

1 Wednesday, 26 November 2025 2 (10.00 am) 3 (Proceedings delayed) 4 (10.06 am) 5 Housekeeping 6 LORD WEIR: May I once again welcome all those who have 7 attended the hearing suite in Edinburgh this morning and 8 also those who are watching and listening to the 9 proceedings remotely to the Inquiry's opening statements 10 hearing. 11 Today marks the next important staging post in the 12 Inquiry's progress as we move away from its necessary 13 but preliminary establishment phase. 14 As its description suggests, the principal purpose 15 of this hearing is to provide a forum for core 16 participants, through their recognised legal 17 representatives, to make opening statements on matters 18 of interest and importance to them arising from the 19 terms of reference fixed by the Cabinet Secretary for 20 Health and Social Care. 21 And also the Inquiry's list of issues, an updated 22 version of which is on the Inquiry website, following 23 the informative period of consultation which followed 24 its original publication and circulation. 25 But the opening statements hearing also serves Page 1	1 engage constructively and to communicate with all of 2 those who are interested in its work. I therefore hope 3 that you will find the hearing to be informative and 4 useful, but I also immediately recognise that the issues 5 likely to be covered remain very difficult and 6 challenging for many. Can I therefore reiterate to all 7 those who are in attendance, or otherwise interested in 8 the Inquiry's work, of the importance of interacting 9 with others with courtesy and respect. 10 As I said on the last occasion but it merits 11 emphasis, it is in such a spirit that the Inquiry is 12 likely to obtain the best possible evidence to support 13 its investigations going forward. 14 In terms of today's practical arrangements, it would 15 be my intention to have a mid-morning break in about one 16 hour from now and we will aim to take a one hour break 17 for lunch at about 1 o'clock. 18 And so with that brief introduction I will now 19 invite Mr Dawson to address the hearing. Mr Dawson, 20 when you're ready. 21 Opening statement by MR DAWSON 22 MR DAWSON: Good morning, sir. I am Jamie Dawson KC and 23 I appear as senior counsel to the Inquiry, along with my 24 learned juniors, Ms Alex Price-Marmion and 25 Mr Cameron Smith, advocates at this opening statement Page 3
1 another very important purpose and that is to provide 2 an opportunity for the Inquiry to provide you all with 3 an update on its work since the preliminary hearing on 4 10 September this year. 5 Senior counsel to the Inquiry circulated in advance 6 of today a detailed outline of where matters stand in 7 that respect and it has been and is open to the 8 representatives of core participants to make submissions 9 on matters arising from that update, as well. 10 Pursuant to the agenda prepared for this hearing and 11 also circulated in advance you may expect to hear 12 submissions this morning from Mr Dawson and thereafter 13 from counsel representing core participants represented 14 by Levy & McRae, NHS Tayside, the Scottish Ministers, 15 the Royal College of Surgeons of Edinburgh, 16 Healthcare Improvement Scotland and NHS Education for 17 Scotland. 18 At my invitation, the chair of the Independent 19 Clinical Review, Professor Wigmore, has also caused 20 a submission to be tendered on behalf of that process 21 and I am grateful to Mr McGillivray for attending the 22 hearing to speak to that submission at the appropriate 23 time. 24 The holding of a bespoke opening statements hearing 25 reflects the Inquiry's previously stated commitment to Page 2	1 hearing of the Eljamel Inquiry. 2 This is the second of the Inquiry's public hearings, 3 a preliminary hearing having taken place on 10 September 4 of this year. As at that hearing, the Inquiry team and 5 you, sir, are joined in the Inquiry's hearing space for 6 this two-day hearing at Waverley Gate in central 7 Edinburgh by a number of core participants or members of 8 the public who are attending in person in the public 9 gallery; by a number of members of the media who are 10 present in the building, watching the proceedings from 11 the media room; by a larger number of core participants 12 or core participant representatives and members of the 13 public and media who are joining us via the livestream, 14 which the Inquiry makes available for those who cannot 15 or do not wish to join us in person but who take 16 an interest in our work; and by legal representatives of 17 our core participants who will play a more active part 18 in this hearing than they were called upon to do at the 19 preliminary hearing in September, as I will come to 20 explain. 21 All are very welcome. 22 As was the case at our preliminary hearing 23 in September, the video feed on YouTube will be 24 transmitted with a delay of a few minutes. This 25 mechanism is part of the systems we have in place to try Page 4

1 to prevent any confidential information being 2 transmitted to the wider public which should not be. 3 Those who have submitted written opening statements have 4 kindly refrained from mentioning individuals in them 5 whom they do not represent or beyond those whose names 6 they are clear can be published. In such cases they are 7 provided or will provide the Inquiry with the actual 8 names separately. This will assist with our 9 investigations but respects also the need for 10 individuals not to be named at this public hearing who 11 have not had the opportunity to apply to ask you, sir, 12 to pronounce a restriction order protecting their 13 identity. 14 I would ask those who are making oral contributions 15 to continue to be vigilant about that in their 16 statements and to avoid naming individuals on whose 17 behalf they cannot speak, in accordance with those 18 principles and aims. 19 In the event that something is said by me or by 20 another contributor which seems to us to contain 21 information which ought not to have been referred to, 22 I will instruct those who are managing the YouTube 23 transmission to cut the feed. They will stop the 24 transmission and we will most likely have a short break 25 to work out how we need to proceed. My apologies in Page 5	1 focus of our preliminary hearing and the need, at this 2 point in our planning, to start to make progress with 3 our substantive investigations which our terms of 4 reference demand that we do. 5 In particular, core participants were asked to cover 6 matters in their statements including the following: 7 contributions were sought which focused on the substance 8 of the Inquiry's work as opposed to procedural matters, 9 including aspects of the Inquiry's terms of reference 10 and list of issues as updated to October 2025 11 post-consultation with core participants; of particular 12 importance to a core participant group; or meriting 13 particular or particularly detailed attention on the 14 part of the Inquiry and why; particular features of 15 neurosurgery undertaken or proposed for Mr Eljamel's 16 patients where core participants felt that things could 17 have gone better or lessons could be learned through the 18 Inquiry process; the extent to which it is submitted 19 that the Inquiry's remit should extend beyond Mr 20 Eljamel's practice at Ninewells Hospital into other 21 parts of the NHS, for example other hospitals at which 22 he may have practiced, for example Dundee Royal 23 Infirmary or within NHS Fife. 24 Other rules which could fall within term of 25 reference 1 relating to appointments beyond those listed Page 7
