are aspects of the patient submissions about our approach which we accept and others we feel we are unable to. It is apt to recognise in this regard aspects of the patients' approach and their interpretation of the remit as set out in the patient group's written submission with which we agree.

It is acknowledged and appreciated that despite inevitable hesitation about doing so, the patient group has been encouraged to engage with the ICR, as the statement points out at paragraph 31. We are required by our terms of reference to seek to assist the ICR to thrive. We have consistently done so.

For this aim to be achieved requires a considerable leap of faith on the part of the patients. We

appreciate this commitment to that process which, I am sure, Professor Wigmore does also.

It is recognised, as is set out in the statement at paragraph 5, that the Inquiry is about not only the failure which led to alleged harms in the first place but also the compounding features of what is characterised in the submission as how those with power displayed a dismissive and condescending attitude while avoiding responsibility for failures that prolonged the suffering.

Terms of reference 4 and 5, complaints and response; 8 to 11, supervision, suspension, resignation, removal of Mr Eljamel's name from the GMC register; term of reference 12, investigations; 13, institutional candour; and 14, document management systems, all have elements which post-date the alleged original harm for many.

The ability of failures in this regard to pile harm on harm is not underestimated by the Inquiry, though the Inquiry is also about things that may have gone wrong at the time of the original treatment which, if done differently, may have prevented harm, for at least some, ever occurring at all in any form.

We note with interest that patients have campaigned from 2014 for a Public Inquiry -- patient group opening statement at paragraph 6 -- a matter which will receive

attention under term of reference 12. Those who were involved in that campaign will be called upon to provide evidence to the Inquiry about their experiences of it.

It is also important to note, not for the first time, the commitment of harmed patients to assisting with the Inquiry's forward-facing function. That commitment cannot be doubted and it is, and it will be, consistently relied upon. The patients say that the harm caused by Mr Eljamel affecting the wider NHS cannot be overstated, at paragraph 21.

They express a desire that the Inquiry seek accountability to ensure that organisations charged with responsibility can be deemed fit for purpose as well as individuals within them, at paragraphs 12 and 14. They do so so that recommendations can be made to avoid similar issues occurring in the future, as they say at paragraph 14.

We, too, commit ourselves to that forward facing endeavour.

One area, however, where I fear there may be a divergence in our interpretation of our remit is in the area of the consequences of the patients' treatment and experience. Though not formally part of the terms of reference, it is important to note, in my view, that the Cabinet Secretary has seen fit to recognise in the

explanatory notes at paragraph (d) to the terms of reference his rightful aspiration, which we share, that the Inquiry will provide an opportunity for public acknowledgement of the suffering of former patients of Mr Eljamel and a forum for public consideration of evidence of their experiences. We know that damage has been done.

Aspects of the extent of the harm amongst the group and in individual cases is helpfully set out in the patient group's written submission. We intend to conduct ourselves in a way that will recognise and be respectful of that fact.

In my submission, that is not the same as saying that the Inquiry requires to undertake a detailed investigation into the consequences for patients of their experiences. Whilst the terms of reference make clear and make reference to aspects of outcome, these are framed in general terms, such as the reference to how certain factors contributed to adverse outcomes in terms of reference 2.

Risks to patient safety, quality of care or experience are referred to in equally general terms in term of reference 5, which relates to the implementation of the outcomes of complaints or feedback processes. In our current interpretation, this means that we need to

understand the broad outcomes for patients in order to be able to adjudicate on the extent of sub-standard care which is at the root of our systemic investigation.

To provide an example, we heard from Ms Cherry yesterday about some of the consequences suffered by patients as a result of their allegedly sub-standard treatment. These were truly harrowing accounts which we are already aware sit amongst many more such patient experiences. We are grateful to her and to the patients involved for allowing these experiences to be shared in this public forum.

She told us that one patient tragically contracted meningitis. The contraction of meningitis is a relevant general physical consequence which helps us identity the nature of possible sub-standard treatment which perhaps ought to have been prevented such that the outcome could have been prevented from occurring.

We also require to look at how that might have been. If more care had been taken, that adverse outcome -- to use the language of the terms of reference -- might have been avoided. We require to investigate whether, if more care had been taken in overseeing infection or other control, or other aspects of patient care, if these consequences could have been avoided by reasonable steps being taken.

That is, in my submission, not the same as saying that the Inquiry requires to undertake a detailed examination of the consequences or loss for individual patients as one would do in a civil litigation.

In my submission, no term of reference requires us to do so.

Equally, it should be noted that the terms of reference of the ICR are limited in this regard though not equally so, in practice. Those terms of reference require that process to provide a view on physical outcomes and to signpost patients to future care, providing, in its term of reference 7, that the ICR will, where possible, analyse what physical damage was caused to the patient and whether that physical damage resulted from the treatment or lack of treatment by Mr Eljamel or medical colleagues under his supervision, on the balance of probabilities.

And analyse the adequacy of follow-up care received by patients beyond the care provided by Mr Eljamel or medical colleagues under his supervision and provide signposting of patients to future care if possible.

It should be added that the neurosurgeons will be asked in their letter of instruction to provide an analysis in their reports of the key sequelae, or consequences, for the patient and of those caused by the

surgery or sub-standard care which they have identified.

