Filed on behalf of Circle Health Group
First statement of Mr Peter James
Statement No. CHG-00245
Dated: 13.05.2026

ELJAMEL INQUIRY WRITTEN STATEMENT OF
MR PETER JAMES, CHIEF MEDICAL OFFICE OF CIRCLE HEALTH GROUP LIMITED

I, MR PETER JAMES, Chief Medical Officer of Circle Health Group Limited,1st Floor, 30 Cannon Street, London, EC4M 6XH will say as follows:

Introduction

I have prepared this statement at the request of the Honourable Lord Weir, the Chair of the Eljamel Inquiry ('the Inquiry'), to assist with the Inquiry's exploration of matters relevant to section 1 of the evidential hearings, and pursuant to Rule 8 of the Inquiries (Scotland) Rules 2007. Specifically, this statement addresses the questions listed in Appendix B of the letter from the Solicitor to the Inquiry (Lynn Carey) to Circle Health Group ('CHG') dated 11.11.2025 and has been prepared in accordance with the directions and numbering provided in that letter.

Before setting out the detail of this statement, I would first like to acknowledge any patients of Mr Eljamel who have experienced harm as a result of his care, whether in the NHS or private sector, and particularly any who are found to have experienced harm during care at BMI Fernbrae.

Part A – Roles and responsibilities

1. **Please set out your qualifications. If there is more than one contributor to the statement, please set out the qualifications of each, with a description of which part(s) of the statement each one contributed and why**

1.1. I am currently the Chief Medical Officer and Responsible Officer ('RO') at CHG and have held these roles jointly since July 2025. Prior to my current role I was the Group Medical Director and RO at CHG from October 2021 to June 2025. Within the relevant period for the Inquiry, I was not employed by BMI or CHG nor undertaking any clinical work in Scotland in either the NHS or the private sector.

1.2. I have, at various times, held Practising Privileges with private hospitals in England, including with BMI and CHG. I have never met Mr Eljamel, nor been involved in any way in the issues at the centre of the Inquiry. I make this statement in my current capacity on behalf of CHG, in an effort to assist the Inquiry in relation to legacy information from Mr Eljamel's period of clinical practise at BMI Fernbrae. Please see below for corporate history information as to why CHG has received the Rule 8 request.

1.3. I completed my medical training at the University of Nottingham, qualifying in 1985. My qualifications are: B.Med.Sci, BM/BS (Hons), FRCS, FRCS (Orth), Dip Biomech. Until I retired from clinical practise in November 2025, I had worked both in the NHS and independent sector as a consultant orthopaedic surgeon, specialising in complex revision knee replacement surgery. Although now retired from clinical practise, I remain on the GMC Specialist Register.

2. Please explain your professional/occupational background, in particular focussing on roles and the responsibilities which you held/hold relevant to or potentially relevant to the neurosurgical practice of Mr Eljamel. If you wish, you may exhibit a CV/CVs with your statement.

2.1. In my current role, I serve as the senior clinical advisor to the board of CHG. My key responsibilities include matters of consultant and medical governance, with oversight of medical performance, clinical strategy and safety. I am also the Responsible Officer for CHG, working closely with the GMC to ensure maintenance of Good Medical Practice across our medical practitioners and all hospital sites.

2.2. Prior to this, I was employed as the Group Medical Director and Responsible Officer of CHG from October 2021 to June 2025. My key responsibilities in this

role included the day-to-day oversight of medical governance and performance for the consultant workforce working within CHG. I liaised closely with the GMC on matters of concern, as I still do now in my role as CMO.

2.3. Before I moved into the corporate roles at CHG, I practised on a full-time basis as a consultant orthopaedic surgeon. I attach my curriculum vitae [CHG-00246].

2.4. I can confirm that I have never met nor supervised Mr Eljamel. I have never been employed by an organisation which employed or granted Practising Privileges (PPs) to Mr Eljamel, and I had no role in his neurosurgical practise at BMI Fernbrae whilst he treated patients there between 2002 and 2013. I write this statement in my current role to assist the Inquiry, on the basis that my current employer CHG acquired BMI in January 2020, and in doing so became the successor organisation with access to such legacy documents that existed within the relevant period of the Inquiry from BMI Fernbrae as continued to exist at the point CHG acquired BMI. BMI Fernbrae had however closed in 2019 and therefore CHG acquiring BMI did not result in CHG ever running clinical operations at Fernbrae Hospital, or employing any of the staff at that hospital.

2.5. The information within this statement therefore does not reflect any direct personal knowledge of the events involving Mr Eljamel and the neurosurgical services at Fernbrae, but reflect information and material secured using CHG's best endeavours in searches from legacy systems. Further details are below in response to question 6 regarding documents. Senior individuals employed at BMI Fernbrae or involved in overseeing BMI Fernbrae during the relevant period may have direct knowledge of events involving Mr Eljamel and the neurosurgical services at BMI Fernbrae. However, as none of those individuals are employed by CHG, I have not been able to explore that further. I have provided the names of individuals who our searches indicate were in such roles at paragraph 8.3.

Part B – Structures and key individuals relating to the neurological service provided by Fernbrae Hospital

3. Please provide an overview as to the role, function and responsibilities of CHG and its predecessor bodies over the relevant period, in particular with regard to

functions of relevance to the provision of neurosurgical care at Fernbrae Hospital, Dundee. Please highlight any significant differences in the role and remit of these various bodies in that regard.

3.1. Based on Companies House records [CHG-00294] and relevant correspondence [CHG-00295], I understand that between 1961 and 1996, Fernbrae Hospital was owned by a company called Fernbrae Private Clinic (Dundee) Limited. In 1996, the Hospital was bought by Fernbrae Hospital Limited, a subsidiary company of Healthcare Management Scotland Limited. In January 2002, CHG's predecessor, BMI Healthcare Limited ('BMI'), acquired the shares of Healthcare Management Scotland Limited (and therefore Fernbrae Hospital Limited) and acquired the leasehold for Fernbrae Hospital on 28 January 2002. I have not found any documentation that reveals what services were offered at the Hospital prior to BMI's ownership. Fernbrae Hospital remained under BMI's ownership until 19 May 2020, when the lease was surrendered. I understand however that BMI had closed the Hospital in April 2019 and therefore no clinical activity or surgical procedures were performed there for the last year of BMI's ownership. Fernbrae Hospital did not therefore form part of the operational BMI services inherited by CHG, as CHG did not acquire BMI until January 2020. The formal lease surrender was a largely administrative step as part of the post transaction process.

3.2. Starting with a broad overview, the role and function of an independent (private) hospital provider, both for the relevant period and in the present day, is to deliver safe acute elective healthcare to patients. This includes the delivery of diagnostic, therapeutic, surgical, rehabilitative and preventive health services to patients. The patient profile of a private hospital will depend on the particular hospital, but can include a mix of self-pay patients, insured patients and, if the hospital has a service contract with an NHS organisation, NHS patients.

3.3. To the extent I can comment on BMI Fernbrae, BMI's responsibilities in the relevant period 1995 to 2015 for the Inquiry (limited to 2002 to 2015 to reflect the period of BMI ownership of Fernbrae within that period), included:

3.3.1. the provision and maintenance of clean, fit-for-purpose hospital facilities, accredited to undertake the range of procedures offered to national standards

3.3.2. the sourcing and procurement of appropriate and safe medical and clinical equipment

3.3.3. the sourcing, procurement and administration of appropriate and safe medication

3.3.4. the engagement of an appropriately qualified and experienced medical workforce to provide medical and surgical care and treatment to patients

3.3.5. the engagement of appropriately skilled and experienced staff to perform the necessary clinical, administrative and operational roles to safely deliver healthcare services

3.3.6. the provision of staff training, where required or otherwise appropriate, to support them in the delivery of their roles

3.3.7. the creation and implementation of policies and procedures, reflecting good practice and national requirements (by law or recommended in national guidance as applicable at the time), to support the delivery of safe care and to protect patients, staff and visitors

3.3.8. compliance with legal and regulatory requirements, including maintaining necessary registrations and other specific licences to operate, and cooperation with regulators across the sector

3.3.9. responding to and investigating incidents, complaints and legal claims

3.3.10. the oversight and management of all services delivered in its hospitals to ensure they remain safe, effective and commercially viable.

The list above is based on my own knowledge from practising as a consultant orthopaedic surgeon during the relevant period. I presume the majority of these responsibilities were identified in legislation and guidance that was either in place or introduced over that period. I am however unable to specify where each of these responsibilities were documented. Senior individuals employed at BMI Fernbrae or involved in overseeing BMI Fernbrae during the relevant period may be able to assist further on this. However, as none of those individuals are employed by CHG, I have not been able to explore that further. I have provided the names of individuals who our searches indicate were in such roles at paragraph 8.3.

3.4. The nature of these responsibilities and the expectations on providers across the sector in terms of how these are met, have evolved significantly over the relevant

time period and in the years following Mr Eljamel's practice. I have detailed this further in my response to question 10 below.

3.5. Consultants delivering medical care from a private hospital provider's facilities are typically engaged through the granting of practising privileges [CHG-00250 and CHG-00262, CHG-00296, CHG-00297, CHG-00298, CHG-00299, CHG-00300, CHG-00301]. I have provided further detail on how practising privileges operate and are granted in my response to question 10 below. A consultant with practising privileges is not employed by the private hospital provider but is authorised to use the provider's facilities to deliver medical care, in conjunction with and support from the provider's clinical teams. When using the hospital's facilities, consultants are required to comply with the requirements set out in the provider's practising privileges policy [CHG-0249 and CHG-00263, CHG-00296, CHG-00300, CHG-00301] and other relevant company policies, along with any updates to those policies that occur periodically. This model of care and the practising privileges framework continues to be widely used in the private healthcare sector, including at CHG Hospitals.

3.6. The services available and scope of those services at a private hospital is influenced by patient demand, hospital facilities and availability of consultant expertise at the hospital. I understand that BMI Fernbrae was a relatively small hospital, comprising in the region of 14 individual patient bedrooms, 1 operating theatre, an imaging department and endoscopy examination area. I do not know when each service was available from and to, but I am aware that during the course of BMI's ownership within the relevant period (2002-2015) BMI Fernbrae offered the following services:

3.6.1. Outpatients
3.6.2. Cardiology
3.6.3. Clinical Psychology
3.6.4. Cosmetic
3.6.5. Dermatology
3.6.6. Ear, Nose & Throat
3.6.7. Endoscopy
3.6.8. Pharmacy

3.6.9. Physiotherapy

3.6.10. Outpatient Fertility

3.6.11. Neurosurgery (Spinal Procedures)

3.6.12. Vascular Surgery (Varicose Veins)

3.7. I believe the neurosurgery service at BMI Fernbrae was small in terms of patient and procedure numbers and, in terms of consultants with PPs providing neurosurgical procedures, data extrapolated from a revenue database (known as "TM1") [CHG-00247] shows activity data for BMI Fernbrae between 2005 and 2019 (when the Hospital closed), broken down by specialty and consultant. From this, it can be seen that the neurosurgery service activity is modest and, until 2013, was delivered primarily by Mr Eljamel, with a smaller service offered by Dr O'Riordan. Thereafter, Mr Demetriades joined the service and his clinical activity is listed from 2014 to the point of closure of the hospital. The data tab regarding funding suggests there were no NHS funded patients receiving neurosurgical procedures at BMI Fernbrae in the (abridged) relevant period 2002 to 2013, and therefore none treated by Mr Eljamel. The revenue database (TM1) does not provide any data for BMI Fernbrae pre-2005. Unfortunately, and for the reasons explained in my response to question 6 later in this statement, where CHG has been able to access legacy systems, it has not always been possible to locate or retrieve a complete set of data from those systems.