1 advance for any interruption which we may need to make 2 of submissions of others for this purpose. This is why 3 it will be necessary to do so. 4 Any such information which is inadvertently referred 5 to must not be referred or otherwise shared outwith this 6 room and is subject to the Inquiry's first order 7 covering those in attendance including members of the 8 media. 9 The plans for this hearing. Sir, the purpose of 10 this hearing is primarily to hear from our core 11 participants via their legal representatives. It is the 12 right of the legal representative of a core participant 13 in the Inquiry to make an opening statement under 14 rule 10 of the Inquiries (Scotland) Rules 2007 unless 15 the chair directs otherwise, although the nature and 16 format of them are matters which are within your 17 control, sir. 18 In accordance with our approach to allow active 19 participation by our core participants in our work, core 20 participants were sent some guidance as to the sorts of 21 matters they might wish to cover and were invited to 22 make written opening statements to the Inquiry as well 23 as oral statements at this hearing. 24 The guidance sought to have the statements focus on 25 more substantive matters given the largely procedural Page 6	1 there and why; manifestations of the effects of workload 2 pressures on the way Mr Eljamel's patients were treated 3 under term of reference 2(c); research projects in which 4 Mr Eljamel was involved in which core participants 5 submit that the Inquiry should take an interest and why, 6 under term of reference 2(e); particular matters which 7 the Inquiry ought to investigate relating to the 8 training and supervision of junior neurosurgical staff, 9 under term of reference 2(b); the extent to which there 10 is a basis for the Inquiry to investigate complaints or 11 concerns raised about Mr Eljamel's practice prior to 12 2012 and the nature of any such complaints or concerns, 13 under terms of reference 4 and 5. 14 Submissions about broad issues with candour, or lack 15 of it on Mr Eljamel's part, under term of reference 7 16 which the Inquiry should investigate; particular issues 17 which core participants submitted arise in connection 18 with Mr Eljamel's clinical supervision, under term of 19 reference 8, or suspension under term of reference 9 20 which merits the Inquiry's investigation and 21 consideration. 22 Aspects of the investigations listed under term of 23 reference 12 which core participants felt merited 24 particular attention with reasonable grounds upon which 25 it is asserted that those investigations could or should Page 8

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1 have worked better. 2 And information about reports made to bodies 3 mentioned in term of reference 13 and reasonable 4 assertions about what reports could or should have been 5 made to them, when and why. 6 Further, the core participants were asked to provide 7 additional issues or matters of greater detail which 8 core participants consider should be investigated by 9 the Inquiry and why, including why they were deemed to 10 fall within the Inquiry's terms of reference; 11 suggestions as to the identity of witnesses from whom 12 core participants submitted that the Inquiry should be 13 taking written statements and/or oral evidence; the role 14 with which such individuals were expected to be able to 15 play; and why their involvement in those ways would be 16 beneficial to the Inquiry's fulfilment of its terms of 17 reference, with reference to the particular issues or 18 terms of reference to which it is thought that these 19 individuals would be able to contribute where possible. 20 We indicated that you, Chair, would be particularly 21 interested to hear from core participants as to the 22 identity of individuals working within NHS Tayside on 23 the medical side, including surgical, nursing or other 24 staff, whether from the neurosurgical department or 25 beyond, or the administrative side whom CPs submitted Page 9	1 to express a view or required further assistance or 2 guidance, for example, processes for anonymity, 3 participation in evidential hearings and the like; 4 recommendations which core participants submitted should 5 be in the Inquiry's thinking at this stage, including 6 the identification of areas connected to the Inquiry's 7 terms of reference which core participants considered 8 would be most likely to benefit from the Inquiry's 9 attention and possibly ultimately recommendations being 10 made, based on the core participant groups' particular 11 experiences or areas of particular interest. 12 And finally, the Inquiry's proposed approach to its 13 trauma-informed policy which in due course will form 14 an important part of its wider engagement strategy and 15 the extent to which core participants propose to 16 contribute to or participate in it. 17 Within the broad parameters of the guidance they 18 were sent, core participants have been given 19 a relatively free rein to set out their clients' 20 perspectives on, aspirations for and contributions to 21 the planning work of the Inquiry. These statements are 22 important to the Inquiry's work. They will be taken 23 into account as part of the Inquiry's genuine commitment 24 to allowing its core participants to have a voice and to 25 play a meaningful part in our work. It is that Page 11
1 would be of assistance to the Inquiry and why. 2 Suggestions as to lines of investigation which core 3 participants thought should be undertaken by the Inquiry 4 and why, beyond those already announced at the Inquiry's 5 preliminary hearing; any key materials which core 6 participant groups held and/or thought should be 7 obtained by the Inquiry and why, as well as any 8 information about key documents thought to be missing 9 which might otherwise have been of assistance. 10 Aspects of the Inquiry's terms of reference or list 11 of issues, or indeed its sectional evidential plan to 12 which core participant groups thought they could 13 contribute to the greatest extent; and matters where 14 their contribution would be of the greatest assistance 15 to the Inquiry's work and why; and beyond plans already 16 announced at the Inquiry's preliminary hearing in the 17 protocol or in the protocols published by the Inquiry, 18 matters which core participants considered should be 19 raised with independent expert witnesses, the areas 20 which expert evidence should cover and the identity of 21 any expert witnesses whom core participants thought 22 would be able to provide technical evidence of 23 assistance to the Inquiry's work and why. 24 Broadly, aspects of the Inquiry's evidential 25 approach and procedures on which core participants wish Page 10	1 commitment which has motivated the Inquiry to hold this 2 hearing in this way and at this time. 3 By holding this hearing now, it is anticipated that 4 the Inquiry will still have the opportunity to 5 incorporate the helpful contributions which have been 6 and will be made over the next two days into our 7 approach as to how we go about our work. It is for 8 those reasons that the floor will shortly pass to the 9 legal representatives of the core participants in order 10 to allow their clients to take centre stage. 11 However, before doing so, sir, I would like to take 12 the opportunity to set out the broad timetable for this 13 hearing but also, as part of the Inquiry's commitment to 14 openness and clarity, to present an update on 15 the Inquiry's work since the preliminary hearing on 16 10 September. 17 Core participants were given information about these 18 developments in a note by counsel to the Inquiry 19 circulated last week on which they were asked to provide 20 written submissions by Monday morning. The Inquiry team 21 is grateful to all those who took the trouble to do so. 22 Though I will try largely to leave the stage to my 23 colleagues representing their core participant clients 24 for their opening statements, I will try to address 25 aspects of the submissions on the procedural issues Page 12