The applicant statement request, which will be sent to those who apply to the ICR, will ask and enable patients to provide details of both physical and mental health consequences of the treatment of the care they received.

The ICR does not require to undertake a detailed analysis of the consequences, however. The ICR reviewers will analyse, in broad terms, the physical consequences, the mental consequences and provide a broad outline of the outcome. This will serve the Inquiry's purposes in this regard as I have defined them.

In any event, it is noted with interest that the patient group's submission identifies a common experience amongst its sizeable patient group, both in terms of treatment provided, which one would imagine would be represented in a number of the applicant statements provided to the ICR and the actions or inaction of NHS Tayside, an allegation which will be the key focus of the Inquiry's work.

As to the former, we note the common experiences identified by the patient group at paragraph 32 of their submission and are pleased to report that in our interpretation all of these are matters on which the ICR

experts will be asked to address their minds in cases where they are relevant considerations. It is that common experience which the Inquiry wishes to capture as a means of fulfilling its systemic remit.

It is undoubtedly worthy of recognition and respect, which the Inquiry has tried to incorporate into the way it will do its work, that many people have suffered both physically and mentally and that lives have been changed, as the patient group says at paragraph 10.

Signposting to means by which these consequences can be addressed is an important part of the remit of the ICR, as I have said. It is also recognised by the Inquiry that trust has been broken and that a thorough and fearless investigation within this Inquiry of the alleged institutional failings has an important part to play in attempting to restore that trust.

I say "attempting" in recognition that for some that may never be possible. Even for those in this position, we hope that our work will go some way to achieving that important aim.

I wish also, sir, to address you in relation to matters raised by Ms Cherry relating to private cases. It must be the logical corollary of the plea to you, sir, to seek to extend the terms of reference to include

the investigation of private systems, a plea to be found at paragraph 22 of the patient group's submission, that it is accepted by the patient group that they are not part of their current ambit. We agree. This is the natural interpretation of the words read in their context. It should also be borne in mind that the inclusion of private systems was a matter which was raised in our public consultation and so was put to the Cabinet Secretary for his consideration in the final terms of reference.

We take it he must logically have considered and rejected their inclusion.

It is our interpretation that these private systems are not included within our remit. 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.

They do, however, require us to look at aspects of private care through that NHS lens, including whether Mr Eljamel's commitments to private practice contributed to adverse outcomes for his NHS patients; term of reference 2(a), and 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; term of reference 3.

The Inquiry was provisionally called "The Eljamel and NHS Tayside Inquiry". Though that name was removed to make clear that the role of other bodies were included, as we have discussed, it is our current interpretation that the terms of reference require to us focus on the NHS and care received there.

It is, I should add, sir, in theory possible for the sponsoring minister to be asked to change the terms of reference if the public interest required it. However, as I said at the consultation event in October last year, if possible, this is best avoided as changes to the terms of what we are here to investigate will interrupt the efficiency of the Inquiry and inevitably result in delay.

In my submission, though it is a matter for you, it is not your role, sir, to seek to make representations to the Cabinet Secretary about an extension of the terms of reference when that course is open to other parties and your understanding of the terms of reference is that they are limited due to the focus which you have been asked to have on public health services.

Though a matter for you, sir, it is not as I understand it your current intention to do so.

This does not mean, however, that there are no aspects of the private sector which fall to be

considered. It does mean, however, that private practice and the systems within it will not and cannot feature in the Inquiry's findings or recommendations. Aspects of the private sphere which we will examine must necessarily be ancillary to our stated remit, though those ancillary investigations may well shed light in areas related to the private sphere.

As was your stated intent throughout this process, sir, we have taken a broad interpretation of the terms of reference where matters relating to private care have been included. Therefore, as regards the patient group's submission in this regard we agree that the Inquiry can competently investigate Mr Eljamel's practising privileges at Fernbrae Hospital as falling within both term of reference 2, relating to his commitments to private practice, and term of reference 3, relating to the interrogation by NHS Tayside of issues in the private sphere.

This is why this matter was included in the updated list of issues which is, again, suggested at paragraph 20 in the patient group opening statement.

We also accept the suggestion, made at paragraph 17 of the patient group statement, that it is within our remit to look at the extent to which private cases featured in decision-making around holding a Public

Inquiry under term of reference 12, as well as the possibility of a joint Inquiry which could look beyond issues that are primarily related to Scottish matters.

It should also be borne in mind that as the Independent Clinical Review will cover private cases as well as NHS ones, individuals will be entitled to have their own cases in private care reviewed and assessed by an independent neurosurgeon. This is, I continue to assert, a generous offer by the Scottish Government which has little, if any, precedent. The results of those reviews will be part of the Inquiry's evidence as well, to inform what was going on and possibly going on wrong in the private sphere broadly, to inform our limited investigations relating to private care, as I have set out under terms of reference 2 and 3.

To that extent, those who are treated in private care and who go through the ICR process will also have an impact on the Inquiry's work. As I have said, private cases do appear amongst those in our top 50 priority cases which will be sent to the ICR first.

A section 1 rule 8 request relating to matters falling within our remit has been sent to Circle Healthcare, the body we understand to have responsibility for treatment at Fernbrae Hospital.