3.8. As is confirmed by this data set [CHG-00247], Mr Eljamel was one of the surgeons who performed neurosurgical procedures at BMI Fernbrae. Our records indicate that Mr Eljamel had practising privileges at BMI Fernbrae for a period of 11 years, running from December 2002 to early January 2014 (although the data indicates that Mr Eljamel did not perform any procedures or complete any clinics at BMI Fernbrae from June 2013 onwards, and therefore his clinical practise at Fernbrae can be regarded as concluding as at June 2013). A separate data set to the TM1 data referred to at paragraph 3.7 above, taken from Ultragenda (patient booking system), provides details of procedures performed by Mr Eljamel from 2003. I have exhibited this data confirming the dates, numbers and nature of surgeries performed by Mr Eljamel over that period [CHG-00248]. This indicates that Mr Eljamel performed 483 procedures at BMI Fernbrae over the period he held practising privileges and maintained a clinical practise (December 2002 to June

2013). It further indicates that Mr Eljamel performed 40 different procedure types at BMI Fernbrae, the most frequent being lower complexity spinal:

Code	Treatment	Number
V2540	CEN036 Posterior Excision of disc Prolapse	138
V2950	CEN2950 Anterior Exc. Of Disc(s) with fusion	77
V5484	CE9999 X-Stop Procedure	60
V2282	CEN162 Prosthetic Intervertebral disc replacement in the cervical spine	48
V3370	CE3370 Microdiscsectomy	42
A6510	OR3302 Carpal Tunnel Syndrome	17
V2560	CEN143 Decompression for central spine stenosis	14
V2544	CEN039 Revision of Posterior Excision of Disc P[…]	14
25150	CE5150 Trigeminal Ganglion injection (LA)	10
V2530	OR2530 Decompression on Spine incl. fusion	9

4. When and how the body with responsibility for the provision of neurosurgical care at Fernbrae Hospital, Dundee has changed since 1995?

4.1. BMI owned and was responsible for BMI Fernbrae Hospital from 2002 up to and including the end of the relevant period for this Inquiry. BMI was, throughout that time, owned by General Healthcare Group (GHG). GHG was a leading provider of independent healthcare services in the UK and offered a range of services through its two main operating divisions, BMI (providing acute hospital services) and Netcare (which secured contracts with the Government to provide public services in the independent sector – for example, to assist with reducing waiting lists or improving patient choice).

4.2. BMI closed BMI Fernbrae in April 2019 for commercial reasons, prior to CHG acquiring BMI.

5. Please explain the extent to which CHG retains legal or regulatory responsibility for the actions of its predecessor bodies which performed similar roles relating to the provision of neurosurgical care at Fernbrae Hospital, Dundee over the

relevant period. To the extent that CHG does not retain such responsibility, please explain what bodies do retain such legal or regulatory responsibility.

5.1. CHG acquired 100% of the share capital of BMI in January 2020 and, in so doing, acquired BMI's assets and liabilities, including those relating to BMI Fernbrae over the relevant period, and despite BMI Fernbrae being closed by the date CHG acquired BMI.

6. Please explain the extent to which CHG retains access to documents held by or on behalf of its predecessor bodies, with relevance or potential relevance to the matters covered by the inquiry's Terms of Reference and List of Issues, in particular the provision of neurosurgical care at Fernbrae Hospital, Dundee. If possible, please explain (a) whether any other bodies have access to or are likely to have access to any such document (b) to the extent that such documents are not retained, any reasons why they have not been

6.1. With the transaction by which CHG acquired BMI in 2020, CHG became responsible for all legacy BMI documents and document storage arrangements across the BMI group of hospitals, including legacy Fernbrae materials. These materials will have been subject to BMI's legacy retention and destruction policies and prior to CHG acquiring BMI, it would have no control nor awareness of any BMI documentation (whether from Fernbrae or elsewhere across the group), destroyed in accordance with such policies [CHG-00283]. From January 2020, BMI legacy documentation would fall under CHG's retention and destruction policy. It may therefore be the case that some materials relating to Mr Eljamel will have been destroyed in the ordinary course of application of either the BMI policy or the CHG policy [CHG-00302], prior to awareness of the Inquiry and the issues it seeks to explore. CHG has a robust process for retention of documents which may be relevant to consultants about whom concerns have been raised, however this would not have applied to Mr Eljamel in the 2002-2013 window predating CHG's ownership.

6.2. Upon public announcement of the Inquiry in September 2023, and in anticipation that legacy BMI documents it held may be of assistance, CHG immediately took steps to locate, ringfence and preserve any documents that could reasonably be

considered relevant to Mr Eljamel's practice at Fernbrae between 2002 and 2013. At that time, the Terms of Reference and List of Issues were not yet available, these being published in 2025. Additional, broader searches were also completed following the Inquiry's Rule 8 request, with additional specificity as to information needed. I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

6.3. CHG, as a large hospital group, holds a significant volume of documentation at physical locations and on a variety of electronic systems, including some legacy systems, across its current business. These practical factors, along with the prior closure of BMI Fernbrae in 2019, the acquisition of BMI hospitals by CHG in 2020, and the historic nature of the records have made the search for records that are relevant or potentially relevant to the Inquiry's Terms of Reference and List of Issues very challenging. We have already made a number of disclosures to the Inquiry, and we make further disclosures as exhibits to this statement and in response to Appendix C requests. We also recognise a continuing duty of disclosure in this Inquiry and are committed to achieving this.

6.4. I have detailed below the electronic systems that CHG has access, or partial access to, and which I am aware hold records that are or may be relevant to the Inquiry:

System	**Type of information/data held**	**Legacy/current**
Medax	Patient charges including primary treatment codes and consultant details	Legacy
Ultragenda	Outpatient appointment booking system (from 2007 onwards)	Current
Peoplesoft	Active patient notes, including billing, appointments & theatre details (from 2007 onwards)	Current
E-tracer	On-site tracker for site records	Current

EDM/Restore	Off-site storage providers for archived records (used for BMI Fernbrae from 2010 onwards)	Current
PACS	Imaging records (from 2007 onwards)	Current
Riskman	Incident & complaints data from December 2016 to November 2023	Legacy
Sentinel	Incident & complaints data pre-December 2016 (date first rolled out unknown)	Legacy
Therefore	Local archiving system for patient medical records used by BMI Fernbrae prior to closure	Legacy
Corporate shared drive	Policies & procedural documentation	Current
iTrent	HR and payroll system	Legacy

6.5. CHG has carried out electronic searches of all of the above systems and ringfenced records that are or may potentially be of relevance to the Inquiry, based on the Inquiry's Terms of Reference, List of Issues and specific requests made to CHG by the Inquiry to date. I have exhibited, a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

6.6. CHG has not been able to access the following legacy system which may hold/have held data relevant to Mr Eljamel's practise:

System	**Type of information/data held**
SAFECODE	Incident & complaints data (dates during which this system were in use at BMI are unknown)

I do not know and have not been able to ascertain which company owned and operated SAFECODE or whether it is still operational. If that company is still operational, it is possible that it could access the SAFECODE system and, potentially, historic BMI incident and complaint data. I believe that the reason that

CHG does not have access to this system is because it was decommissioned for use in the business a significant period of time before CHG acquired BMI in January 2020. I do not know the dates that it was used within BMI. It is possible that SAFECODE was the incident reporting system that was used at BMI immediately before the company replaced it with a new system (Sentinel). I have not been able to ascertain if that is the case or when Sentinel was introduced, but I am aware Sentinel remained in use until 2016. As identified at paragraph 6.4 above, BMI replaced Sentinel with another system (Riskman) in December 2016. From November 2023, CHG replaced Riskman with RADAR.

6.7. CHG has also completed physical searches of archived records from BMI Fernbrae, which had been held at CHG's Albyn Hospital (formerly also part of BMI) pending transfer to off-site storage. I am aware that BMI Fernbrae previously used a company called C21 Data Services to store archived records locally. However, it appears C21 Data Services was acquired by a company called Recall in 2015, and then by OASIS in 2016. CHG approached OASIS to establish if that company held any legacy storage boxes from BMI's Fernbrae or Albyn Hospitals (where some documentation was known to be transferred to following Fernbrae Hospital's closure in 2019). OASIS confirmed that it held no such boxes, these having been destroyed or permanently withdrawn. [CHG-00443 and CHG-00444]

6.8. The searches detailed above have been performed primarily by members of the IT and legal team at CHG. However, where appropriate, enquiries of other individuals and teams in the business have been pursued where it appeared these may enable further documentation to be located. I have exhibited, a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

6.9. Where it has not been possible to locate all relevant or potentially relevant records from the relevant time period, we have identified this below. The most likely reasons for this appear to be:

6.9.1. Some records may have been destroyed in accordance with relevant record retention and destruction policies at BMI and CHG prior to the Inquiry being

launched, although we have been unable to establish the specific dates. It appears that BMI first implemented a record retention policy (identifying the minimum period for which records should be retained) in 2004, which related solely to pharmacy records. The earliest version of that policy that we have been able to locate is from 2009 (version 3) [CHG-00303]. A broader record retention policy, extending to all business documentation and healthcare records, was introduced by BMI in November 2009 [CHG-00283]. I understand that BMI will have had various iterations of this policy up to the end of the relevant period (2015) and indeed until BMI was acquired by CHG in January 2020. Thereafter the BMI policy will have been superseded by CHG's *Management of Records and Clinical Documentation* policy version 6.0 dated September 2024 [CHG-00302].

6.9.2. Records may no longer be accessible due to the various transitions to new electronic systems that have occurred over the course of the relevant period. Records held on historic systems and technologies may not be accessible due to aspects of these being corrupted or no longer being in use. For example, in 2007, BMI transitioned to a new system for recording inpatient and outpatient data and appointments. The transition was from a system known as 'Medax' to two separate systems referred to as 'UltraGenda' (which records all outpatient data and appointments) and 'PeopleSoft' (which records all inpatient data and appointments). Some Medax data was preserved, but this is incomplete and held in code format. CHG, with support from its IT team, has extracted all clean, translatable data that remains available from this system.

6.9.3. Archive files in CHG's corporate shared drive contain some historic policies and documentation. The manner and consistency with which those documents were saved depends on the individuals and teams involved at the time. While some BMI policies and documents are available through these archives, our searches of the archives have not located a complete set of BMI policies or documents that were in place throughout the duration of Mr Eljamel's practice (2022 to 2013) and the relevant period. It is possible that some documents on the shared drive have not been identified as ones that are relevant or potentially relevant to the Inquiry due to the labelling practices

at the time, and the inherent difficulties in locating documents arising from the broad nature of the search. Further, prior to BMI Fernbrae's closure, it is likely that at least some of these documents were also saved on a local shared drive at BMI Fernbrae but CHG has not been able to identify if or where these were transferred to on closure. I have exhibited, a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

6.9.4. Prior to 2020, identifiers for patient records being sent to EDM were manually entered into EDM's system on receipt to enable those records to be tracked. Human factors may have resulted in some of those patient identifiers being mistyped, meaning they may return a false negative result. It is also possible that some records were sent to storage without being indexed or recorded in a way which enables them to now be traced. After CHG's acquisition of BMI in 2020, all records being sent to EDM were labelled with an electronic barcode to remove that risk.