1 raised in counsel's note as I go along for the sake of 2 clarity and the best use of time. 3 The opening statements hearing timetable. The 4 opening statement hearing will be attended by 5 representatives of the following core participants on 6 whose behalf written and oral opening statements have 7 been or will be submitted or delivered, as follows: 8 Firstly, the 138 former patients of Mr Eljamel and 9 21 representatives of former patients of Mr Eljamel 10 represented by Levy & McRae solicitors as individual 11 core participants. These patient core participants are 12 represented by my learned friends Joanna Cherry KC and 13 Mr Euan Scott. They appear on behalf of this group 14 today and have provided with you a written opening 15 statement and a written submission on the CTI note. 16 Ms Cherry will address you after I have spoken. 17 NHS Tayside are represented by my learned friend 18 Ms Una Doherty KC and Ms Cat MacQueen. They have 19 provided a written opening statement and a written 20 submission on the CTI note as well. Ms Doherty will 21 deliver an oral opening statement on their behalf this 22 afternoon. 23 The Scottish Ministers are represented by my learned 24 friends Laura Thomson KC and Mr David Blair. The 25 current plan is that Ms Thomson will deliver an oral Page 13	1 represented at this hearing by Ms Christine O'Neill KC. 2 She will make an oral opening statement on their behalf 3 tomorrow morning. 4 Additionally, as happened at the preliminary 5 hearing, you have also invited the Independent Clinical 6 Review to be represented at this hearing. I have sent 7 them the same advanced materials as were received by 8 core participants and extended to them the same rights 9 of reply and participation on the procedural matters 10 raised in the CTI note for the same objective of seeking 11 to allow them to contribute to the efficient work of 12 this hearing and of the Inquiry. 13 I will return to the ICR as a separate item on my 14 agenda in due course. The ICR is represented by 15 Mr Ewan McGillivray of Morton Fraser MacRoberts 16 solicitors. The ICR has provided a written submission 17 and Mr McGillivray will address you on behalf of his 18 clients tomorrow on matters raised in the CTI note. 19 The legal representatives of the 20 University of Dundee have submitted a short written 21 opening statement. They are not represented at the 22 hearing. It is of note that in their written opening 23 submission and at paragraph 6 of their written 24 submission on the CTI note, the patient group have 25 raised an issue about the apparent lack of engagement Page 15
1 opening statement on their behalf this afternoon after 2 Ms Doherty has addressed you, sir. 3 As was the case at the preliminary hearing, my 4 understanding is that my learned friends represent the 5 Scottish Ministers in their capacity as core 6 participants in and material providers to the Inquiry, 7 as opposed to representing the ministers in any other 8 capacity, such as the Cabinet Secretary in his capacity 9 as sponsoring minister of the Inquiry or the Independent 10 Clinical Review. 11 The Cabinet Secretary for Health and Social Care was 12 invited to be represented in his capacity as sponsoring 13 minister of the Independent Clinical Review for 14 particular reasons to which I will return. He is, as 15 I understand it, not so represented at this hearing. 16 Healthcare Improvement Scotland have provided 17 a written opening statement and are represented at this 18 hearing by Mr Shane Dundas. He will make an oral 19 opening statement on their behalf tomorrow morning. 20 NHS Education for Scotland have provided a written 21 opening statement and are also represented at this 22 hearing by Mr Shane Dundas. He will make an oral 23 statement on their behalf tomorrow morning, as well. 24 The Royal College of Surgeons of Edinburgh have 25 provided a written opening statement and are also Page 14	1 which the University of Dundee have had with this 2 Inquiry and raise again the importance of matters which 3 relate to the university in the Inquiry's 4 investigations. They highlight, quite rightly, the 5 importance of the university's engagement with 6 the Inquiry which is the basis upon which you granted 7 them core participant status, sir. 8 In the university's short written statement they 9 make reference to significant financial constraints 10 which are a matter of public record as a contributing 11 factor to this position. The university remains 12 a welcome core participant in the Inquiry and requires 13 make its own decisions about what it wishes to do so in 14 that capacity, including participation in this hearing. 15 For the sake of those who have concerns in this 16 regard, may I clarify that their lack of participation 17 in their capacity as core participants should not be 18 confused with their participation in their capacity as 19 organisational witnesses or material providers to 20 the Inquiry. 21 The Inquiry will be asked to provide evidence by way 22 of written statement, oral evidence as is deemed 23 necessary and in the form of documents relevant 24 the Inquiry's investigations in its capacity as 25 a witness or material provider. In those capacities, Page 16

1 the university will not ultimately have the option as to 2 whether to participate; it will require to provide 3 evidence which it holds or can provide and which is 4 relevant to our work by use of the Inquiry's powers of 5 compulsion, if necessary. It is hoped that that will 6 not be necessary. The university is currently in 7 receipt of a rule 8 request for documents and 8 a corporate witness statement relevant to section 1 of 9 the Inquiry's hearings programme which is currently 10 being worked on, as we understand it. 11 When the opening statements of our core participants 12 who are represented here have been heard, I will address 13 you further, sir, raising any matters which I think it 14 would be worth addressing at this stage in this public 15 forum. 16 As this hearing is predominantly for the core 17 participants to make their statements, I do not plan at 18 this stage to have a lot to say in reply, but will be 19 listening with interest to what is submitted and will 20 reply on any matters which appear to be worthy of 21 further reply or clarification on behalf of the Inquiry. 22 It may be, sir, that the timings do not run 23 precisely to the planned agenda. However, based on 24 projections made by my colleagues and the allocation of 25 two days rather than one for this hearing, we are as Page 17	1 hearings in the first half of next year are 2 in February 2026, three weeks from 9 February and in the 3 spring, three weeks from 20 April. The plan which was 4 announced at the preliminary hearing was that the 5 evidential hearings in section 1 of our evidential plan 6 would be held in the February window and that the first 7 set of evidential hearings in section 2 would take place 8 in the spring of 2026. 9 Regrettably, the Inquiry has experienced a number of 10 issues in its progress so far, with the result that you 11 have taken the decision, sir, that the hearings which 12 were to have been held in February will now not go ahead 13 as planned. There are a number of reasons for this, 14 which I would like to set out in the spirit of openness 15 and clarity in which we endeavour to undertake all of 16 our work. 17 I will turn to these in a moment but first of all, 18 may I set out how this development will affect our 19 planning. 20 The hearings in section 1 which were due to take 21 place in February will now take place in the three-week 22 slot available to us in the week commencing 23 20 April 2026. The next hearing room slot available to 24 us will be in the autumn of 2026, at which time we will 25 hold the section 2 hearings which, as you know, sir, Page 19
1 sure as one can be that everyone will be able to 2 contribute what they want to say and all relevant issues 3 will be amply ventilated. We will, of course, be 4 respectful of the needs of those in attendance for 5 breaks. 6 Therefore, sir, by way of an update on progress and 7 planning, I intend to address you, sir, on the following 8 topics: firstly, future hearings dates. Secondly, 9 an Inquiry staffing update. Thirdly, a core participant 10 update. Fourthly, the Inquiry's list of issues. 11 Fifthly, rule 8 requests and section 21 notices. Then 12 the Independent Clinical Review, instruction of expert 13 witnesses and the consultation on the Inquiry's 14 trauma-informed approach. 15 Future hearing dates. As far as the planning of 16 future hearings is concerned and as those who take 17 an interest in our work will be aware, the Inquiry has, 18 for reasons of expediency and economy, entered into 19 a venue sharing agreement with the Scottish COVID-19 20 Inquiry, which means that its hearings will be held at 21 the premises at Waverley Gate in Edinburgh which have 22 been used for the hearings of that public inquiry and 23 where we find ourselves for the opening statement 24 hearing today. 25 The windows available to this Inquiry for its Page 18	1 will focus on the evidence of patients, patient 2 representatives and evidence emanating from the 3 Independent Clinical Review. 4 In order to try to mitigate the effects of the delay 5 and to seek to try to get the hearings back onto the 6 timetable they were originally designed to follow, 7 the Inquiry has reserved a slot running for four weeks 8 from 7 September 2026 with our colleagues at the 9 Scottish COVID-19 Inquiry. Core participants will, of 10 course, be informed of the precise plans for the hearing 11 of oral evidence over that period. However, it is hoped 12 that this broad plan may allow the Inquiry to get back 13 to where it would otherwise have been in its 14 timetabling, with section 2 taking place in the autumn 15 of 2026 as had previously been announced. 16 The reasons why this change of schedule is taking 17 place are as follows: as I have said previously, sir, 18 the Inquiry strives constantly to balance speed and 19 reasonable thoroughness in its investigations. Both 20 considerations are important and both are integral to 21 our remit, as set out by our terms of reference. 22 Constant vigilance is needed to ensure that that 23 balance is being properly maintained. This is difficult 24 and sound judgment is required to ensure that we are 25 making decisions in that regard which comply with our Page 20