At present, we are minded also to include in the

investigation the following matters raised in the patient group opening statement, though we keep an open mind as to the extent to which these factors require to be investigated pending further evidence. First of all, eagerness to refer patients to private care possibly for unnecessary surgeries. We think that this forms part of the consideration of Mr Eljamel's private practice under term of reference 2 and may form part of the matters which clinical governance systems ought to have picked up under term of reference 3, or involve lack of candour by Mr Eljamel under term of reference 7.

Patients who should have received earlier treatment in the NHS due to the gravity of their conditions will also be considered. We consider this to form a part of sub-standard practice which could be addressed by the ICR experts and should be raised by patients in their applicant statements if they wish to do so and which could have been picked up by clinical governance systems under term of reference 3. They may also possibly involve lack of candour under term of reference 7.

Sir, I would also like to say something to you about representations that have been made about NHS Fife. The patient body suggests, at paragraphs 6 and 5 of their written submission, that the role of NHS Fife could be explored under term of reference 6, with reference to

the consistent re-referral of patients to Mr Eljamel from within the NHS Fife area, which meant that they ought to have been aware of poor outcomes within their patient group which could have been acted upon. They call upon the Inquiry to issue a section 1 rule 8 to NHS Fife.

It appears to be the case from the NHS Tayside written opening statement that this may not quite be accurate. This seems to suggest that this was a referral route available to those doctors within NHS Fife, as the NHS Tayside neurosurgical service covered Fife as well which had no such service of its own. Referral would, therefore, be made from NHS Fife doctors to Tayside for this sort of care.

In such a case, the patient would have been treated within NHS Tayside and the case could potentially be considered, if of significance to the Inquiry's remit, no matter where the patient resided. The Scottish Government submits that NHS Fife is not covered by the terms of reference as it is not named in them. Ms Thomson hypothesised, perhaps with some basis, that if the suggestion was that the importation of work from the Fife area created workload issues within Tayside that affected patient outcomes, that that, too, could be covered under our term of reference 2(c). Our view is

that that possibility would indeed be covered if evidence emerged of it.

However, our interpretation of the possibility that NHS Fife should be included as a body under term of reference 6 as one which could have done something about the emerging evidence relating to Mr Eljamel's practice, is one which we will require to give further thought to. At present, our view is that the investigations which are being proposed would involve looking at what individual doctors working within NHS Fife could have done, as opposed to the body itself.

Such individuals within NHS Tayside are covered under term of reference 3. It seems to us likely that undertaking investigations to cover such individuals within NHS Fife would be casting the net too wide.

This would logically also exclude the inclusion of NHS Fife in the section 1 ambit in any event based on the approach the Inquiry has taken to that section, seeking information about key bodies and their role in matters pertaining to the practice of Mr Eljamel within the NHS Tayside system.

This does not mean, I should say, that individual doctors from the NHS Fife area may not have relevant evidence to bring to the Inquiry about what they knew and when. If they do so, the Inquiry wants to hear from

them. They can apply for anonymity which will be granted if you, sir, deem it appropriate. The evidence of medics like them will be addressed in section 3. If anyone knows who these doctors may be, their names will be welcomed by the Inquiry. Any such potential witnesses listening now or later could choose to engage with us via the legal team or our engagement strategy, which is designed, in part, to attract and liaise with these types of witnesses.

Those and any other medics, nurses or other hospital or medical staff who have relevant evidence to give are urged to get in touch with us as soon as possible.

Hospitals. We note that it is suggested by the patient group that the remit of the Inquiry should extend to Dundee Royal Infirmary and to Perth Royal Infirmary, though Ms Cherry, I think, added the word "possibly" to the involvement of the latter when she spoke yesterday.

We note that NHS Tayside has helpfully also explained that the former, Dundee Royal Infirmary, will need to be included as Mr Eljamel will have worked there; it is accepted that it must be. NHS Tayside will be pursued to explain in the first instance where records are held relating to the neurosurgical services provided at that hospital.

As to the latter, Perth Royal Infirmary, we would appreciate some further information from the patient group as to why they say that work occurred there which should be included within the Inquiry's terms of reference and remit, noting that, at paragraph 10 of their written opening statement, NHS Tayside makes clear that Perth and Kinross is covered within the geographical area covered by NHS Tayside's statutory remit. It therefore remains feasible that Mr Eljamel did work at Perth Royal Infirmary, though as the NHS Tayside statement also provides no suggestion that a neurosurgical service was offered from there, it remains unclear as to what Mr Eljamel could have done there. We will willingly listen to any further explanation that can be provided.

Medical records. Concerns were rightly expressed by Ms Cherry on behalf of her clients about the accuracy and completeness of NHS Tayside medical records. A large range of detailed issues about medical records are now contained in the list of issues, drawing in large part from the particular issues raised by the patient group and which I outlined yesterday.

These issues can be assessed by the Inquiry on their review of the records, which, as I have said, is already underway.

In addition, such issues, of which patients are clearly already aware, can be ventilated insofar as possible and necessary at public hearings. In the applicant statement request for the ICR, patients will be able to raise issues they have with the care they received in a residual question where any such issues with records can be highlighted.

The ICR experts who will, of course, have the records are specifically asked to address the question of the accuracy or comprehensiveness of the hospital records including any discrepancies between those hospital records and the primary care records to which they will also have access.