6.10. While CHG has made every endeavour to ensure systems are searched fully and to the best of its abilities, it is possible that the companies referred to above, who own and operate the systems or off-site storage units, hold records that CHG has not been able to locate through its own searches. Save for where I have otherwise indicated, CHG has not previously approached the companies who own the legacy systems to request that they complete their own searches. The complex nature of CHG's own internal searches and associated demand on internal resources, alongside the timetable set by the Inquiry to produce this statement and the associated disclosure, required CHG's efforts to date to focus on locating documentation that it had direct access to.

7. Please provide an explanation of the areas in which CH or its predecessor bodies (a) had exclusive responsibility; and (b) had shared competence with other government department, agencies, public or private bodies over the relevant period for systems relating to the provision of neurosurgical care at Fernbrae Hospital, Dundee. As regards (b) please set out how CH or its predecessor

bodies' responsibilities overlapped or interacted with the responsibilities of those other bodies in that regard.

7.1. I have detailed the exclusive responsibilities of CHG's predecessor, BMI, in my response to question 3 above.

7.2. In the course of its operations, I believe BMI Fernbrae will have interacted with various other organisations and stakeholders in the sector. I have set out below those that I believe the Hospital will have had the most interaction with, and the nature of that interaction:

Organisation	**Nature of role**	**Overlap with BMI responsibilities / nature of interaction**
NHS Tayside	Acute hospital provider	Reciprocal contractual relationship to deliver services. CHG's searches have not located the relevant contracts or records establishing any process(es) governing the sharing of information between NHS Tayside and BMI Fernbrae during the relevant period. Note however that the data suggests no NHS funded neurosurgical patients were treated by Mr Eljamel in the relevant period at Fernbrae.
Private insurance companies	Access and funding for patients	Contractual relationship to deliver services to insured patients.
Sector regulators, including: • Care Commission / NHS Quality	Regulators of health sector providers in Scotland	BMI Fernbrae was subject to the regulatory and inspection regimes of these bodies during the relevant period. Based on the quality accounts for BMI Fernbrae (2018) [CHG-

Improvement Scotland (2003 – 2011) / Healthcare Environment Inspectorate (2009 – 2011) • Healthcare Improvement Scotland (HIS) (2011 – present) • HSE Scotland		00304], HIS carried out an unannounced inspection of the Hospital in January 2018, following which BMI Fernbrae scored a rating average of 4 (Good) and 5 (Very Good), across a range of Quality Themes [CHG-00304]. I have been unable to locate earlier ratings for the hospital.
GMC	Professional regulator	During the relevant period the GMC was responsible for ensuring professional standards were met by individual registrants, and taking action where appropriate in cases where consultant performance fell short of those standards. BMI would be expected to refer any concerns about consultant performance to the GMC, where those concerns met the threshold.

7.2.1. The organisations listed, or their successors where applicable, are likely to be able to provide a fuller answer to this question. It is possible that BMI had interactions with other organisations that are not included within the table above and which are listed elsewhere in the Inquiry's request (or example, the organisations listed at question 9). CHG's searches have not identified any information to enable me to establish if that is indeed the case and, if so, to what extent or what that relationship looked like.

8. Please provide a high-level overview of the structure of CHG and its predecessor bodies and a list of key individuals and their roles within CHG and its predecessor bodies over the relevant period, insofar as relevant to the neurosurgical service provided by them and the matters covered by the Inquiry's Terms of Reference and List of Issue by way of organogram, if necessary.

8.1. My comments are based on my understanding of the structure at BMI prior to CHG acquiring it. I was not personally involved in BMI's management. See my earlier comments regarding GHG's ownership of BMI. I am not aware of anyone who is currently a senior manager at CHG who would be able to provide information beyond that provided in this statement. For completeness however, I confirm that there are two individuals (Emma Kavanagh, now Head of Litigation and Sharon Stewart, now Director of Clinical Governance and Quality Improvement) who are employed by CHG who were also in the same/similar posts for parts of the relevant period. Both individuals had some involvement in responding to complaints/claims (described at paragraphs 42 and 43 below) that arose about Mr Eljamel after he stopped practising at BMI Fernbrae. To assist in preparing this statement, both individuals have been consulted with and completed their own searches (in addition to the searches run corporately) for any documentation they may hold. The information that was obtained through these discussions and individual searches, which was relatively limited, is reflected in this statement.

8.2. Please see the exhibits referred to in my response to question 10 (below) for an overview of my understanding of BMI's framework for clinical and medical oversight during the relevant period.

8.3. CHG's searches have identified the following who may be considered key individuals. Please note that this list is based on searches of the legacy HR and payroll software (iTrent) which was in use at BMI, and subsequently CHG, from 2013 until February 2024. This software does not hold information about individuals employed prior to 2013, unless they continued to be employed after the date that iTrent was introduced. Further, due to the nature of how information is stored on this legacy system, CHG would need to know the name of the individual who was employed prior to 2013 in order to locate any additional details held for them on that system. Where I have listed individuals who commenced and

concluded their roles prior to the introduction of iTrent in 2013, those details have been located through wider searches, such as via Companies House or where names have been noted in other documents:

8.3.1. Former Chief Executive Officers (CEO) of BMI:

8.3.1.1. Peter Edmund Charles Farrier – 01.09.2000 – 05.04.2005

8.3.1.2. Ian Richard Smith – 07.01.2005 – 27.06.2006

8.3.1.3. Adrian Fawcett – [start date unknown] - June 2011

8.3.1.4. Stephen Collier – 31.05.2011 to 01.11.2015

The primary responsibilities of the CEO are to set the overall strategic direction for the company, lead on key corporate decisions and to lead the executive management team of the company to achieve the defined goals of the company. They are ultimately accountable to the company's board of directors. Knowledge and input on matters relating to neurosurgical services at BMI would therefore likely have been limited to high-level strategic decisions or high-risk concerns.

8.3.2. Former Medical Directors of BMI:

8.3.2.1. Dr David Ashton – [?1999] – [date unknown]

8.3.2.2. Professor Duncan Empey – 08.01.2008 – 30.11.2013

8.3.2.3. Mark Ferreira – 01.09.2011 – 29.05.2015

The primary responsibilities of the Medical Director are to oversee matters of clinical and medical governance across all of CHG's hospitals. If and when serious medical performance concerns arise, the medical director will oversee the appropriate investigation and support the hospital's Executive Director accordingly. Knowledge and input on matters relating to neurosurgical services at BMI would therefore likely have been limited to higher-level strategic decisions or higher-risk concerns.

8.3.3. Former Executive Directors/Registered Managers of BMI Fernbrae:

8.3.3.1. Anne Miller – 2002 - [date unknown]

8.3.3.2. Kenneth Hay – 23.02.2000 – 02.01.2012

8.3.3.3. Marshall Dallas – 10.12.2012 – 13.09.2013

8.3.3.4. Louise Buchan – 01.11.2013 – 30.09.2015

The Executive Director/Registered Manager of BMI Fernbrae would have responsibility for ensuring the Hospital complied with regulatory, quality and safety requirements and for operational management including development and achievement of local strategic plans, managing budgets and overseeing daily operations of the Hospital. The Executive Director/Registered Manager will have made strategic decisions about the services delivered at the Hospital, including the neurosurgical service, aligning with wider BMI strategy as appropriate. As described in my response to question 10 below, the Executive Director/Registered Manager was responsible for decisions regarding the granting or withdrawal of practising privileges for consultants, and for identifying and responding to any concerns about consultant practise, in consultation with the Hospital's Medical Advisory Committee (MAC). Please see my response to question 10 for further details.

8.3.4. Dr Matthew Checketts - former MAC Chair at BMI Fernbrae (appointed in 2007, length of tenure unknown)

I have exhibited a document setting out the role of the MAC Chairman dated 08 October 2003 [CHG-00305]. This role included responsibility for working with the Hospital's Executive Director and MAC on matters relating to clinical governance and the hospital's clinical quality strategy. The MAC Chair was also expected to advise the MAC and Executive Director on matters such as granting and withdrawal of practising privileges (please see my response to question 10 for further detail), clinical competence reviews, audit and outcome reviews. It would therefore be expected that the MAC Chair would be aware of, and have input into the management of, any performance concerns relating to consultants at the Hospital, including consultants in the neurosurgical service.

9. Please explain how the role of CHG and its predecessor bodies over the relevant period fitted with the role/remit of the following key organisations which did or could have had a role in the oversight of aspects of the professional practice of Mr Eljamel: (a) NHS Tayside or its predecessor organisations; (b) The Scottish

Executive/Government; (c) insofar as relevant to the provision of healthcare over the relevant period, the UK Government; (d) NHS Education Scotland and its predecessor organisations; (e) The Department for Medical Education; (f) The University of Dundee; (g) The Royal College of Surgeons (Edinburgh); (h) The Royal College of Surgeons; (i) The General Medical Council; (j) The British Medical Association; (k) The Health and Safety Executive; and (l) Any other bodies which held a remit relevant to matters falling within the Inquiry's Terms of Reference.

9.1. I believe I have answered this question to the best of my ability in response to question 7 above. I have no other direct information regarding bodies (a) to (l) above and their interaction in the relevant period with BMI in the context of its oversight of neurosurgery services at BMI Fernbrae (save for my general awareness of the sector and those organisations/functions).

10. By way of comparison with systems which may or may not have been in place within NHS Tayside, please explain the main principles of policies and practices governing the role of CHG and its predecessor bodies, including how these evolved over the relevant period, insofar as they were relevant or potentially relevant to the practice of Mr Eljamel, relating to:

(a) Appointments of and the granting of practising privileges to consultants over the relevant period, including but not limited to the process by which consultants' professional qualifications and competence were verified (ToR 1);

(b) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3);

(c) Broad systems and rules about work patterns within Fernbrae Hospital, balancing work between the NHS and the private sector (ToR 2/ 3) and about supervision/ training of junior colleagues (ToR 2);

(d) Complaints and feedback systems within Fernbrae Hospital, in particular for patients who received treatment privately and within NHS Tayside (ToRs 4 and 5);

(e) Internal and external information sharing systems, candour, including with patients and the GMC (ToRs 7 and 13);

(f) The creation and maintenance of effective document management systems over the relevant period and subsequently (ToR 14); or

(g) Any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues.

10.1. I am unable to provide any comparison with systems that operated at NHS Tayside during the relevant period, as I have no knowledge or information available to me on that matter. Senior individuals employed at BMI Fernbrae or involved in overseeing BMI Fernbrae during the relevant period may have some knowledge of how BMI's systems compared with those of NHS Tayside. I have identified at paragraph 8.3 any such individuals who have been identified through CHG's searches. However, as none of those individuals are employed by CHG, I have not been able to explore that further. Similarly, senior employees at NHS Tayside may be able to offer further assistance on this question.

(a) Appointments of and the granting of practising privileges to consultants over the relevant period, including but not limited to the process by which consultants' professional qualifications and competence were verified (ToR 1);

10.2. With regard to question 10(a), I can confirm that:

10.2.1. During the relevant time, and as is the case now, the majority of private healthcare providers operated a consultant-led model of care. Under this model, consultants were granted practising privileges. [CHG-00249, CHG-00250 and CHG-00262, CHG-00296 to CHG-00301]. This means that consultants, although not employed by the healthcare provider, were authorised to use the private healthcare provider's inpatient and outpatient facilities appropriate to the consultant's specialty and scope of practice to provide medical services in line with the provider's applicable policies and processes.

10.2.2. To be granted practising privileges, I understand that consultants were required to formally apply to the relevant BMI Hospital's Executive Director

and supply evidence in support of their application, including evidence of their qualifications, experience, occupational health clearance and a reference (most commonly from the NHS Trust that substantively employed them) in support of their application. I have exhibited a copy of BMI's Practising Privileges policy for its Scottish hospitals from September 2003 and template offer letter from December 2002 [CHG-00249 and CHG-00250]. These are the earliest versions of the Scottish documents used by BMI that my colleagues and I have been able to locate, save for earlier drafts of this document. Page 12 of that policy details the evidence that consultants were required to provide on applying for, or seeking renewal of, their practising privileges, along with the Regulations this was based on at the time [CHG-00249_12].