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1 terms of reference, our principles, our objectives and 2 to recognise the fact that some of what we do is 3 dependent on others. 4 In this instance, that judgment has been exercised 5 in a way which will result in a change in our planning 6 which has been determined to be the best way to balance 7 these factors in exercise of your discretionary right to 8 fix the Inquiry's procedures as you see fit, subject to 9 considerations of fairness and economy. 10 First, many core participants have pointed out 11 issues with the Independent Clinical Review process, 12 upon which the Inquiry is evidentially reliant as things 13 currently stand. To reiterate, the Inquiry is reliant 14 on the ICR's evidential output as, A, the basis for 15 understanding what went broadly clinically wrong and 16 when, as the foundation for our broadly systemic 17 investigation, and, B, as the source of direct evidence 18 of patients and patient representatives in the form of 19 their applicant statements. 20 Both Ms Cherry and I raised concerns about the 21 progress of the ICR project at the preliminary hearing 22 in September. The situation, as far as the Inquiry was 23 concerned, was urgent at that time. Progress, you will 24 recall, was demanded. I will return to the progress 25 made in that regard to this point in due course, but the Page 21	1 statements by the scheduled April hearings window for 2 the first tranche of the section 2 hearings has appeared 3 increasingly unrealistic and most importantly unfair. 4 Such unfairness requires to be avoided. 5 The importance of that body of evidence to both the 6 patient witnesses and to the Inquiry is amply set out in 7 the written opening statement of the patient group. It 8 is hoped that the adjustment to the timetable will 9 assist in according that evidence the attention and 10 importance it clearly merits in what you, sir, have 11 designed as an Inquiry with the patients at its centre. 12 Thirdly, in the course of the preparation of the 13 section 1 evidence which the Inquiry has now sought and 14 to which I will return the Inquiry has received some 15 intimation of issues with meeting deadlines with rule 8 16 requests which have been sent out. Some recipients have 17 raised issues arising from the time of year. Some 18 organisations in receipt of rule 8 requests have been 19 asked to provide updates on their progress as they were 20 required to do by 20 November. 21 These progress reports have given rise to further 22 issues and requests for extensions, which the Inquiry 23 considers to be not wholly unreasonable in the 24 circumstances. Those in receipt of such requests 25 deserve to be treated fairly too. These issues Page 23
1 time the Inquiry team has spent on ICR-related matters 2 and issues standing in the way of progress beyond 3 the Inquiry's control are matters of lingering concern 4 which have impacted on the change of timetabling. 5 Secondly, and related to this, the Inquiry team has 6 taken time to consider the implications of these delays 7 on the applicants to the ICR, patients and in some cases 8 their representatives. They will, the Inquiry hopes, in 9 early course, be called upon to produce applicant 10 statements to the ICR. It is reasonably anticipated 11 that that will be a difficult process for many and one 12 which will need to be prioritised in the joint planning 13 of the two processes. The applicant statements will be 14 needed for the ICR neurosurgical reviews to be 15 completed. Equally, the Inquiry will need them to see 16 and take account of their content in its work. 17 Though the Inquiry already has an eye to the 18 identity of patients or patient representatives from 19 whom it will, in due course, seek its own Inquiry 20 statements, the procedures which have been developed 21 between the two processes have been designed to try to 22 minimise what will inevitably be a heavy burden on those 23 who are involved. 24 Thus, the prospect of being able to complete both 25 applicant statements and in some cases Inquiry Page 22	1 therefore require to be factored into the Inquiry's 2 planning in order to make the hearings as productive and 3 inclusive as possible. 4 It is clear that more time should allow those who 5 have been asked to contribute evidence the time to 6 provide more meaningful contributions, as well as 7 permitting the necessary processing of statements and 8 documents and their onward disclosure to our core 9 participants. 10 Those who have requested that deadlines be extended 11 will have their applications assessed after these 12 hearings. Core participants will be updated about the 13 plans for disclosure as soon as there is any updates to 14 provide. Those involved should, however, not expect 15 lengthy extensions and work should continue at pace, 16 given that delaying the hearings from February to April 17 is only in the order of around ten weeks. 18 Fourthly, as you are well aware, sir, the Inquiry 19 has in place systems to allow core participants to 20 participate in key aspects of its work in its 21 preliminary phase. These opportunities are important to 22 the Inquiry's principles of clarity, openness and 23 collaboration. 24 Though core participants were asked to contribute to 25 the text of standard form letters of instruction for the Page 24

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1 ICR experts, the Inquiry has not yet had the opportunity 2 to engage core participants in the instruction of its 3 own expert witnesses. As this expert evidence forms 4 an important part of the evidential context in which 5 the Inquiry's work will be undertaken, the Inquiry 6 wishes to allow core participants a reasonable 7 opportunity to make such a contribution which could not 8 reasonably have been expected of them before now. 9 As this evidence is scheduled to be part of 10 the Inquiry's evidential section 1, the delay in the 11 section 1 hearings until April should, we hope, allow 12 the established process of participation to take place 13 as planned. 14 Fifthly, the Inquiry requires to engage the services 15 of key members of its own team whose role will directly 16 relate to the hearings, namely a hearings and operations 17 manager and a witness liaison officer. I will return to 18 the issue of Inquiry staffing in a moment but without 19 these key members of our team, the hearings in February 20 simply could not function adequately for our purposes 21 and in accordance with the need of those who would be 22 attending to provide evidence. 23 Sixthly, the Inquiry's trauma-informed policy public 24 consultation has just recently got underway. Given the 25 importance of the contributions which is we hope will be Page 25	1 participants will be informed of any plans for a further 2 preliminary hearing. 3 Inquiry staffing update. Since the preliminary 4 hearing the Inquiry has had the benefit of being able to 5 add a number of key members to the Inquiry team. For 6 the information of core participants, the following 7 senior roles have now been filled by the following 8 individuals: the important role of Secretary to 9 the Inquiry has been filled by Ms Natalie Smith. 10 Ms Smith already has significant experience from her 11 long career in the UK civil service, including as Deputy 12 Secretary of The Lampard Inquiry, an ongoing public 13 inquiry set up by the UK government into the deaths of 14 mental health patients in Essex. 15 In that role, she was involved in many aspects of 16 the Inquiry's work which will be of considerable 17 relevance and assistance to the work of this Inquiry, 18 including financial and project management, development 19 of strategic policy on governance and coordinating 20 engagement with the Inquiry's stakeholders. She is 21 a most welcome addition to the team. 22 The Inquiry's former interim secretary, 23 Mr Dan Farthing has taken the role of deputy secretary. 24 In this role amongst other important responsibilities 25 Mr Farthing will continue to take the lead in Page 27