They are also asked to provide a view on whether they were prevented in their important work in providing a view on any matters they were asked to cover by any issues with the materials which might also encompass missing medical records.

The Inquiry will provide a broad assessment of these issues in its report under term of reference 14. Expectations as regards the management of hospital records will be part of the matters put to the Inquiry's experts in a general sense. This should hopefully provide a benchmark against which any alleged deficiencies can be evaluated.

It is hoped that these systems provide some reassurance that the Inquiry's investigative mechanisms will enable it to reach a clear position on the various issues relating to medical records which have been raised and which have, quite reasonably, been of considerable concern to the patient group.

As regards other matters which were raised, Ms Cherry stated that her clients would like to see the memorandum of understanding which existed between Healthcare Improvement Scotland and the Health and Safety Executive. The nature of the relationship between these two bodies and any such documentation, which may include such an MOU, has been investigated as part of the rule 8 request for section 1 sent to both organisations.

It would be useful to have more information from the patient group about the underlying medical conditions which they claim were ignored by Mr Eljamel, as referred to at paragraph 32 of the patient group opening statement, to ensure, as I think it is, that this is indeed part of the remit of the instruction going to the experts in the ICR.

Sir, I turn, now, to the subject of the NHS Tayside log books. It is indeed troubling that NHS Tayside has admitted to potentially important theatre log books

relating to Mr Eljamel's practice having been destroyed. I do not go as far as Ms Cherry did when she described these revelations as "beggaring belief". The Inquiry requires to take a more objective approach.

What I would observe is that the written opening statement by NHS Tayside is replete with statements to the effect that it is a learning organisation which wishes to rebuild of trust of patients both in this group and more widely and that at times committed to doing so, in particular in light of admitted data protection breaches which, it has rightly admitted, have further undermined patient trust.

This is a most unfortunate event to have occurred in that context. Equally, for the Inquiry's evidential purposes, we will expect that the measures which NHS Tayside have said they will put in place to prevent any recurrence are more robust from now on.

The Chair has asked me to make clear that these events will be the subject of careful further scrutiny by the Inquiry. Such logs had been asked for as part of the disclosure expected to come along with the section 1 rule 8 request. In that request, as in all such requests, NHS Tayside have been asked generally to provide an explanation of what documents they have produced, including addressing the question of what

documents they know they held in the past but do not hold now.

In such cases, they are asked to explain how the documents they once held came not to be available in response to the request. Thus, it will be necessary for NHS Tayside, as part of its corporate statement in response to the section 1 request, to provide such an explanation.

Though NHS Tayside's candour in bringing this event to the Inquiry's attention should be commended, I should say that the explanation provided in the materials presented to the Inquiry will not suffice. More will be expected. If the corporate position is not sufficient, further explanation will be sought from individuals responsible.

At paragraph 52 of their opening written statement, NHS Tayside says that the individuals involved were not aware of the connection between the theatre log books and Mr Eljamel. Blaming the individuals will simply not do when those individuals were acting in the course of their employment with the board. The board has a responsibility to ensure that the obligations placed on it by the Inquiry are adhered to in its work.

The matter can be ventilated publicly and questions asked, if appropriate, at the section 1 hearings. It is

asserted in the written opening statement by NHS Tayside that it is hoped that the information contained in the logs, spanning the entirety, as I understand it, of Mr Eljamel's practice with them, may be found in other places, such as patient medical records.

It is for the reason that those records themselves have been found to have been inaccurate and incomplete that the Inquiry has been charged with investigating document management systems under term of reference 14. The Inquiry, and no doubt patients who harbour these concerns about their records, will approach NHS Tayside's claim that the evidence will be found in them with a degree of scepticism. It is noted by the Inquiry in that context that this is an admitted failure of document management which has occurred in real time rather than historically.

The legal position is that this occurrence can have potentially serious consequences in terms of both sanction under section 35 of the Act and evidentially. As such, I will say nothing more on the matter.

As I have said, the Inquiry will have to gather evidence about how this breach has been allowed to happen in order to assess what steps to take and the apparent evidential impact and will do so in early course, by seeking clear explanations in the form of

necessary written statements in the first instance. Any such evidence will, of course, be disclosed to core participants for their consideration in the normal course.

Sir, I turn, now, to documentary production times. It is understood to be the case that the main material providers to this Inquiry in terms of the volume of documents to be produced will be NHS Tayside and the Scottish Government. Both of these material providers have received, or will receive, separate general disclosure requests in short order, separate from their section 1 rule 8s.

This approach has been designed to allow the evidence associated with section 1 to be recovered separately to allow progress to be made toward the section 1 hearings including disclosure before it, but also for the recovery of the general documentary disclosure held by these bodies to be made early in the life of the Inquiry.

This will allow that documentation to be assessed, assimilated, disclosed and published in an orderly fashion, reducing the potential for delay to impact upon our process. In this regard, it is concerning to note that in the written opening statement of the Scottish Government reference is made to particular

complexities which may result from the nature of the platform on which their documents are stored and that, as they say, full review and disclosure will inevitably take some time.

This is a matter for the Scottish Government and will not be accepted as a reason for delay. It is concerning that the Scottish Government, a body frequently subject to Freedom of Information and Subject Access Requests, as well as requests for orders from Public Inquiries or courts, would seek to rely on the apparent inadequacy of a storage system which it has chosen to use.