10.2.3. I do not know, and have not been able to establish, how professional qualifications and competence were verified at that time, although I understand weight will have been placed on the reference(s) provided as part of the supporting evidence of the application. Senior individuals employed at BMI Fernbrae or involved in overseeing BMI Fernbrae during the relevant period may be able to confirm how qualifications and competence were verified during that time. I have identified at paragraph 8.3 those individuals who have been identified through CHG's searches. However, as none of those individuals are employed by CHG, I have not been able to explore that further. It should nonetheless be noted that surgical competence was, and is, a matter that is closely reviewed by a more senior doctor as part of a doctor's specialty training programme that is completed in the NHS. The specialty training programme also requires doctors to complete exams and the programmes will vary in length depending on specialty. Successful completion of the specialty training programme enables doctors to join the GMC Specialist Register and to be recognised and work as a consultant. This process applied during the relevant period in the same way as it does today. Private providers and NHS Trusts place reliance on a doctor's evidence of successful completion of the specialty training programme to satisfy themselves that they are competent and able to appropriately practise in a consultant role.

10.2.4. The current verification process used at CHG is detailed within the CHG Practising Privileges policy (see Appendix 3 of this policy) [CHG-00306]. Typically, papers provided by the applicant consultant will be checked by the Executive Director and Clinical Chair at the Hospital. The consultant's application will then be scheduled for review by the Hospital Medical Advisory Committee (MAC). In the event any concerns about the application are raised, these are explored further by the Executive Director, with follow up to other stakeholders (such as the NHS Trust(s) and/or other providers where the consultant works, the GMC etc) as necessary.

10.2.5. Based on my understanding of the BMI process as described in 2002, if the application for practising privileges was supported by the Executive Director, the consultant's application would be referred to the Hospital's MAC for approval. The MAC membership at BMI at the time consisted of consultant representatives or specialty leads from all key clinical specialties at the hospital, along with the Executive Director and the Director of Clinical Services/ Director of Nursing of the Hospital. I believe this would have been the case at the time that Mr Eljamel was practising at BMI Fernbrae (2002 – 2013). However, the neurosurgery service was small in comparison to other services at the hospital and therefore the MAC at BMI Fernbrae may not have included a representative for neurosurgery. The only BMI Fernbrae MAC representative that I have been able to identify from CHG's searches is the MAC Chair appointed in 2007 (Dr Matthew Checketts). I have exhibited copies of the BMI MAC Constitutions located through CHG's searches [CHG-00251, CHG-00259, CHG-00307, CHG00308 and CHG-00309]. The MAC Constitution that I believe applied to BMI Fernbrae is CHG-00251.

10.2.6. Based on the documentation setting out the responsibilities of the MAC (for example, CHG-00309), and on my own knowledge from my practice as a consultant, I believe that hospital MACs would routinely consider a consultant's application for practising privileges and seek input from the relevant representative or speciality before a decision to grant or refuse practising privileges was made. If the MAC had a concern about the credentials or experience of a consultant, I expect this would generally be

shared with the BMI hospital's Executive Director and, if those concerns could not otherwise be resolved, practising privileges would not be granted.

10.2.7. During the relevant period at BMI, a consultant's practising privileges were granted for a two-year period. On expiry of that term, a decision would be made by the Hospital's Executive Director regarding renewal of the practising privileges, on advice from the MAC. Before reaching such a decision, data on the consultant's activity and performance would usually be collated and reviewed by the MAC; this process is called a "biennial review". For consultants such as Mr Eljamel, who practised in the NHS as well as privately, the biennial review would usually be informed by the evidence and outcome of the NHS 'full practice' appraisal, which NHS consultants would undergo annually as part of their substantive employment by the NHS Trust (please see section 6.4 of the Practising Privileges policy (September 2003) [CHG-00249_9].

10.2.8. In 2012, the GMC introduced a requirement for doctors to undergo a revalidation exercise every 5-years. This process requires doctors to demonstrate that their skills and knowledge are up to date, and that they are therefore fit to practise and maintain their licence to work in the UK. Without a GMC licence to practise, doctors cannot practise medicine in the UK and would not be able to maintain their practising privileges. The revalidation process is therefore another checkpoint, in addition to the annual appraisal and incident monitoring, for reviewing doctors' practise and ensuring that they are keeping up to date and delivering good care.

(b) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3);

10.3. With regard to question 10(b), I can confirm that:

10.3.1. Based on my own experience, recollection and knowledge, I am aware that clinical governance structures in hospitals across the sector during the time that Mr Eljamel was practising were much less robust than they are now. The

changes and growth in this area have been prompted by evolving legislation, improved regulatory systems and increasing sophistication of regulators and high-profile cases where individuals (such as Paterson re. breast surgery) have been shown to have unsafe or inappropriate practices and retrospective reviews have identified harm to patients. The learning from such issues has heavily informed and improved the current oversight and governance of consultants.

10.3.2. Historically, and in the earlier years of the relevant period, clinical governance concepts were still in their infancy and structures were largely developed and led locally by each BMI Hospital. Over the years, central oversight of local clinical governance structures has developed significantly, culminating in present day sector-wide practice of implementing detailed and robust governance frameworks across hospital groups which ensure the consistent flow of information from ward to board to ward.

10.3.3. To further illustrate the changes in the approach to clinical governance over the relevant period, I exhibit to this statement the following BMI documents:

10.3.3.1. Exhibit CHG-00252 – draft Clinical Governance Strategy, dated 1999

10.3.3.2. Exhibit CHG-00253 – Clinical Governance Overview, dated 1999

10.3.3.3. Exhibit CHG-00254 and CHG-00333 – Clinical Governance policy (draft and clean copy versions), dated 1999

10.3.3.4. Exhibit CHG-00255 – Clinical Governance Management Strategy (Roles and Responsibilities), dated 1999

10.3.3.5. Exhibit CHG-00257 to CHG-00264 – Clinical Governance Management Strategy documents, dated 2003

10.3.3.6. Exhibit CHG-00265 and CHG-00266 – Clinical Governance Overview and Policy, dated 2003 (please note that this document has tracked changes applied. It is my understanding that those tracked changes were made historically and this is the only version of the document held by CHG. Our searches have not located a ‘clean’ or final version of the same).

10.3.3.7. Exhibit CHG-00267 - A Strategic Policy Document For Quality and Risk Management, dated 2007. This was issued by General Healthcare Group, of which BMI Healthcare formed part, and provides an indication of the structure of the Group and the interaction of the component organisations and BMI Hospitals at that time, as well as the regulatory and legal framework it was working under. It also gives some insight into the planned changes and improvements to internal governance structures at that time.

10.3.3.8. Exhibit CHG-00311 to CHG-00314 – Clinical Governance Policy, dated 2010

10.3.3.9. Exhibits CHG-00316 to CHG-00332 – Clinical Governance Policy and Appendices, dated 2013

10.3.3.10. Exhibit CHG-00268 – BMI National Committee Structure – Terms of Reference – June 2015

10.3.4. Internal professional governance of consultants over the relevant period was, as I understand it, largely led on by the MAC as part of the MAC remit to advise the Hospital's Executive Director. The BMI MAC Constitution for Scotland in 2002 [CHG-00251] confirms that the BMI MAC functions included:

10.3.4.1. Advising and making recommendations to the Executive Director and BMI on all aspects of medical audit, including the review of clinical effectiveness and outcome data. This included a review, every 6 months as a minimum, of patient adverse outcomes by specialty, procedure and by clinical responsibility on the clinical work undertaken at the Hospital by all consultants with practising privileges.

10.3.4.2. Advising the Executive Director on the granting, renewing, restriction, suspension and withdrawal of practising privileges of consultants at the Hospital

10.3.5. As is also confirmed in the 2002 MAC Constitution [CHG-00309], in the event the Executive Director or MAC was concerned about the performance of a consultant with practising privileges at the Hospital, it was open to them to convene a Professional Review Panel ("PRP") to consider the consultant's

practice further. As a minimum, the PRP would consist of 3 individuals, one of whom was required to be of the same speciality as the doctor whose practice was under review, commissioning external input if required. A decision about the consultant's practising privileges following PRP review would rest with the MAC and Executive Director, on advice from the PRP.

10.3.6. I have exhibited a copy of GHG's Public Interest Disclosure ("Whistleblowing") Policy, dated September 2003 (introduced in June 2000) which, on the basis that GHG owned BMI, was presumably also applied to BMI hospitals and therefore to BMI Fernbrae [CHG-00269]. My colleagues and I have been unable to locate subsequent versions of this policy, save for those introduced by CHG following its acquisition of BMI in 2020, or any associated documentation to provide further insight of how whistleblowing processes operated and were used during the relevant period. CHG's searches have not located any documents to suggest a similar policy existed before 2000. CHG's searches have not found any evidence that BMI whistleblowing procedures were engaged in relation to Mr Eljamel during his period of clinical practice at Fernbrae in 2002 to 2013.

(c) Broad systems and rules about work patterns within Fernbrae Hospital, balancing work between the NHS and the private sector (ToR 2/ 3) and about supervision/ training of junior colleagues (ToR 2);

10.4. In answer to question 10(c):

10.4.1. It was expected that consultants would only conduct private practice during times when they did not have commitments at other organisations where they worked, such as the NHS [CHG-00334 and CHG-00335]. Consultants working under practising privileges, rather than as employees, are not subject to any requirements to complete a minimum number of hours or attendances at a private hospital. However, where they were providing medical services for BMI during the relevant period, they were required to ensure that they were available, or otherwise had arranged appropriate cover, to oversee the care of their patients throughout the duration of the patient's care journey. As is confirmed in the template Practising Privileges offer letter, consultants were

required to visit patients at least once daily, or more frequently if requested by the Hospital team [CHG-00250].

10.4.2. Unlike in the NHS, the independent sector does not have a model or framework for training junior doctors and junior doctors are not therefore employed in the independent sector and nor are they granted PPs. During the relevant period, all BMI hospitals would have engaged a Resident Medical Officer (RMO). The RMO is a UK registered medical practitioner who provides full-time medical cover at the hospital, including assisting in the management of patients, supporting consultants and attending and assisting the clinical team and consultants in emergencies. The RMO role is a non-training position. Typically, RMOs are engaged through an external agency, although some are employed directly by the private hospitals they work in. While BMI operated a consultant-led care model, and therefore consultants retained responsibility for their patients at all times, consultants with practising privileges would not be expected to play a role in supervising or training RMOs. Noting that BMI Fernbrae was operating for over 10 years within the relevant period, it is likely that there would have been more than one RMO at BMI Fernbrae during this time, owing to common factors such as re-locating, and taking up alternative posts/career progression. CHG's searches have not been able to identify the names of the RMOs that worked at BMI Fernbrae. Given the relatively small size of BMI Fernbrae, it is likely that only one RMO was in post at any given time. The RMO would provide medical support across all services at the Hospital and would not be dedicated to neurosurgery.

10.4.3. Some consultants may engage the use of a Surgical or First Assistant to assist them during a surgical procedure. Where that is the case, supervision by the consultant is expected. The expectations around supervision and management of Surgical and First Assistants are detailed further in the draft Policy for the Certification and Management of Surgical Assistants, dated August 2003 [CHG-00270].