1 made to this policy in that process and in turn to our 2 engagement strategy as a whole, the postponement of the 3 hearings will allow greater account to be taken of these 4 highly important considerations in our work at the first 5 set of evidential hearings. 6 In the meantime, core participants are reminded that 7 the public hearings of the Inquiry will be 8 live-streamed. Transcripts of evidential hearings will 9 be published on the Inquiry's website. Information 10 about the conduct of those evidential hearings and the 11 broad outline of the process which will be followed in 12 advance of it and at it is set out in the Inquiry's 13 public hearings protocol. 14 I should point out, sir, that it is entirely 15 possible that you may wish to order a further 16 preliminary hearing be held before the section 1 17 hearings, which are scheduled for the week commencing 18 20 April 2026. You may do so, sir, if you consider that 19 there are matters which require public ventilation and 20 resolution including, but not limited to, any issues 21 which you have with the recovery of evidence relating to 22 those section 1 hearings, or expected progress with the 23 work of the ICR which will have a direct bearing on our 24 section 2 hearings now scheduled for September 2026 and 25 our preparation for further hearings beyond that. Core Page 26	1 the Inquiry's engagement strategy and trauma-informed 2 policy based on his extensive experience in the 3 charitable sector. The current developments in this 4 area are ones to which I will return. 5 The legal team has also benefited from the 6 appointment of another junior counsel, Mr Cameron Smith 7 and two assistant solicitors, Ms Clair Sherrard and 8 Ms Jennifer Barr whose work, for now, will focus on the 9 preparations of sections 1 and 2 of the evidential 10 hearings to which I've already referred. These 11 colleagues are also most welcome additions to the team, 12 with considerable previous experience in the work of 13 Public Inquiries and/or in the medical sphere in which 14 this Inquiry will operate. 15 The Inquiry continues to engage in active 16 recruitment processes for a number of other positions in 17 its team, including the important positions of hearings 18 and operations manager and witness liaison officer, to 19 which I've already referred. Those who take an interest 20 in the work of the Inquiry should be aware that the 21 processes of recruitment to these key positions is 22 heavily dependent on the recruitment processes operated 23 by the Scottish Government. 24 I have already made clear that the Inquiry requires 25 to balance speed and reasonable thoroughness in its Page 28

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1 work. The latter requires experienced and dedicated 2 individuals to be recruited to our team in order to seek 3 to address the former, the Inquiry sought to negotiate 4 it with its Scottish Government sponsors, a management 5 agreement which sought to provide for priority to be 6 given to the Inquiry's recruitment and other 7 requirements, in particular for speed and control in 8 engaging the right people. 9 This agreement remains unsigned by government for 10 reasons unconnected to the provision relating to 11 recruitment. Provisions and expectations of the Inquiry 12 related to recruitment were and are, as we understand 13 it, uncontroversial. The Inquiry continues to consider 14 that the agreements provisions relating to the priority 15 required in recruitment decisions and processes are 16 entirely reasonable, given the importance of 17 the Inquiry's work in the public's interest, the 18 requirement that it report as soon as reasonably 19 practicable under term of reference 19 and the delays 20 beyond the Inquiry's control which have been encountered 21 to this point. 22 It is a fact that the Scottish Government's 23 recruitment processes have not worked as the Inquiry 24 would have expected, in particular as regards the speed 25 with which they operate. Core participants should, Page 29	1 21 former patient representatives. 2 The Inquiry's Rules 2007 enable a chair to grant 3 core participant status at any time during the lifetime 4 of an Inquiry. Therefore you, sir, will continue to 5 consider applications from individuals or bodies who 6 wish to be designated as core participants beyond the 7 initial application period set out in the Inquiry's core 8 participant protocol. 9 However, you, sir, are mindful of the need for core 10 participants to be able to participate fully and equally 11 in the Inquiry's work as, A, the current group of 12 individuals and organisations, two of which have been 13 granted core participant status, already represent 14 a wide range of interests and matters to be covered by 15 the Inquiry; and, B, as I have said, key stages in 16 the Inquiry's plans for active participation have now 17 passed or will pass soon. 18 As the Inquiry's preliminary phase nears its end, 19 you have indicated, sir, that you may be less mind to 20 grant further core participant status to future 21 applicants and will indeed require an explanation of the 22 timing of any future application from such individuals 23 or bodies. 24 Core participants who wish to receive funding for 25 their legal representation to support their Page 31
1 however, be aware that processes are well underway for 2 the recruitment of further staff to important Inquiry 3 positions, as the Inquiry moves from its preliminary to 4 its evidential phase. 5 Those within Scottish Government should, in my 6 submission, take note of, A, the reasonable requests of 7 our core participants for the Inquiry to be enabled to 8 get on with its work. B, the Inquiry's right and need 9 to remain independent, including in the selection and 10 engagement of its staff and, C, the plans for 11 the Inquiry's hearings timetable which I have set out 12 today. 13 I sincerely hope that these requests, that 14 requirement and those plans will be borne in mind when 15 Scottish Government assistance is sought with ongoing 16 and future recruitment and that adequate priority will 17 be given to providing it. 18 Core participant update. On 25 September 2025 in 19 response to an application received from Levy & McRae, 20 you, sir, granted the core participant status to 21 a further five former patients of Mr Eljamel and two 22 representatives of former patients represented by that 23 firm. This takes the total number of patient and 24 patient representative core participants in that group 25 to a total of 159, comprising 138 former patients and Page 30	1 participation in the Inquiry should be aware that the 2 solicitor to the Inquiry will imminently issue a further 3 invitation for funding to be granted by the Inquiry to 4 cover funding for the Inquiry's evidential phase, or at 5 least the first part of it. 6 As it is anticipated that requests for written 7 statements will be part of the next phase of 8 the Inquiry's work, the invitation will cover 9 applications for legal representation for the provision 10 of such witness statements, as well as legal 11 representation involved in being a core participant in 12 the Inquiry. 13 At the preliminary hearing on 10 September an issue 14 was ventilated relating to the support being offered by 15 NHS Tayside to its current and former employees. 16 NHS Tayside had set out its position in that regard in 17 a written submission to the Inquiry. As far as 18 the Inquiry was concerned, the position remained 19 unclear. Various issues were raised by me at that 20 hearing, in particular the apparent lack of legal 21 support being offered to current or former employees of 22 the board and the question of their representation. 23 As was the Inquiry's stated intention at that 24 hearing, the Inquiry has followed this matter up with 25 NHS Tayside's representatives. They have clarified Page 32