Equally, the Inquiry will expect documents to be produced in an orderly fashion, clearly referenced to the calls made in the requests for them. It will not be tolerable to be given a haystack and the Inquiry and its core participants left to find the needles.

Rule 8s will be drafted in an ordered way. It will be expected that discovery will be produced in an ordered way as a result. Internal document retrieval and production mechanisms should be set up immediately in accordance with these reasonable demands.

Those who take an interest in how much Public Inquiries cost and why they take so long might have regard to the potential for disorderly documentary

production, both to stall an Inquiry's progress and cost huge sums of public money. This Inquiry will tolerate neither.

As I have said before, the documents produced and received for sections 1 and 2 should be relatively self-contained. The general document discovery will be required for analysis and disclosure for section 3 onwards.

As regards the expectation that documents will be available and capable of being produced in an orderly manner, we note that it is NHS Tayside's position that they created an information log relating to the Eljamel affair as part of the 2023 due diligence review.

Though we do not accept that the database contained everything that we will need or, indeed, that should have been compiled at that time, this starting point, we reasonably anticipate, will make finding and cataloguing many of the relevant documents far easier than in most Public Inquiries as this bulk is already encapsulated in a self-contained space.

Equally, we note the Scottish Government's position that their involvement in the Eljamel affair stems only from late 2013 and revolved largely around calls for external review, as opposed to having had any involvement in the primary matters with which we are

involved relating to Mr Eljamel's career.

Equally, we would expect that this limited involvement should mean that documents were collated and catalogued in an orderly fashion. To produce documents from one review to a subsequent review, ie the Inquiry, should be a more straightforward exercise. These circumstances should mean that there can be no good reason for delay in the production of documentary material. We will expect deadlines to be adhered to, as is the case with all recipients of evidential requests.

It should not be expected that the forced postponement of the evidential hearings which had been scheduled for February will be repeated. Deadlines will be set to make sure that it is not.

We note with appreciation that NHS Tayside commits fully to assisting the Inquiry. Similarly, and with the same degree of appreciation, with regard to the same approach which is being taken by the Scottish Government, who also commit to working collaboratively with us. Such full assistance we expect will involve adherence to the reasonable standards and expectations I have set out.

It would be ironic in the extreme if the Scottish Ministers were to set the Inquiry the task of reporting as soon as reasonably practicable under term

of reference 19, only then to frustrate the Inquiry in meeting that requirement by not producing documents on time and allowing progress to be made.

I turn now, sir, to the NHS Tayside admissions. The Inquiry is not a civil litigation. It is not confined in its investigations or evidence it can ventilate by admissions made by those who might be criticised, as would be the case where such admissions made in a civil court.

It is, however, relevant to the necessity for, or the proportionality of, those investigations and that evidence, especially in extent, where criticisms which are made are already accepted.

Indeed, it is both encouraged and appreciated that this is acknowledged where this is the case. Such concessions will inevitably assist with the sense of justice so rightly demanded by those who have suffered harm. The earlier they are made the better, in order to try to offer what, for many, has been a long road to justice, as Ms Cherry set out very amply yesterday.

Such concessions represent a constructive and responsible approach to the public work of an Inquiry such as this, both in terms of achieving justice and also limiting the amount of time and money which might be needed to achieve it, in particular, where they are

made by public bodies with public facing responsibilities. A similar approach to apologies might be said to be appropriate.

However, in order for sessions or admissions to be of value for these reasons, they must be unequivocal and they must be clear. Clarity is one of the Inquiry's principles, after all. It is my submission that the concessions made by NHS Tayside in its opening statement are not clear. The Inquiry will endeavour to clarify them by evidence in light of our position on them. The concessions made by NHS Tayside are matters for them and not matters for the Inquiry to seek to define. However, it may be of value for NHS Tayside to use their corporate response to the section 1 rule 8 which they have received to provide needed greater clarity in this regard.

They are asked in that rule 8 request to provide the main conclusions of the various investigations listed under term of reference 12, for example, as well as being asked to define the nature of the apology which was given on their behalf via the media in advance of our preliminary hearing.

In doing this, they may be able to define with greater clarity what they accept and what they do not as a clear basis from which further investigations within

the Inquiry can progress.

Though I think it would be fair to say that this applies to all such concessions or apologies which have been offered as part of their written opening statement or beyond, consideration might be given to their position on the following matters:

They say, in paragraph 2 of the opening written statement, that they wish to extend their sincerest apologies to all patients who have suffered because of the treatment they received from Mr Eljamel. What are they apologising for here? What part of their role in that treatment, with which the Inquiry is primarily concerned, do they accept merits an apology on their part and why?

They say, in paragraph 3 of the opening written statement, that patients were let down when they put their belief and trust in NHS Tayside to keep them safe. How do they accept they were let down? At what times and in what ways? Who was responsible and why?

They say, in paragraph 3 of the opening written statement, that the situations in which patients found themselves were exacerbated by the way in which NHS Tayside managed patients' complaints and concerns. What failure of management of complaints or concerns, if any, do they accept? Noting that the 2023 due diligence

review appears to be limited when considering patient complaints at least by their failure to look further back than complaints received in 2011, 2012 and beyond.