(d) Complaints and feedback systems within Fernbrae Hospital, in particular for patients who received treatment privately and within NHS Tayside (ToRs 4 and 5);

10.5. With regard to question 10(d), I have exhibited copies of BMI's Complaints policy, dated October 2001 [CHG-00336], May 2002 [CHG-00271] and August 2006 [CHG-00337]. I have also exhibited the 2010 version of the Complaints policy [CHG-00273 to CHG-00277]. I have not been able to locate any other versions of this policy for the relevant period through the searches completed to date, or any information relating to local arrangements between BMI Fernbrae and NHS Tayside regarding the sharing of complaints and feedback between the two organisations.

(e) Internal and external information sharing systems, candour, including with patients and the GMC (ToRs 7 and 13);

10.6. In answer to question 10(e):

10.6.1. The terms and conditions under the BMI 2002 practising privileges policy [CHG-00296] included a requirement on consultants to advise the Executive Director of any matters which affect their ability to practise, and of any occurrence or outcome relating to their practise which might reasonably be expected to have the potential of bringing into disrepute their professional standing. This would include, but not be limited to, the following:

10.6.1.1. the commencement of disciplinary proceedings (whether clinically based or otherwise) at any other Hospital or unit at which the consultant practised;

10.6.1.2. any suspension of, or voluntary undertaking by the consultant to limit the scope of, their practising privileges or clinical practice at any other Hospital; or

10.6.1.3. any investigation into their clinical outcomes or clinical practises.

10.6.2. The BMI practising privileges letter also confirms that, by accepting the terms and conditions, the consultant agrees to the Hospital approaching any other hospital or unit at which the consultant practices at and request clinical practice data (on an anonymised basis) to enable it to form a view as to any clinical incident or other issue related to the consultant's clinical practice [CHG-00250, CHG-00262, CHG-00297 to CHG-00299].

10.6.3. CHG's searches have not identified the existence of a formal process during the relevant period for the sharing of information between NHS Tayside and BMI Fernbrae. It should however be noted that the Medical Profession (Responsible Officer) Regulations 2010 did not come into force until 01.01.2011 and therefore the legal framework that now exists for ensuring timely communication of concerns about consultants between organisations did not exist until towards the end of the relevant period.

10.6.4. Our searches have located a copy of the BMI Being Open policy that was first introduced in March 2010. A copy of this and the associated appendices is exhibited [CHG-00279 to CHG-00282]. It appears this policy was reviewed in 2014. I have exhibited a copy of the reviewed version and associated appendices [CHG-00339 to CHG-00342].

(f) The creation and maintenance of effective document management systems over the relevant period and subsequently (ToR 14);

10.7. With regard to question 10(f), I have exhibited the earliest version of the BMI Policy for Retention of Records that our searches have been able to locate [CHG-00283]. This is dated November 2009 and supersedes an earlier version dated February 2003 (we have not found a copy of the earlier version). Please also see my answer to question 6 above. I am unable to assist further on the creation and maintenance of effective document management systems at BMI. I suspect that this may well have been overseen corporately by the Chief Information Officer (or equivalent) and by local management teams, as is the case at CHG now.

(g) Any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues.

10.8. I have no additional information to provide in response to question 10(g).

11. Please explain the neurosurgical service offered at Fernbrae Hospital over the relevant period, including key individuals, roles and responsibilities, with

particular regard to the matters covered by the Inquiry's Terms of Reference and List of Issues.

11.1. For detail on key individuals, roles and responsibilities, please see para 3.7 above and my response to question 8, along with the role of the Executive Director and MAC described in my response to question 10. CHG's searches have located the details of one of BMI Fernbrae's MAC Chairs during the relevant period (Dr Matthew Checketts, appointed in 2007). The searches have not located any documentation revealing the wider MAC membership or other MAC Chairs for BMI Fernbrae during the relevant period. Senior individuals employed at BMI Fernbrae during the relevant period may be able to provide this information. I have identified at paragraph 8.3 those individuals who have been identified through CHG's searches. However, as none of those individuals are employed by CHG, I have not been able to explore that further. I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

11.2. I understand from the available data and historic information that during the relevant period, the neurosurgery service was small and the consultants only consisted of Mr Eljamel and Mr O'Riorden. However, each of these consultants was working as an independent contractor under practising privileges and would not therefore have had a direct working relationship with one another.

12. How did patients come to be referred for neurosurgical care to Fernbrae Hospital over the relevant period? In particular, was there any geographical or other catchment area for potential patients? How else was eligibility to be treated there determined?

12.1. Please see para 3.6 and 3.7 above regarding the services provided at BMI Fernbrae in the relevant period. Patients could seek private medical care and self-fund the treatment or have access via Private Medical Insurance (PMI), or via NHS referrals. The data currently available [CHG-00247] suggests no NHS referrals of patients to the neurosurgery service occurred in relation to Mr Eljamel, and that his patients were all therefore self-funded or funded through PMI. In terms of

eligibility, each hospital would have a clinical criteria for admissions for certain procedures but this would not be geographically determined. Such clinical criteria would apply to all patients, regarding of funding status. CHG's searches have not located any documentation confirming the clinical criteria for admissions during the relevant period.

13. **Please set out the key individuals working within the Fernbrae Hospital neurosurgical team, including lead clinicians within the department. Please also set out the broad responsibilities of each, insofar as relevant to the professional practice of Mr Eljamel, in particular line management responsibilities for Mr Eljamel/ responsibility for (a) surgery planning discussions and (b) the organisation of his clinical sessions?**

13.1. Please see para 3.7 and the response to question 11 above. Responsibility for planning surgery and organising clinical sessions would usually rest with the patient's treating consultant. I am not aware that there was any provision in place during the relevant period for multi-disciplinary team consideration of neurosurgical or spinal surgeries and note that such requirements have only recently been introduced. As independent contractors (rather than employees), consultants were not line managed within BMI Fernbrae. Line management would be via the relevant RO for the consultant – usually in association with their NHS role. This would be subject to GMC scrutiny (albeit pre revalidation this would be reactive not proactive). However, performance was monitored and managed locally via the Executive Director and MAC, in line with the processes described in my response to question 10.

13.2. I have exhibited some Theatre and Medication Charge Sheets from 2012 that were located in CHG's searches [CHG-00348]. These relate to 14 different patients' procedures and detail the names of the consultant anaesthetists and other clinical team members who assisted during those procedures.

13.3. In addition to this information, the information within the available data set [CHG-0024] shows other consultant anaesthetists who had practising privileges at BMI Fernbrae. The only one of these consultants who may have had practising privileges for BMI Fernbrae for at least part of the relevant period was Dr S

Kanakarajan (GMC 5203328). I have not been able to establish if this consultant did support Mr Elajmel's theatres at BMI Fernbrae. The two other anaesthetists that appear on the spreadsheet, Dr M Neil and Dr R Khan, did not obtain practising privileges until 2016.

13.4. I have not been able to establish names of other clinical team members that worked on neurosurgical cases at BMI Fernbrae during the relevant period. These would likely have been members of the Hospital's routine theatre team, which would typically consist of an Operating Department Practitioner, Theatre Nurse(s) and theatre assistants, all of whom would perform clinical tasks within theatres. There would likely have been a Theatre Manager in post during the relevant period; their role would be to oversee the day-to-day operation and staffing of theatre suites. In addition to the theatre team, Mr Eljamel may have been supported by a Surgical Assistant or First Assistant. I have explained these roles in my response to question 23. Such assistance would be engaged where the procedures being performed involve activities that are outside the normal course of duties of the Hospital's Theatre team. CHG has not been able to identify whether Mr Eljamel was assisted by a Surgical Assistant or First Assistant during the period he had practising privileges at BMI Fernbrae. Unfortunately, for the reasons set out in my response to question 6 and at paragraph 8.3 above, CHG is unable to access the details of staff employed prior to 2013 without knowledge of the individuals' names. CHG's searches have not located any rotas or other documentation to help us identify who worked with Mr Eljamel, or how regularly they did so.

14. Please set out the identity of other individuals with whom Mr Eljamel regularly worked over the relevant period and their roles within other departments (clinical and managerial) with whom Mr Eljamel regularly came into contact in his neurosurgical work at Fernbrae Hospital.

14.1. I believe I have addressed this historic detail this to the best of my ability in my responses to questions 8, 10, 11 and 13 above.

15. Please explain the broad trajectory of the work undertaken by Mr Eljamel at Fernbrae Hospital, Dundee during the period he provided neurosurgical services

there, including the nature of the roles he held, the terms and conditions of his employment and the nature of the practising privileges he enjoyed there.

15.1. Please see my response to question 3 above. Mr Eljamel was granted practising privileges to utilise BMI Fernbrae Hospital to deliver medical neurological services to privately funded patients as a consultant neurosurgeon. I have described, in my response to question 6, the searches that have been completed to locate information relating to Mr Eljamel, his patients, and systems, policies and practices during the relevant period. These have not located Mr Eljamel's practising privileges file (which would normally include a copy of a consultant's application, their practising privileges agreement and any supporting documentation). I therefore believe that we do not hold this file, either because it was destroyed or lost prior to notification of the Inquiry.

15.2. Those engaged under practising privileges are not employed by the hospital provider. Please also see my response to para 3.7 above regarding the year-on-year activity details for the procedures performed by Mr Eljamel. His role remained purely a clinical one at BMI Fernbrae during his time under PPs there. Consultants can apply to be a member of the hospital's MAC, including the position of MAC Chair. I am not aware that Mr Eljamel held such a post during his practise at BMI Fernbrae, but CHG searches have not located any MAC documentation to enable this to be verified and I am not aware of any staff members within the business who are able to provide this information. It is possible that one of the former staff members, detailed at paragraph 8.3, may be able to verify this position. However, as those individuals are not employed by CHG, I have not been able to explore that further.

16. What standards was he expected to adhere to in his role at Fernbrae Hospital under (i) the terms of his employment and (ii) his professional obligations?

16.1. As an independent contractor with practising privileges, Mr Eljamel was not employed by BMI or BMI Fernbrae. The terms and conditions of the practising privileges, which include the requirements and responsibilities of consultants, are detailed within the BMI Practising Privileges letter and policy. [CHG-00249, CHG-

00250, CHG-00262, CHG-00263, CHG-00296 – CHG-00301 and CHG-00306] These include requirements on the consultant to:

16.1.1. Practise to a high clinical standard, appropriate to the undertaking of single-handed private practice;

16.1.2. comply with the GMC's Good Medical Practice and other guidelines on professional performance and conduct issued from time to time by the GMC, the UK Medical Royal Colleges or any other professional association relating to the consultant's specialty or other competent agencies on clinical, medical and ethical issues;

16.1.3. hold and continue registration with the GMC and be on the Specialist Register of the GMC;

16.1.4. treat patients for conditions, and within the scope of procedures that fall within the consultant's established normal practice and specialty, as routinely undertaken by them;

16.1.5. maintain a complete set of medical records for each of the consultant's patients;

16.1.6. secure patient consent and to document this within the patient's health record; and

16.1.7. advise the Executive Director of any matters which affect the consultant's ability to practise, and of any occurrence or outcome relating to their practise which might reasonably be expected to have the potential of bringing into disrepute their professional standing, or the reputation or commercial standing of the hospital (including, for example, any investigation into the consultant's clinical outcomes or clinical practises).

17. What products or devices were regularly used in surgery on Mr Eljamel's private patients at Fernbrae Hospital, in particular any products which were unlicensed or where their use was experimental?

17.1. I am unable to answer this question from the knowledge or documentation I have available to me regarding Mr Eljamel's care of private patients at BMI Fernbrae, albeit subject matter experts reviewing patient records from this period may be able to provide insight to this. I do not have any knowledge of who was responsible for the products and devices used by Mr Eljamel at BMI Fernbrae and

CHG's searches have not located any documentation to assist in providing further insight on this.