1 and updated NHS Tayside's position in a written 2 submission which was sent to core participants along 3 with a note by counsel, both of which will be published 4 after these hearings. The Inquiry is grateful to the 5 representatives of NHS Tayside for their clarification 6 of their position in this regard. 7 Given that NHS Tayside indicated in their written 8 note that they have or had concern that their 9 arrangements may cause concerns within the patient body, 10 other core participants were invited to make submissions 11 if they wish to do so on NHS Tayside's proposed 12 arrangements for providing legal support in light of 13 observations in this regard made in the counsel to the 14 Inquiry note. The Inquiry is obliged to the patient 15 group for having done so. It remains open to 16 representatives of the core participants to take matters 17 up further in their oral opening statements if they 18 wish, in light of NHS Tayside's wish to understand the 19 perspective of others on the arrangements which they 20 propose. 21 The NHS Tayside note clarifies that their position 22 is that they will offer legal support as well as 23 pastoral and administrative support to current and 24 former employees who wish to avail themselves of that 25 support or any part of it. The proposed arrangements Page 33	1 The written note provided by the legal 2 representatives of NHS Tayside makes it clear that they 3 do not represent former or current employees of the 4 board. As they were invited to do in their more recent 5 submission, NHS Tayside have clarified that the Inquiry 6 was correct in its assumption that NHS Tayside's 7 recognised legal representatives do not consider 8 themselves to be the recognised legal representatives in 9 terms of the Inquiry (Scotland) Rules of any individual. 10 They are the recognised legal representatives of the 11 board and the board alone. 12 That status brings with it certain rights and 13 responsibilities under the legislation governing 14 the Inquiry, the associated rules and in the Inquiry's 15 procedures. No provision is made in any of those for 16 a party providing legal support in connection with 17 the Inquiry's work. 18 It was pointed out in the note by counsel to the 19 Inquiry that it would require care on the part of 20 NHS Tayside and its employees to ensure that their role 21 as legal supporters should not be confused as their role 22 as recognised legal representatives of the board. It 23 was pointed out that steps would require to be taken to 24 ensure that appropriate systems are in place to 25 facilitate reasonable legal support, a concept of the Page 35
1 are broadly acceptable to the Inquiry, subject to 2 certain administrative matters which may still require 3 to be raised by the Inquiry with the representatives of 4 NHS Tayside, relating in particular to the 5 practicalities of assistance which they may be able to 6 offer in tracing individuals from whom the Inquiry 7 wishes to take evidence. 8 The Inquiry will signpost the available legal 9 support services to those former or current employees of 10 NHS Tayside who receive a rule 8 request or a section 21 11 notice for a written statement or for documents to be 12 provided. This will include the broad nature of the 13 support services being offered by the NHS's central 14 legal office and the possibility that individuals may 15 wish to consider seeking alternative representation, as 16 is included in all requests sent to individual rule 8 17 recipients. 18 In the case of medical professionals, for example, 19 this may include legal representation by a medical 20 defence organisation or the Nursing and Midwifery 21 Council. Solicitors regularly instructed by medical 22 defence organisations have been in touch with 23 the Inquiry to state that they expect to receive such 24 instructions in some cases and that in those cases they 25 will provide legal representation in the normal way. Page 34	1 board's making, as this capacity is one which appears to 2 the Inquiry to be one which is not contemplated by the 3 rules. 4 It was observed that this would require to be 5 addressed by the Inquiry in certain respects in due 6 course, including in relation to the permissions 7 allowing access on the part of legal advisers to 8 material when they are not recognised legal 9 representatives of the individual witnesses. 10 It has been made clear in NHS Tayside's note that 11 the arrangements would include an assessment being made 12 by NHS Tayside as to whether the legal support service 13 being offered could be extended to an individual based 14 on whether there appeared to be a conflict of interest 15 between the position of that individual and the position 16 of the board. 17 Given the relatively unusual nature of the legal 18 support being offered, viewed in terms of the rules 19 governing the Inquiry and those governing legal 20 professionals more generally, as well as the need for as 21 much clarity as can be achieved at this stage, the 22 recognised legal representatives of NHS Tayside were 23 asked to provide clarification as to how it will be 24 ensured that there is an appropriate separation between 25 the advice or support being provided to individuals and Page 36

1 the advice or support being provided to the board. 2 In particular, in light of the apparent acceptance 3 on behalf of the board that: 4 "It would not be necessary or desirable for 5 NHS Tayside itself to have sight of a rule 8 request or 6 section 21 notice sent to an individual current or 7 former employee, or indeed their response to that 8 request." (As read). 9 The board has now helpfully clarified that the legal 10 advice being offered to individual former or current 11 employees will be provided by a senior solicitor within 12 NHS's central legal office, separate from the team which 13 will be advising the board. It remains unclear whether 14 this means that this senior solicitor will now be the 15 recognised legal representative for these individuals in 16 cases where the central legal office feels able to offer 17 legal support. This is because it remains unclear 18 whether that senior solicitor from the central legal 19 office acts on behalf of the board or not. 20 The separation appears to be intended to remote 21 an appropriate degree of distance between the 22 representation of the board and the legal support 23 offered to former or current employees. That would tend 24 to suggest that the apparent impediment to providing 25 representation for the board and for these individuals Page 37	1 However, subject to these considerations and the 2 inevitably administrative consequences which will need 3 to be ironed out, in general terms, this broad 4 separation seems to the Inquiry an appropriate way to 5 balance the requirement for legal support with the need 6 for there to be clarity about the role of the board in 7 evidence provided by individual current or former 8 employees. The Inquiry is grateful to the legal 9 representatives of the board for giving this matter 10 their attention. We will listen to any further 11 submissions made by any party in this regard about any 12 lingering details or concerns with interest. 13 The Inquiry's list of issues. During the public 14 consultation on the terms of reference, a number of 15 helpful suggestions were made by participants in that 16 process as to matters which should be included in 17 the Inquiry's remit but which were deemed to be too 18 detailed or specific for the terms of reference. 19 A considerable number these were incorporated into 20 the Inquiry's provisional list of issues dated June 2025 21 which is and will remain a living document setting out 22 in greater detail the matters which the Inquiry intends 23 to investigate and ultimately to determine. 24 As was set out at the last hearing, the Inquiry 25 deliberately devised a number of steps to allow core Page 39