Over what time period do they accept any such failures occurred? Who was responsible and why? To what extent do they accept that patient outcomes were exacerbated as a result?

They say, at paragraph 4 of their statement, that NHS Tayside knows that it failed to react at an adequate pace when there were concerns raised about Mr Eljamel's clinical practice and in that regard, that it let patients down. What concerns do they say they failed to react adequately to? With what pace do they say that they did react and what pace would have been adequate? Who was responsible and why?

They say, at paragraph 4 of their statement, that patient trust has been eroded by NHS Tayside because of its failures to ensure its systems of supervision and oversight were adequate. In what way and to what extent do they accept that their systems of supervision and oversight were inadequate? What would adequate systems have looked like and why? How would current systems, to which they refer, ensure that they would be alerted at an early stage, as they say they would be now at paragraph 5? Who was responsible and why? How do they

accept that this has worsened the outcome for patients?

They say, at paragraph 20 of their statement that Mr Eljamel was not open and honest with patients and colleagues and that they have overhauled their professional governance systems. In what ways and at what times do they accept that Mr Eljamel was not open and honest? In what way and to what extent do they accept that their systems of professional governance failed or at least played a part in this failure of honesty with patients and colleagues? What would adequate professional governance systems have looked like and why? How would current systems have made a difference? Who was responsible and why? How do they accept that this has worsened the outcome for patients, if at all?

At paragraph 20, they say the way in which some of those signs of poor practice were joined up was lacking. In what way and to what extent do they accept that their systems of triangulation for monitoring poor practice were lacking? What would adequate, joined up systems have looked like and why? Who was responsible and why? How do they accept that this has worsened the outcome for patients, if at all?

Similar considerations apply to other such apparent concessions, including: variability in organisational

response; some complaints not leading to formal investigation; decision-making being delegated too far down the organisation; the inadequacy of practising restrictions in 2013; decision-making not being sufficiently well documented; the lack of reliable documentation from earlier reviews; and lack of oversight around the nature and timing of reviews, which can be found at paragraphs 20 and 46.

All of these concessions and others are relevant to our remit. We require clarity around what they mean.

Similarly, we note that at paragraph 47 of its written opening statement, NHS Tayside informs the Inquiry that the 2023 due diligence review looked at governance and not individual actions of former employees. It states that the Inquiry's investigation into previous reviews would benefit from looking at the rationale behind individual decision-making within NHS Tayside in a more detailed way.

One thing in this regard needs to be made clear: NHS Tayside is a corporate entity which is created by statute, as the submission makes clear. As a corporate entity, it has no means of interacting with the outside world. It exists in the abstract, a concept without physical presence. In order to interact with the outside world it requires to rely on physical agents,

doctors, nurses, administrative staff, to act on its behalf. It is through that physical interaction the corporate entity discharges its legal responsibilities to patients and others.

This Inquiry will expect NHS Tayside to answer for the actions of its agents, the individuals who did things in its name, on its watch and in the discharge of its legal responsibilities. The idea that in some way the corporate entity does not need to answer for the way in which those individuals interacted with the outside world on its behalf will not be tolerated, for the avoidance of any doubt, whatever the position of the board is, as far as its representation of the interests of those individuals is now.

I turn, sir, relating to some matters relating to civil litigation. In the NHS Tayside written opening statement they raise their position in relation to time-bar in civil litigations from paragraph 59. As the Inquiry is prevented from making findings of criminal or civil liability, it offers no current view on these matters.

It is correct to say, as Ms Cherry did and I have done, that the Inquiry is not prevented from exploring matters within its remit for fear that those investigations may result in findings from which

criminal or civil liability might be inferred by others.

It is important, however, to understand the limitations of that provision. The investigation of matters pertaining to civil or criminal liability, including considerations of time-bar per se, cannot be the primary aim of our work. However, it is permissible if those matters may be inferred incidentally from the product of it.

I turn now, sir, to procedural planning. In her opening statement, Ms Cherry made some submissions about her clients' position with regard to the explanation I had set out regarding the Inquiry hearing scheduled for February being postponed until April; a delay of around ten weeks.

Ms Cherry was right to point out, from a temporal point of view, that the delay would result in the oral hearings of the patient-focused section 2 of the Inquiry being delayed from April until September.

However, she characterised this delay of five months as being a delay in the patients' voices being heard. I disagree with this characterisation of developments.

It should, I hope, be evident that in their capacity as core participants, Ms Cherry's clients patient voices are being heard. They have been since before the Inquiry was set up in our public consultation on our

terms of reference. In fact, they were even before that, as our starting point before setting up was with the voices of patients who had raised them in the media about their stories about the issues that they had experienced.

From an evidential perspective it would also be wrong to suggest, as she did, that patient voices are not heard until the early hearings in section 2 in September. As I set out yesterday, our initial analysis of the evidence available to us has included a careful review of the patients' complaint files, over 100 in number, where the patient perspective and patient voices can certainly start to be heard.

Equally, the main means by which evidence be contributed to this Inquiry, as I have said before, will be via written statements. As I said yesterday, the voices of the patients will not only be heard but will be actively listened to in an evidential sense via their ICR applicant statements which the Inquiry hopes and expects will be sought from next week and subsequent Inquiry statements taken thereafter.