18. What systems existed (if any) for:

(a) The monitoring of the number and type of and reasons for patients being referred for private treatment from Mr Eljamel's NHS practice?
(b) The workload of Mr Eljamel arising from his commitments to his NHS and private practice over the relevant period, as well as other professional commitments?
(c) The division of responsibility for patients being referred for private treatment from Mr Eljamel's NHS practice?
(d) The monitoring of outcomes for patients being referred for private treatment from Mr Eljamel's NHS practice?

(a) The monitoring of the number and type of and reasons for patients being referred for private treatment from Mr Eljamel's NHS practice?

18.1 I have not been able to establish the answer to question 18(a) based on the searches CHG have conducted of legacy BMI Fernbrae information or data. I am not aware of anyone who would be able to provide information on this. I am aware that in 2003, the Department of Health published a Code of Conduct for Private Practice with which consultants were expected to comply [CHG-00335]. I am not aware of a dedicated system through which consultant adherence to this was monitored and I suspect one is unlikely to have existed.

(b) The workload of Mr Eljamel arising from his commitments to his NHS and private practice over the relevant period, as well as other professional commitments?

18.2 With regard to question 18(b), I am not aware of any system that specifically monitored consultants' NHS or other commitments over the relevant period. I believe this responsibility sat with the consultant, who would also (presumably) discuss workloads and time commitments within the context of performance reviews with their RO within NHS line management.

(c) The division of responsibility for patients being referred for private treatment from Mr Eljamel's NHS practice?

18.3 In answer to question 18(c), the decision to offer private treatment will have rested with Mr Eljamel. The decision to seek privately funded treatment will have rested with the patient. Once a patient came under BMI Fernbrae's services, BMI Fernbrae and Mr Eljamel will have shared responsibilities for the delivery of patient care, reflecting the provider level responsibilities of an independent hospital, and the independent contractor nature of PPs.

(d) The monitoring of outcomes for patients being referred for private treatment from Mr Eljamel's NHS practice?

18.4 With regard to question 18(d), I believe that this would have been, at least in part, monitored via the local MAC. Please see section 2.4 of the MAC Constitution document for 2002 [CHG-00251]. This confirms that one of the functions of the MAC was to: *advise and make recommendations to the Executive Director and the Company on all aspects of medical audit, including the review of clinical effectiveness and outcome data. As a minimum, the Committee shall review not less frequently than every six months, information collated by specialty, procedure and by clinical responsibility on the clinical work undertaken at the Hospital by all consultants with practising privileges*. A footnote to the document confirms that this should include: *as a minimum – overall and peri-operative mortalities; unplanned re-admissions; unplanned returns to theatre; unplanned transfers to other hospitals; adverse clinical incidents; incidence of post-operative DVT; and post operative infection rates for the Hospital.*

18.5 However, documentation located in CHG's searches indicates that in or around 2007, BMI was taking steps towards a more centralised oversight of patient outcomes. I have exhibited copy of the Group Strategic Policy Document for Quality and Risk Management dated March 2007 [CHG-00267].

18.6 CHG's searches completed to date have not been able to locate any patient outcome data for neurosurgery for the relevant period. Based on the clinical governance and MAC documentation referred to earlier in this statement, I believe it is likely that some patient outcome data for neurosurgery will have been available during the relevant period. I suspect however that this was held locally and, for the reasons explained in my response to question 6, has not been retained. I have exhibited, a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

19. Please set out a statistical breakdown of the work undertaken by Mr Eljamel and the other consultants in the Fernbrae Hospital neurosurgical service, including the nature and types of surgery which he/ they undertook there. In particular, please provide this detail relating to the work of Mr Eljamel over the relevant period, broken down into:

(a) Spinal cases, broken down by type of surgery including degenerative spinal cases;

(b) Skull base work;

(c) Neuro-oncology;

(d) Neuro-radiology;

(e) Deep brain stimulation work for movement and other functional disorders including OCD; and

(f) Other types of work undertaken by Mr Eljamel.

19.1 I have exhibited a spreadsheet which provides data on procedure types across all BMI Fernbrae services in the period 2005-2015, reflecting the data that our searches have retrieved from the revenue system (TM1). We have not been able to establish this data prior to 2005 [CHG-00247]. I have also exhibited a separate data set, taken from Ultragenda (patient booking system), which provides details of procedures performed by Mr Eljamel from 2003 [CHG-00248].

20. How complex were the medical issues with which Mr Eljamel's patients presented for treatment/ care?

20.1 Please see my response to question 3 above, including the exhibited spreadsheet which confirms the dates, numbers and nature of surgeries performed by Mr Eljamel over the relevant period [CHG-00248]. Based on this data, I understand that Mr Eljamel performed 40 different procedure types at BMI Fernbrae, the most frequent being lower complexity spinal surgeries. Without subject matter expertise and reviewing patient records, it is difficult to provide further comment as to the relative complexity of the procedures undertaken by Mr Eljamel at BMI Fernbrae.

21. Please set out the surgical (a) re-admission data and rates (b) return to theatre data (c) patient fatality data and (d) waiting times relating to Mr Eljamel's patients, compared to those of his neurosurgical consultant colleagues. How were these aspects of his practice monitored and managed?

21.1 I am unable to answer this question from the knowledge or documentation I have available to me. Please see my response to question 18 above for details on how patient outcome data relating to consultants was monitored at that time. Searches of the legacy incident reporting systems have returned one result for Mr Eljamel. The incident occurred in January 2011 and involved an extended length of stay and return to theatre for a patient [redacted]. The associated report is exhibited [CHG-00285]. Please note that this documentation was sent to us via the GMC with redactions already applied. Our searches indicate that we do not possess a non-redacted copy. I am unable to say whether the reason for the absence of any other incident reports or data is due to it not existing or having been lost/destroyed. I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

22 **How many patients were under Mr Eljamel's care over the relevant period, divided over time periods and by type of medical issue being treated?**

22.1 I have exhibited details of procedures undertaken by Mr Eljamel over the relevant period at BMI Fernbrae [CHG-00248]. This data describes the procedure type but does not specify the medical condition the procedure is treating,

specifically (such information should be available in each individual patient's medical records).

23 **What proportion of professional responsibilities in the care and treatment of Mr Eljamel's patients was undertaken by him and what proportion was undertaken by junior colleagues in training?**

23.1 Please see my response to para 10.4.2 above regarding the absence of any trainee clinicians in BMI Fernbrae. Surgical care and treatment for patients would likely have been the sole responsibility of Mr Eljamel. In delivering that care, he would have been supported by nursing and clinical teams in the theatres and on the wards. If Mr Eljamel engaged the support of another surgeon when performing surgery, that surgeon would share surgical responsibility for the patient. It seems unlikely that such an arrangement would have been engaged by Mr Eljamel at BMI Fernbrae, as I understand the main procedures he performed there were generally lower complexity spinal surgeries (please see paragraph 3.8). In the event a patient required input from another doctor or consultant during the course of their care journey, that individual would be responsible for the care that they provided.

23.2 Surgeons at BMI Fernbrae may have been directly assisted during a surgical procedure. During the relevant period I would expect that this would have been through the support of a Surgical Assistant or First Assistant. Individuals undertaking either role may be a registered medical practitioner, a registered nurse, or a suitably trained and/or experienced Operating Department Practitioner. There is a distinction between the two roles. A Surgical Assistant works as part of the surgical team and provides skilled assistance to the surgeon undertaking the relevant procedure, but may not be under that surgeon's direct supervision at all times. The First Assistant provides skilled assistance under the direct supervision of the surgeon. Typically, a First Assistant would be engaged by the Hospital rather than the surgeon. In contrast, the Surgical Assistant may be employed or engaged by the Hospital or by the surgeon.

23.3 Such assistance would be engaged where the procedures being performed involve activities that are outside the normal course of duties of the Hospital's

Theatre team. CHG has not been able to identify whether Mr Eljamel was assisted by a Surgical Assistant or First Assistant during the period he had practising privileges at BMI Fernbrae. It may be possible to establish this through a closer review of the medical records of his former patients, however we appreciate the Inquiry is being informed by independent clinical reviews, which may provide this information based on reviews of each patient record, where available. Unfortunately, for the reasons set out in my response to question 6 and at paragraph 8.3 above, CHG is unable to access the details of staff employed prior to 2013 without knowledge of the individuals' names. CHG's searches have not located any rotas or other documentation to help us identify who worked with Mr Eljamel, or how regularly they did so.

24 **How did the numbers under his care over that period compare with averages for patient numbers under the care of neurosurgeons at his various levels of seniority?**

24.1 I do not have the knowledge, data or expertise to provide analysis or comment on this issue, or opine on comparative data issues. As indicated at paragraphs 3.7 and 3.8, based on the data within CHG-00247, there were three consultant neurosurgeons who performed surgeries at BMI Fernbrae during the relevant period. CHG has only been able to locate this data for part of the relevant period, running from 2005 to 2015. Based on that data, the volumes for those consultants were:

24.1.1 Mr Eljamel (2005 to 2013): 422 surgeries (although note that a separate data set, based on Ultragenda (patient booking system) provides data for Mr Eljamel from 2003 to 2015, with a total number of procedures at 483 [CHG-00248].

24.1.2 Dr O'Riordan (2007 to 2013): 20 surgeries

24.1.3 Mr Demetriades (2014 and 2015): 247 surgeries

25 **What interview/ assessment process was undertaken in connection with Mr Eljamel's appointment to this role at Fernbrae Hospital and by whom were these undertaken?**

25.1 Mr Eljamel was granted practising privileges in December 2002. These will have been granted by the Executive Director in post at BMI Fernbrae at that time. Our searches indicate that this was either Anne Miller or Kenneth Hay. Unfortunately, the legacy system does not resolve the apparent overlap in post for these respective individuals. CHG has been unable to locate the BMI Fernbrae practising privileges file for Mr Eljamel to further check the papers he submitted for his application, or how these were considered by the hospital at that time, or who else was involved in that process in 2002. I have described, at paragraphs 10.2.1 to 10.2.3, the process that I understand would have been followed at the time, based on the documentation relating to practising privileges and the MAC during the relevant period [CHG00296 – CHG00301, CHG-00305, CHG-00306, CHG-00307 – CHG-00309]. As hospitals would be expected to create a record evidencing the practising privileges application and subsequent monitoring of consultant performance, I believe it is likely that a practising privileges file for Mr Eljamel existed, but has either been lost or destroyed prior to knowledge of the Inquiry. It is possible that Anne Miller or Kenneth Hay could provide further information on this but, as neither individual is employed by CHG, I have been unable to explore that further.

25.2 I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

25.3 From my own experience as a consultant orthopaedic surgeon working in private practice, I am aware that the process of applying for practising privileges involved completion of an application form with evidence of GMC registration, entry on the appropriate specialist register to evidence completion of specialty training along with appropriate medical indemnity. Once complete, there was a formal discussion with the hospital director. Each individual applicant was then discussed with the MAC. References were also obtained to verify the quality of clinical care from colleagues at the local NHS trust.