1 is removed by this system, which in turn would tend to 2 suggest that there's no impediment in principle to 3 representation being provided by that separate senior 4 solicitor. 5 On the other hand, the submission still proceeds on 6 the basis that all that would be provided would be legal 7 support as opposed to representation, however "legal 8 support" is defined. It would be useful if all of this 9 could be clarified as, as I say, if the senior solicitor 10 is not a legal representative of the individuals 11 concerned, that will require certain provisions to be 12 made by the Inquiry to recognise the more limited status 13 of the legal support being offered. 14 No doubt, consideration will be given as to whether 15 it would be appropriate for counsel to be instructed on 16 behalf of those individuals, for example, in connection 17 with those individuals being called to give oral 18 evidence to the Inquiry at its hearings, in particular 19 in section 5 of its evidential plan. 20 I assume that this remains a logical possibility as 21 under the previous proposal as I understood it legal 22 support included the support of the whole legal team 23 including counsel. Again, clarification of the extent 24 of legal support and the possible involvement of counsel 25 would be helpful. Page 38	1 participants to contribute meaningfully to the Inquiry's 2 important preliminary formative phase, building on 3 the Inquiry's public consultation on its terms of 4 reference which took place last year. 5 Opportunities afforded to core participants 6 included, or will include, the holding of the 7 preliminary hearing in September, including the 8 opportunity to make written and oral submissions; the 9 opportunity comment on the Inquiry's detailed 10 provisional list of issues, to which I will return; the 11 opportunity to contribute to the wording of the standard 12 form letter of instruction to be used to instruct 13 experts in the ICR; the holding of this separate opening 14 statement hearing, including the opportunity to make 15 written and oral statements and written submissions on 16 the CTI note; in due course, the opportunity to make 17 contributions to the letters of instruction to be issued 18 to the Inquiry's experts within section 1 of its 19 evidential plan. 20 These opportunities have been supplemented by the 21 availability of the Inquiry team to deal with issues as 22 they arise and to offer explanation and solutions as 23 necessary. 24 It is hoped and expected that this period has been 25 used constructively by those instructed on behalf of Page 40

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1 core participants, both to prepare themselves to 2 undertake the busy work of the Inquiry's impending 3 evidential phases, but also to take detailed 4 instructions from their clients about their aspirations 5 for the work of the Inquiry and its investigations. 6 Since the preliminary hearing, the Inquiry has 7 received helpful suggestions from core participants 8 relating to matters which in their view should be 9 covered in the list of issues. The Inquiry is grateful 10 for these contributions. These have been considered 11 carefully by the Inquiry team and additional issues have 12 been included in an updated version of the list 13 to October 2025, available on the Inquiry's website. 14 Amongst the additional areas included are the 15 following: policies, regulations, systems, guidance or 16 mechanisms which existed relating to clinicians working 17 within NHS Tayside in so far as relevant to the care of 18 former NHS patients of Mr Eljamel, regarding the 19 completeness and accuracy of medical records whether 20 imposed by NHS Tayside or other agencies and the systems 21 involved in ensuring compliance with them, under term of 22 reference 14. 23 Medical records being sufficiently legible, 24 intelligible or detailed for their purposes; medical 25 records being completed by junior staff as opposed to Page 41	1 The differing interpretations and implementation of 2 clinical governance, corporate governance and 3 professional governance within NHS Tayside, term of 4 reference 3. 5 Mr Eljamel's external and internal training 6 requirements or compliance; reporting of issues to the 7 Health and Safety Executive, both of which also fall 8 under term of reference 3. 9 Systems for issues about Mr Eljamel being brought to 10 the attention of bodies listed under term of reference 6 11 and the extent to which the outcome of previous reviews 12 related to Mr Eljamel, or systems surrounding his 13 practice, was reported to the Scottish Government under 14 term of reference 12. 15 The Inquiry believes that the provisional list of 16 issues published in June 2025, as now updated, provides 17 a proper framework in which to include all of the issues 18 and matters that the Inquiry is likely to enquire into 19 and a sufficient indication for persons and 20 organisations who have relevant information as evidence, 21 as well as core participants to be able to commence 22 their preparations for the work of the Inquiry's 23 evidential phase and their involvement with it. 24 It is anticipated that that will now have happened 25 and that core participants and their representatives Page 43
1 senior staff, including consultants; medical records not 2 being completed contemporaneously to the events they 3 describe; medical records being altered retrospectively; 4 falsification of medical records; medical records 5 insufficiently or inaccurately recording patient consent 6 to treatment; assessment of Mr Eljamel's technical 7 capabilities in surgery at the time of his key 8 appointments in NHS Tayside, under term of reference 1; 9 the organisation of the neurosurgical service offered 10 within NHS Tayside and the role of its possible 11 restructuring or withdrawal in the handling of issues of 12 Mr Eljamel; Mr Eljamel's use of products or devices in 13 surgery, in particular where they were unlicensed or 14 used experimentally; issues with multidisciplinary 15 meetings or pre-operative clinics in Mr Eljamel's 16 practice, term of reference 3; formal information 17 sharing arrangements between NHS Tayside and 18 Fernbrae Hospital, term of reference 3; the involvement 19 of NHS Tayside and the maintenance of Mr Eljamel's 20 practising privileges at Fernbrae Hospital, under term 21 of reference 3; the role of Mr Eljamel's position at the 22 University of Dundee in training and the lack of 23 compliance by junior staff in NHS Tayside, 24 whistleblowing or other clinical governance processes, 25 term of reference 3. Page 42	1 will be ready to progress with the work required of them 2 in the Inquiry and in the Independent Clinical Review 3 for those to whom that work applies. The list of issues 4 to be addressed and indeed, those to be addressed in 5 each of the Inquiry's evidential sections, however, will 6 be further developed once the response to say rule 8 7 request for evidence have been received. 8 Sir, I intend, now, to move on to providing some 9 information about our progress with rule 8 requests and 10 section 21 notices. That's 11 o'clock when we're due to 11 take a break. I'm in your hands as to whether you would 12 like to do that now. 13 LORD WEIR: Is it a very significant section, Mr Dawson? 14 MR DAWSON: Yes, I still have a number of aspects of my 15 submission to cover, so I would suggest that we do so. 16 LORD WEIR: All right, everyone, thank you very much, we 17 will take a break for 15 minutes and resume again after 18 that. 19 (11.02 am) 20 (A short break) 21 (11.23 am) 22 LORD WEIR: Thank you, please be seated. 23 MR DAWSON: Thank you, sir. Before the break I had reached 24 part 5 of my submission updating people as to the 25 progress that the Inquiry has made. This section Page 44