It is set out in the Inquiry protocol on its approach to evidence and written statements at paragraph 12 that evidence contained in documents, including in witness statements provided to the Inquiry,

will be deemed by the Inquiry to be evidence in the Inquiry which the Chair of the Inquiry can consider in making findings and recommendations in fulfilment of the Inquiry's terms of reference.

Such evidence will be able to be relied upon without the need for it to be spoken to in oral evidence and hearings or otherwise adduced formally. Such formality would be inconsistent with the inquisitorial nature of the Inquiry and likely to involve unnecessary cost.

Written evidence will be disclosed to core participants and published, as well as ventilated and explored at evidential hearings as the Inquiry deems necessary in the interests of fairness, thoroughness, economy and consistent with the Chair's obligations under the Inquiries Act 2005.

Further, it states at paragraph 17 that by providing written evidence in the form of an ICR applicant statement, all applicants to the ICR who consent to their applicant statements being shared with the Inquiry will, by their applicant statements, have provided evidence to both the ICR and the Inquiry. That evidence will be considered and analysed along with all of the other evidence available to the Inquiry.

It will ultimately be disclosed to core participants and published, consistent with the requirement for

public acknowledgement and consideration of evidence of the suffering and experiences of former patients of Mr Eljamel and subject to the provisions of the Inquiry's general restriction order and its protocol on disclosure, publication, restriction and anonymity which contain provisions which seek to respect the rights and legitimate wish of certain former patients or their representatives to confidentiality and privacy.

And from paragraph 19, the Chair of the Inquiry is aware that for many patients and their representatives providing written statements to the Inquiry is likely to be a traumatic experience. In accordance with its trauma-informed approach, the Inquiry wishes to minimise the number of times such individuals will have to provide written statements containing evidence of their experience. This principle underpins the approach to further written statements which may be requested by the Inquiry.

With that important principle in mind and in light of the broadly systemic remit of the Inquiry's investigation, it is considered likely that for many former patients or their representatives, the applicant statement to the ICR about their clinical experience is likely to provide sufficient evidence for the Inquiry's purposes. It is hoped that for certain of Mr Eljamel's

patients, and/or their relatives or representatives, their experience will have been adequately set out in those applicant statements and that it will not be necessary for the Inquiry to seek further statements from them, the content of their applicant statements already being evidence in the Inquiry.

Given the Inquiry's systemic remit, it will not be feasible or necessary for the Inquiry to examine individual cases of all former patients of Mr Eljamel or even all of those who have suffered harm. The Inquiry will seek to draw conclusions from their collective experiences as reflected in the applicant statements. This is not to undermine the importance of those cases or any individual's experience. It is a recognition of the Inquiry's systemic remit and the obligation the Inquiry has to discharge its terms of reference in an efficient manner in the interests of the public as a whole.

Sir, these systems have been carefully designed to make sure that patients' voices are heard, consistent with our obligations, our remit and the commitment we have made to putting patients at the centre of our process. The patient group is right to say that the Inquiry needs to look at individual clinical cases and hear and listen to the voices of the patients as

a basis of understanding and advancing its systemic remit.

The Inquiry needs to know what they say went wrong to understand what might have been avoided with better systems. However, to suggest that this remit requires a full examination of every clinical case is not accurate, in my submission. A broad picture, a collective experience of what went wrong and when will suffice in that regard.

In any event, undertaking such a clinical investigation within the Inquiry would be to undermine the structure of this Inquiry and its constitutional requirement to rely on the evidence from the ICR. In fact, this Inquiry will have available to it, through that process, a louder expression of the patient voice than perhaps has ever been available to any public Inquiry; a voice much louder than the Inquiry itself would ever have heard had the Inquiry been the only means by which such evidence was gathered.

To dismiss the ICR project as mere outsourcing of the clinical analysis and the evidence being gathered is, in my submission, to undersell its true value. A highly eminent surgeon with intimate knowledge of its workings recently described the ICR as the biggest examination of neurosurgical practice in UK history.

The ability of any patient who wishes to make a statement which will ultimately be evidence in the Inquiry and also have an individualised clinical review by an independent expert is an unprecedented offering, as far as I am aware, in any public investigation of this nature.

Ms Cherry rightly asked me to provide what clarity I could at this point about the timing of the hearings of section 2 of the evidence. As I have set out, the oral hearings form only part of the way that patient voices will be heard in this Inquiry. The current intention, as per the detailed plan I have set out, is that the patient voice on the matters within the Inquiry's remit will be heard in the four weeks of hearings which we have reserved from the week commencing 7 September 2026.

Though I have already said at the preliminary hearing that the Inquiry would keep an open mind about the calling of further patient evidence if important testimony was required to be ventilated in public emerges in our investigations, the plan would then to be move to section 3.

Sir, as regards Inquiry experts, the possibility of instructing a neuroradiology expert is raised by the patient group in their written submission at

paragraph 10. This helpful suggestion is noted and recognised as a distinct medical discipline. Roles, demarcation and the importance of the relevant disciplines will be covered in the section 1 letters of instructions to the Inquiry's experts. We remain open to later involvement of such expertise if this proves to be a significant discipline in issues arising in cases where there has been sub-standard treatment.