26 **Why and by whom was the decision to award him this role arrived at?**

26.1 I believe I have answered this question to the best of my ability in responses to questions 10(a) and 25 above.

27 **What qualifications and other experience did he present as part of his application?**

27.1 I believe I have answered this question to the best of my ability in my responses to questions 10(a) and 25 above.

28 **What investigation was undertaken by CHG or its predecessor bodies of the material presented in support of his application including, in particular, any concerns which had been raised about his professional practice before his time in Tayside?**

28.1 I believe I have answered this question to the best of my ability in my responses to questions 10(a) and 25 above.

29 **In particular, what investigations were undertaken relating to/ with:**

a) Mr Eljamel's medical qualifications from Libya, in particular with Tripoli Medical School;
b) The Royal College of Surgeons in Ireland;
c) The Walton Centre for Neurology and Neurosurgery, Walton Hospital, Liverpool, where he claimed to have been a Senior House Officer in Neurosurgery;
d) The Beaumont Hospital in Dublin, Ireland;
e) Liverpool University;
f) The Royal College of Surgeons; or
g) Hartford Hospital in Connecticut, USA.

29.1 Unfortunately, I have no additional information or data from BMI Fernbrae from 2002 upon which base a response to the above question. I believe I have therefore answered this question to the best of my ability in my responses to questions 10(a) and 25 above.

30 **What was the outcome, if any, of those investigations?**

30.1 See para 29.1 above.

31 **What reliance was placed on the information presented in awarding him the role?**

31.1 See para 29.1 above.

32 **How accurate was the information presented? Had any inaccuracies been brought to light, what difference would they have made to the success of the application?**

32.1 See para 29.1 above. I am sorry not be able to add to the information in this regard.

33 **What assessment was undertaken by CH or its predecessor bodies of Mr Eljamel's surgical/ technical capabilities and experience? Was that assessment adequate?**

33.1 I have answered this question to the best of my abilities in my responses to questions 10(a), 25 and 29.1 above. We have no legacy BMI information to inform this issue from 2002.

34 **What assessment was undertaken by CH or its predecessor bodies of Mr Eljamel's (a) communication/ interpersonal engagement skills (internally and externally) and (b) ability to train others?**

34.1 CHG has been unable to locate the practising privileges file for Mr Eljamel to further check the papers he submitted or how these were considered by the hospital at that time, or who else was involved in that process. With regard to question 35(a), I have described, at paragraphs 10.2.1 to 10.2.3, the process that I understand would have been followed when considering applications for practising privileges during the relevant period. This is based on the documentation relating to practising privileges and the MAC during the relevant period [CHG-00417-CHG-00439, CHG00296 – CHG00301, CHG-00305 - CHG-

00309]. This documentation does not however specifically address how communication or interpersonal engagement skills were considered and, from my own experience, I do not believe a dedicated assessment of these skills formed part of the process when considering applications for practising privileges. Noting the process that is described within the documentation referred to above, I believe however that the process allowed opportunity for individuals to flag if they had sufficient concern about the consultant's skills in this regard.

34.2 With regard to question 35(b), it should however be noted that it is unlikely there would have been assessment of Mr Elajamel's ability to train others as, unlike in the NHS, the independent sector does not have a model or framework for training junior doctors and junior doctors are not therefore employed in the independent sector. Training of colleagues would not therefore typically form part of the role of a consultant being granted PPs in the independent sector in 2002.

35 **What was the nature of the inductions which Mr Eljamel received for his role at Fernbrae Hospital?**

35.1 CHG has been unable to locate the practising privileges file for Mr Eljamel to further check the information that was provided to him on awarding him practising privileges in 2002, or who was involved in his induction at the hospital. Based on my own experience as a consultant orthopaedic surgeon working in private practice during the relevant period, on confirmation of practising privileges and before commencement of clinical work, it was (and remains) usual practise to have a further meeting with the hospital director and wider senior management team to include heads of departments to help orientate the consultant in to the hospital workings and culture

35.2 It is likely that any induction would have been developed locally at BMI Fernbrae. It appears a formal induction policy was first introduced at BMI in 2010 [CHG-00344 and CHG-00345] and updated in 2013 [CHG-00346 and CHG-00347].

35.3 I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

36 **How might concerns regarding Mr Eljamel's professional practice have been brought to the attention of CH or its predecessor bodies either (a) arising from his practice within Fernbrae Hospital or (b) arising from his NHS practice?**

36.1 Based on BMI's legacy policies available, there was a process for patients to raise concerns or complaints and for those to be investigated and responded to [CHG-00271, CHG-00273 – CHG-00277, CHG-00336, CHG-00337]. There was also a whistleblowing policy and process, through which colleagues could raise concerns [CHG-00269]. These matters were also underpinned by the BMI Being Open policy for some of the relevant period [CHG-00279 – CHG-00282, CHG-00344 to CHG-00347].

37 **In particular, what systems existed for information sharing between the body with responsibility for Fernbrae Hospital, Dundee and NHS Tayside relating to concerns or issues with Mr Eljamel's professional practice over the relevant period?**

37.1 I have not been able to locate any information relating to any local arrangements between BMI Fernbrae and NHS Tayside regarding a formal system (if one existed) for the sharing of concerns or issues with Mr Eljamel's practice between the two organisations. It should however be noted that the Medical Profession (Responsible Officer) Regulations 2010 (the "Regulations") did not come into force until 01 January 2011 and therefore the legal framework that now exists for ensuring timely communication of concerns about consultants between organisations did not exist until towards the end of the relevant period. These Regulations set out the responsibilities of Responsible Officers (ROs). A RO is accountable for the local clinical governance process in their healthcare organisation, with a focus on the conduct and performance of doctors. The responsibilities set out within the Regulations include a requirement to:

37.1.1 ensure medical practitioners have qualifications and experience appropriate to the work to be performed, that appropriate references are obtained and checked and to take any steps necessary to verify the identity of medical practitioners;

37.1.2 review performance information held by their healthcare organisation, including patient outcomes and identify and respond to any concerns arising from that information;

37.1.3 ensure medical practitioners receive regular appraisal;

37.1.4 ensure procedures are in place to investigate concerns about a medical practitioner and, where appropriate, (a) take any steps necessary to protect patients and (b) recommend to the medical practitioner's employer that the practitioner should be suspended or have conditions or restrictions placed on their practise. Under this responsibility, ROs are expected to share information with other organisations where the medical practitioner works where this is appropriate to safeguard patient safety;

37.1.5 where appropriate, refer concerns about the medical practitioner to the GMC; and

37.1.6 make recommendations to the GMC about medical practitioners' fitness to practise.

37.2 On an informal basis however, there would at the relevant period (particularly towards the end of the relevant period) be potential for medical director to medical director (or hospital director) discussions from a patient safety or a consultant performance perspective regarding any concerns. In relation to Mr Eljamel, CHG searches have identified an email from BMI's former Group Medical Director, Dr Mark Ferreira, and the Executive Director of BMI Fernbrae, Louise Buchan, confirming that Dr Ferreira had spoken to the Medical Director of NHS Tayside, Dr Russell, by telephone on 01 August 2014. The telephone call was in relation to the concerns that had emerged about Mr Eljamel [CHG-00287]. Our searches to date have not located any emails between NHS Tayside and BMI Fernbrae regarding Mr Eljamel. The conversation and email of 01 August 2014 occurred after Mr Eljamel had ceased clinical practice at BMI Fernbrae.

38 **What systems existed for the monitoring or assessment of Mr Eljamel's technical and other patient care responsibilities in the maintenance of his practising privileges for his role at Fernbrae Hospital, Dundee?**

38.1 Please see my responses to questions 10 and 18(d) above. In the earlier part of the relevant period, monitoring of consultant performance and outcomes was primarily carried out by the local MAC, which was required to review clinical effectiveness and outcome data every 6 months [CHG-00251, CHG-00293, CHG-00305, CHG-00307 – CHG-00309]. Documentation located in CHG's searches indicates that in or around 2007, BMI was taking steps towards a greater degree of centralised oversight of patient outcomes, although the local MACs will likely have continued to perform individual oversight [CHG-00267, CHG-00268, CHG-00311, CHG-00314 and CHG-00316 - CHG00332]. For the reasons explained in my response to question 6, CHG's searches have not been able to locate documentation to provide further useful detail on specifically how the shift towards centralised oversight progressed during the relevant period.

38.2 As is outlined in the 2002 MAC Constitution, in the event the Executive Director or MAC was concerned about the performance of a consultant with practising privileges at the Hospital, it was open to them to convene a Professional Review Panel ("PRP") to consider the consultant's practice further [CHG-00251]. As a minimum, the PRP would consist of 3 individuals, one of whom was required to be of the same speciality as the doctor whose practice was under review, commissioning external input if required. A decision about the consultant's practising privileges following PRP review would rest with the MAC and Executive Director, on advice from the PRP.

38.3 In addition, during the relevant period at BMI a consultant's practising privileges were granted for a 2-year period. On expiry of each 2-year term, a decision would be made by the Hospital's Executive Director regarding renewal of the practising privileges, on advice from the MAC. Before reaching such a decision, data on the consultant's activity and performance would be collated and reviewed by the MAC; this process is called a "biennial review". For consultants such as Mr Eljamel, who practised in the NHS as well as privately, the biennial review would usually be informed by the evidence and outcome of the NHS 'full

practice' appraisal, which NHS consultants would undergo annually (please see section 6.4 of the Practising Privileges policy (September 2003)) [CHG-00249].

38.4 In 2012, the GMC introduced a requirement for doctors as GMC registrants to undergo a revalidation exercise with the GMC every 5-years. This process requires doctors to demonstrate that their skills and knowledge are up to date, and that they are therefore fit to practise and maintain their licence to work in the UK.

39 **In particular, what role/involvement did NHS Tayside have, if any, in any such systems?**

39.1 NHS Tayside was not directly involved in BMI Fernbrae's internal process for monitoring consultant performance. However, as part of a consultant's biennial review and in line with the process described in the Practising Privileges policy during the relevant period, I would expect that BMI Fernbrae would have obtained a copy of Mr Eljamel's NHS 'full practice' annual appraisal to inform the decision regarding the appropriateness of renewing his practising privileges. I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

39.2 CHG's searches completed to date have not found any evidence that BMI Fernbrae was made aware of any concerns by NHS Tayside during the period that Mr Eljamel held practising privileges at Fernbrae. The only email identified is that referenced in para 37.2 above, and exhibited [CHG-00287].

40 **To what extent, on what grounds and by whom could complaints or concerns about the professional practice of a consultant neurosurgeon, such as Mr Eljamel, have been raised with CH or its predecessor bodies over the relevant period or subsequently? In particular: (a) What action or censure was CH empowered to take with regard to such issues? (b) Were any such systems of raising complaints or concerns available to members of the public, including patients? (c) What whistleblowing opportunities/ mechanisms did CH provide for other surgeons or staff members regarding the performance or conduct of neurosurgical consultants, like Mr Eljamel?**

(a) What action or censure was CH empowered to take with regard to such issues?

40.1 In relation to 40(a), in the event concerns had been raised with BMI Fernbrae regarding Mr Eljamel's competence or conduct, during a period where Mr Eljamel held PPs at Fernbrae, a process was in place to establish a panel to investigate the issue and decide what action needed to be taken in the event the concerns were substantiated [CHG-00251]. Ultimately BMI Fernbrae could terminate any consultant's PPs in the event it was considered that they did not meet the requirements and expectations set out under the PP arrangements. Referral to the GMC would also be a route open to anyone with concerns, including BMI Fernbrae if they had received such concerns and considered referral was required.

(b) Were any such systems of raising complaints or concerns available to members of the public, including patients?

40.2 In relation to patients (40(b)), BMI had a complaints process in place [CHG-00271 and CHG-00273 to CHG-00277, CHG-00336 and CHG-00367].

(c) What whistleblowing opportunities/ mechanisms did CH provide for other surgeons or staff members regarding the performance or conduct of neurosurgical consultants, like Mr Eljamel?

40.3 In relation to colleagues, (40(c)), BMI/CHG had an established policy for whistleblowing concerns including investigation and management [CHG-00269]. The relevant period in the Inquiry predates the now well-established Freedom to Speak Up (FTSU) processes in place sector-wide.

41 **What systems existed for sharing information relating to such complaints or concerns being raised between CH or its predecessor bodies and NHS Tayside?**

41.1 The PP policy sets out the expectations placed on consultants regarding self-disclosure of concerns raised in their NHS practice that would be relevant to their private practice.

41.2 I have not been able to locate any information relating to any local arrangements between BMI Fernbrae and NHS Tayside regarding a formal system (if one existed) for the sharing of concerns or issues with Mr Eljamel's practice between the two organisations. It should however be noted that the Medical Profession (Responsible Officer) Regulations 2010 did not come into force until 01 January 2011 and therefore the legal framework that now exists for ensuring timely communication of concerns about consultants between organisations did not exist until towards the end of the relevant period. I have provided further detail on that legal framework at paragraph 37.1 above.

41.3 Please see para 37.2 above regarding informal communications between NHS Tayside and BMI Fernbrae regarding Mr Eljamel's clinical practice [CHG-00287].

42 **Were any such complaints or concerns raised? If so, (a) by whom? (b) When? (c) What was the nature of the complaint or concern? (d) What process or investigation took place? (e) What was the outcome/ how were the complaints or concerns resolved? In answering this question, please make clear whether the complaints or concerns which were raised related to Mr Eljamel's professional practice at Fernbrae Hospital or his NHS practice.**

42.1 The records located in CHG's searches indicate that the first complaint regarding Mr Eljamel's practise at BMI was notified to Fernbrae in April 2014, after Mr Eljamel's practising privileges had been withdrawn. The complainant was Mrs [redacted]. It appears that the complainant in that case made the complaint to the GMC in February 2014, rather than directly to BMI. The GMC subsequently informed BMI of the complaint and requested BMI to provide any information that may be relevant to their investigation into the concerns. BMI's response confirmed that there had been no other complaints, incidents or concerns raised about Mr Eljamel during the period he had PPs at Fernbrae. The GMC contacted BMI in August 2014 confirming that their investigation into the patient's complaint had closed without further action. Copies of the correspondence relating to this matter are exhibited. [CHG-00285, CHG-00293]. Please note that CHG-00285 was sent to us via the GMC with redactions already

applied. Our searches indicate that we do not possess a non-redacted copy BMI Fernbrae received complaints from other patients of Mr Eljamel in June 2014 (1 complaint raised by CAT D) [CHG-00402 – CHG-00416, CHG-00441 and CHG-00286_30-59], July 2014 (1 complaint concerning CAT D) [CHG-00286_24-29, CHG-00400, CHG-00440, and CHG-00401], August 2014 (1 complaint CAT D) [CHG-00286_19-21 and CHG-00392, CHG-00393, and CHG-00394], September 2018 (1 complaint raised by CAT D) [CHG-00395, CHG-00396, CHG-00397, CHG-00398 and CHG-00399], and in November 2018 (2 complaints – one of which was from CAT D who had originally complained to the GMC in February 2014) [CHG-00286_10-18 and CHG-00293] and another raised by CAT D [CHG-00286_4-9 and 60 and CHG-00292]. BMI Fernbrae was also notified of a potential claim by a patient (CAT D) in March 2016 [CHG-00286_1-3]. Between 2014 and 2018, a total of 8 BMI patients had raised concerns regarding Mr Eljamel.

42.2 The actions taken by BMI in response to the complaints are detailed through the exhibited correspondence as outlined above. In broad terms, the concerns were reviewed and responded to. In response to the complaint by CAT D , an independent review of the patient's care was obtained. That review was completed in November 2014 by Professor Peter Hutton, (part of FH Partnership), who it appears (based on a GMC search) was a consultant anaesthetist with the GMC number: 2430524 [CHG-00286_45-54]. The report also indicates that input from a specialty advisor was also sought, but the name and details of that individual are not cited in the document. The report concluded that it appeared that Mr Eljamel had "*seriously misinterpreted the MRI scan on 31st August 2010 and subsequently undertook an unnecessary operation*". It further indicated that this raised a question as to "*whether or not Prof SE has the clinical competence to work as an unsupervised consultant in this area of practice*". Louise Buchan, Executive Director of BMI Fernbrae, also made the decision to refer the concerns arising from CAT D 's case to the GMC, and provided the GMC (Jonathan Hall, GMC Investigating Officer) with a copy of FH Partnership's report. That notification was sent on 11 November 2014 [CHG-00290_11]. A decision to refer the case to the GMC was also made in relation to the concerns about CAT D 's care. That step was taken by/on the advice of Group Medical Director, Mark Ferreira, in or around August 2014 [CHG-00400, CHG-00440 and CHG-00401. The reason for

these decisions is not specified but I presume was due to those involved having considered that the nature of the concerns were sufficiently serious to warrant this action. It also appears that BMI's Medical Director (Mark Ferreira) had a discussion about the emerging concerns with NHS Tayside's Medical Director (Dr Russell) on 01 August 2014 [CHG-00287]. At this stage, BMI had received 3 patient complaints CAT D, CAT D and CAT D (as outlined above). Based on that discussion, BMI decided that a retrospective review of Mr Eljamel's BMI patients was not required. The details of that discussion are summarised in an email from Mr Ferreira to Louise Buchan, the Executive Director of BMI Fernbrae, dated 01 August 2014 [CHG-00287].

42.3 Please also see my response to question 43 below.

43 **What intimation was made to CH or its predecessor bodies of the following events, including procedures taken leading to the following events:**

(a) Mr Eljamel's clinical supervision within NHS Tayside on 21 June 2013 (ToR 8);
(b) Mr Eljamel's suspension by NHS Tayside on 10 December 2013 (ToR 9);
(c) Mr Eljamel's resignation from his position with NHS Tayside on 31 May 2014 (ToR 10); or
(d) The voluntary removal of Mr Eljamel's name from the GMC medical register in 2015 (ToR 11).

Please explain the broad actions taken by CH or its predecessor bodies as a result of any such intimation.

43.1 An internal email sent by Louise Buchan, Executive Director of BMI Fernbrae, on 19 December 2013 indicates that Mr Eljamel had informed BMI in July 2013 that he was unwell and that he had not treated a patient at Fernbrae since then [CHG-00288]. Theatre Registers covering the period from 12 August 2013 - 14 August 2014, show no lists for Mr Eljamel, further confirming the likelihood that no procedures were undertaken at BMI Fernbrae after July 2013 [CHG-00445]. On 10 December 2013, Mr Eljamel wrote to the Executive Director (Louise Buchan) of BMI Fernbrae to inform her that he had been suspended from

his NHS post [CHG-00288_9]. This appears to be the documented date that BMI was first notified of concerns relating to Mr Eljamel. It was noted in Louise Buchan's email dated 19 December 2013 that the suspension was due to a number of patient complaints in the NHS and concern around the incidence of surgery being performed at the incorrect spinal level [CHG-00288_3]. In response to this communication, I understand that BMI terminated Mr Eljamel's PPs. The data [CHG-00247 and CHG-00248] supports that this action was taken, as there is no activity for Mr Eljamel after June 2013. However, if a letter was sent to Mr Eljamel to confirm that his PPs had been withdrawn, CHG's searches have not located this.

43.2 BMI were also informed on 24 February 2014 by the GMC that the concerns regarding Mr Eljamel were being investigated by the GMC, as Mr Eljamel's professional body [CHG-00288_6]. The GMC further contacted BMI in April 2014 [CHG-00285] regarding a separate investigation they had opened following receipt of a complaint from a BMI patient [redacted], the details of which are provided at paragraph 42.1 above.

43.3 In August 2015, BMI was notified that Mr Eljamel had obtained voluntary erasure from the GMC register, which had prompted the GMC to close their investigation. The GMC notified BMI of this on 13 August 2015 [CHG-00288_10].

44 **What intimation was made to CH or its predecessor bodies about the investigations listed in ToR 12 being commissioned and why they were commissioned when they were? When was any such intimation made?**

44.1 Please see paragraphs 43.1 to 43.3 above. Searches have only revealed the documents/communication exhibited to this statement. It is possible that some additional knowledge was held locally. I have detailed known staff members who may be able to assist at paragraph 8.3 above. As they are no longer employed by CHG, I have been unable to explore this further.

45 **What involvement did CH or its predecessor bodies have in any of these investigations, including any role in fixing their scope, the identity of the party carrying them out or their process? Please set out the identity of key individuals**

within CH or its predecessor bodies who had such involvement and the broad role they played.

45.1 Aside from sharing information with the GMC, as described at 42.1 and 42.3 above, I am not aware of any involvement of BMI in these processes and no searches have identified evidence of this to date in relation to the investigations referred to in ToR 12.

46 **What intimation was made to CH or its predecessor bodies of the outcomes, findings or reports of these investigations? When was any such intimation made? What, if any, action was taken by CH or its predecessor bodies or was CH or its predecessor bodies aware of being taken by NHS Tayside as a result of these investigations?**

46.1 Please see paragraphs 43.1 to 43.3 above. Searches have only revealed the documents/communication exhibited to this statement. It is possible that some additional knowledge was held locally. I have detailed known staff members who may be able to assist at paragraph 8.3 above. As those staff are no longer employed by CHG, I have been unable to explore this further.

47 **What involvement in these investigations would CH or its predecessor bodies have expected to have had which it did not and why?**

47.1 I am unable to comment on what local arrangements might suggest BMI's expectations were in 2013/14 in relation to the investigations and CHG's searches have not identified any documentation to provide further insight on this. I have detailed known staff members who may be able to assist at paragraph 8.3 above. As those staff are no longer employed by CHG, I have been unable to explore this further. It is fair to reflect that in 2026 close collaboration between organisations would probably occur, however in 2013/14 this was less likely to be routine practice as coordination and information sharing across the sector was less well-embedded. From a patient safety perspective, one would anticipate safety concerns being explored with organisations where a clinician is providing patient care, to ensure patient safety is maintained.

48 **Please set out the broad locations of where documents thought to be relevant to the requests made in this rule 8 request were stored, including hard copy or electronic systems, and the identity of the party who or which controls or administers such systems.**

48.1 I believe I have answered this to the best of my ability in my response to question 6 above.

49 **As far as the searches for documents undertaken by CH as per the request made in Appendix C below are concerned, as regards of the categories of documents which has been requested:**

(a) Please indicate what searches for documents have been undertaken for each category, including where such searches were undertaken and why these searches were thought to be comprehensive as regards the documents sought in each category, including details of search terms used on electronic systems of document storage;

(b) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of CH, please identify what these are;

(c) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of CH, please identify broadly what has happened to them (including whether they have been lost or destroyed and, if so, when and why); and

(d) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of CH and CH is aware of these being held by or on behalf of another party, please indicate the nature of these documents and by whom CH believes them to be held.

49.1 Please see the detail provided in response to question 6 above. I have exhibited a spreadsheet detailing the searches CHG has undertaken, by whom

and when, as well as any limitations on those. This spreadsheet also provides an overview of the output from those searches [CHG-00289].

50 **Please certify that the documents which have been produced in response to this rule 8 request are, to the best of CH's knowledge and belief, all documents held by CH, on its behalf or under its control.**

50.1 I certify that the documents which have been produced in response to the Inquiry's rule 8 request are, to the best of CHG's knowledge and belief, all documents held by CHG, on its behalf or under its control.

I believe that the facts stated in this written statement are true.

Signed CAT C .....

Dated Wednesday 13 May 2026