I move, sir, to the search for Mr Eljamel. At the last hearing in September, I provided an update on the steps which had been taken by the Inquiry to seek to get in touch with Mr Eljamel. I recognised that though the remit of the Inquiry is predominantly systemic in nature, 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 will, in turn, require consideration of the Inquiry's obligations to serve warning letters on him under rule 12 and subsequent rules of the 2007 Rules.

Certain comments ventilated in the press shortly after the hearings and more recently appear to have been critical of the adequacy of the steps we had taken. To

be clear, those steps were taken in the particular procedural context in which the preliminary hearing took place. A window was open for those with a significant interest in the work of the Inquiry, including those who might be criticised in its evidence or its report to apply for core participant status. It was incumbent upon the Inquiry at that stage to seek to engage with Mr Eljamel, if he wished to engage with us.

The Inquiry, as it has moved on, has now taken further steps in this regard as it has been called upon to do. A section 21 notice has been served on a body in Scotland seeking information which it is believed to hold about aspects of Mr Eljamel's financial arrangements in this country.

Further investigations are being undertaken relating to another aspect of Mr Eljamel's business affairs in this country. I provide that information by way of reasonable update but go no further, in case doing so publicly might frustrate those lines of enquiry.

Those who take an interest in this line of the Inquiry's investigation should be aware that these steps could only ever be preliminary ones in an effort to seek to have Mr Eljamel participate in the work of the Inquiry and answer the very reasonable and voluminous questions which we and others would have for

him.

Further, any such questions which would be posed to him would be posed as part of a later section in the Inquiry's procedural plan. There is a stepwise approach being taken to understanding the questions and evidence available related to them before putting them to those who may have been responsible for alleged failures.

It should be realised that finding Mr Eljamel would only be a very preliminary part of the process. If he were in Libya, where we believe him to be, the Inquiry would have no power to bring him here to answer for what he did. Its jurisdictional reach extends only to Scotland, as I have previously set out. This is not to say that we will not continue to try to engage him in our process; we have done and we will continue to do so.

Equally, we will continue to work in our analysis on the assumption that he will not engage with us, as he has not done so far. This is not the end of the story. We will try to recreate a reasonably accurate picture of what happened in his absence by accessing what evidence is available to us. We will invite you, sir, to draw reasonable inferences from the evidence we do have in the fulfilment of our important remit. This is an exercise not unusual in our judicial system where the

truth can only be found by careful investigation, even from an unhelpful starting point.

Sir, there are some aspects of detail in the submissions on which we intend to seek further information from core participants. By way of example, the patient group's reference to a complaint about Mr Eljamel being made by Tayside Local Medical Committee at paragraph 39, and the details of their allegations of conflict of interest in investigations into Mr Eljamel set out in the same paragraph.

Sir, we will examine the submissions and opening statements which have helpfully been provided to us with care again and, if any further matters arise, we will not hesitate to engage with those who made them. This is the essence of the active participation we expect and upon which we certainly rely.

Having made those closing remarks, I have nothing further to add, other than to thank those who have participated once again for their very helpful contributions in writing and orally at these opening statement hearings. These hearings have been approached by my colleagues in the constructive and collaborative spirit in which they were designed and in accordance with the Inquiry's principles.

We and the Inquiry team very much look forward to

continuing to work with our core participants and their legal representatives in that spirit as the evidential phase of the Inquiry progresses.

Thank you, sir.

LORD WEIR: Those following the agenda will now appreciate that we have reached the end point for that agenda and, with Mr Dawson's remarks concluded, that also brings to a conclusion this opening statements hearing.

Cumulatively, the various submissions serve to emphasise and to confirm the wide public interest and importance of this Inquiry's investigations. From what you have heard over the last day and a half or so, it will perhaps be apparent that those investigations, now well underway, are the product of many moving parts and that is why, amongst other reasons, it was thought appropriate to arrange this event as a bespoke hearing, to bring you and the wider public up to date with the point we have reached.

Above all, I do hope that this has been a useful and an informative exercise. For my part, I know that the Inquiry team has derived benefit, support, but also learning from the contributions that have been made to its work hitherto.

By way of example, the list of issues consultation brought to notice a number of matters which, as counsel

mentioned, have been incorporated into what remains a living document and we are greatly appreciative of that.

I hope that, for those who are interested in or concerned about it, you will participate in the public consultation on the trauma-informed policy that we intend to implement in our work going forward. There is a consultation document now published on the Inquiry website and, for those interested, I do encourage you to have a look at it and participate if you choose to do so.

You can, in any event, expect to hear from us regularly as we take our evidential investigations forward, and you have already heard from Mr Dawson about some of the ways in which your further engagement and assistance will be sought.

It only remains for me to reiterate the thanks that have already been expressed to all of you, whether you have attended in person or joined remotely and in whatever capacity you have done so, for the interest you continue to show in our work.

The task my team has been set is, on any view, a challenging one, but that engagement genuinely encourages us in what we do and we are very grateful for it.

May I also, then, conclude by thanking all of those who were involved in the preparation for and delivery of the opening statements we have now heard. I do not underestimate the work involved in that exercise; it is much appreciated.

We will meet again soon. The hearing will now adjourn. Thank you.

(12.49 pm)

(The hearing concluded)

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