1 relates to rule 8 requests and section 21 notices issued 2 by the Inquiry. 3 Section 1 of the Inquiry's investigations is 4 primarily concerned with setting the scene for the rest 5 of the evidence to be heard by the Inquiry. It will be 6 an introductory section at which it is intended that 7 evidence will be heard relating to a number of areas 8 which are designed to provide evidential context to the 9 hearing sections to follow, including general 10 background, structure and roles of the various key 11 organisations, key people and key policies, in 12 particular, as well as the systems for complaints and 13 areas in which complaints were made and when. 14 Evidence relating to term of reference 1, 15 appointments, including evidence about the broad 16 trajectory of the career of Mr Eljamel and statistical 17 evidence about the nature and spread of his work. 18 Evidence relating to the systems underpinning term of 19 reference 14, relating to document management systems 20 within NHS Tayside; the broad ambit and findings of the 21 investigations to be looked at under term of 22 reference 12; and independent expert evidence on rules 23 and systems relating to key areas covered by 24 the Inquiry's terms of reference, to which I will 25 return. Page 45	1 broad ambit of matters which you, sir, will require to 2 resolve mean that these are detailed, as even the 3 limited number of matters covered by section 1 demands 4 a detailed context to be examined. 5 The recipients of these section 1, rule 8 requests 6 are: NHS Tayside; the Scottish Ministers; the 7 University of Dundee; Healthcare Improvement Scotland; 8 NHS Education Scotland; the Royal College of Surgeons; 9 the Royal College of Surgeons of Edinburgh; NHS Lothian; 10 the General Medical Council; the 11 British Medical Association; the 12 Health and Safety Executive; Circle Healthcare; 13 Police Scotland; the BBC; and three members of the 14 Scottish Parliament who have had a prominent role in 15 relation to campaigning for this Inquiry. 16 In addition, a general disclosure rule 8 request has 17 been prepared for NHS Tayside as well as for others 18 whose section 1 rule 8 request do not cover all 19 documents they hold relating to the Inquiry's terms of 20 reference. These will be issued to the relevant 21 recipients in due course when the precise role of these 22 bodies in matters to be investigated by the Inquiry 23 becomes clearer. In the meantime, the focus will be on 24 the completion of responses to the section 1 rule 8 25 requests. Page 47
1 A fuller provisional scope for section 1 of the 2 hearings has been released to core participants and 3 published. It should be emphasised that as section 1 of 4 the evidence is intended to provide important factual 5 context to the sections which follow, it will not be 6 necessary for all issues to be ventilated with witnesses 7 who are called to give evidence in section 1. 8 It is intended that a fuller exploration of the 9 detailed issues of controversy which arise from the 10 analysis of the full range of evidence available to 11 the Inquiry will be undertaken at later sections in 12 the Inquiry's plan. 13 The Inquiry will willing to consider having 14 witnesses to return to provide oral evidence again at 15 an appropriate later stage in its hearings in line with 16 this approach. 17 Rule 8 requests for corporate written statements and 18 the production of documents relevant to the scope of 19 section 1 of the Inquiry's evidential plan have now been 20 completed and issued. These have included reference to 21 matters relevant to the section 1 scope, which arose 22 from the consultation with core participants on 23 the Inquiry's list of issues to which I have referred. 24 Though these sections are introductory in nature, the 25 length of time covered by the Inquiry's remit and the Page 46	1 Section 2 of the Inquiry's investigations will focus 2 on the evidence of patients and the evidence which has 3 emerged from the Independent Clinical Review, of the 4 timing, nature and extent of clinical issues arising 5 from Mr Eljamel's practice. 6 In section 2, the Inquiry will hear evidence from 7 a selection of patients and if necessary their 8 representatives, relating to the key clinical themes of 9 sub-standard practice experienced by patients, including 10 factors listed in term of reference 2 and those with 11 experience of matters listed in term of reference 8 to 12 11; key aspects of the terms of reference relating to 13 the patient experience of relevant systems, including 14 but not limited to complaints and feedback processes; 15 campaigning for a public inquiry and the experience of 16 other investigations listed under term of reference 12; 17 lack of candour, terms of reference 7 and 13; and issues 18 with document management and access under term of 19 reference 14. 20 In section 2 of the hearings, the Inquiry will also 21 hear evidence from the Independent Clinical Review about 22 its findings of sub-standard clinical practice on the 23 part of Mr Eljamel or those working under his 24 supervision from that process. 25 It is important to note the Inquiry intends to call Page 48

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1 oral evidence in its section 2 hearings from those who 2 fall into two broad categories. 3 First, those patients whose cases are exemplary of 4 the key broad clinical themes emerging from the ICR. 5 This will allow the Inquiry to explore the kinds of 6 things which that process has found went wrong from 7 a patient perspective, which systems that were put in 8 place to protect patients perhaps ought to have done 9 something to address. It is anticipated that that sort 10 of evidence will emerge from the cases which start to be 11 reviewed within the ICR, in particular the priority 12 cases to which I will return. 13 Second, there will be cases which have more of 14 a bearing on the broad position as regards the systems 15 which the Inquiry is predominantly charged with 16 investigating from the patient perspective. For 17 example, witnesses may have important evidence to bring 18 to bear on the clinical supervision which was imposed on 19 Mr Eljamel under term of reference 8, or the adequacy of 20 complaints or feedback systems or their follow-up under 21 terms of reference 4 or 5; the process of previous 22 investigations, including campaigning for a public 23 inquiry under term of reference 12, or indeed other 24 aspects of our terms of reference. 25 It is intended that witnesses who appear to have Page 49	1 The Inquiry will continue to recover records for 2 applicants to the ICR following the procedures agreed in 3 the memorandum of understanding between the two 4 processes. 5 The Inquiry has informed the patients who are core 6 participants and whose medical records have been 7 recovered, by way of patient notification letters. 8 The Inquiry will continue to issue these patient 9 notification letters as it recovers records going 10 forward. 11 However, beyond the requirement that these materials 12 be recovered for the ICR reviews, the Inquiry has begun 13 analysing these materials for the following purposes: 14 Firstly, informing the creation of a list of 15 priority cases for the ICR, to which I will return. 16 The hospital records for all 50 of these cases have 17 been recovered, as well as the GP records for almost all 18 of them. The remainder will be sought when information 19 about current GP details can be shared with the Inquiry 20 by the ICR, along with information about the cases 21 provided by Messrs Levy & McRae on behalf of their 22 clients, complaint files and publicly available 23 information about the cases. 24 This has allowed a clinical list of 50 priority 25 cases to be compiled which, it is hoped, will provide Page 51
1 important evidence to provide of their experiences in 2 this regard will be called upon to provide witness 3 statements in the Inquiry in accordance with 4 the Inquiry's protocol on that subject. 5 Of course, there will be patients who fall into both 6 categories whose evidence will be derived from both the 7 ICR applicant statements and ultimate review and written 8 evidence gathered by the Inquiry itself. 9 Medical records and complaints files. In order to 10 inform this process of seeking appropriate evidence and 11 in light of the delays in the ICR commencing its work, 12 the Inquiry has not been idle in recent months. It has 13 already gone about starting to recover medical records 14 and NHS Tayside complaints files using its powers of 15 statutory recovery under the 2005 Act under section 21, 16 relating to certain former patients of Mr Eljamel whose 17 cases appear to the Inquiry to be of particular 18 significance to its remit and in anticipation of cases 19 which it will refer to the ICR for review or otherwise 20 assist in within the ICR process. 21 So far, the Inquiry has recovered all complaints 22 files held by NHS Tayside, medical records from 23 NHS Tayside from Circle Healthcare, or from general 24 practitioners. Records of 125 patients have been 25 recovered falling into at least one of these categories. Page 50	1 key evidence of the sort of broad patterns of things 2 which may have gone wrong clinically to inform 3 the Inquiry's further investigations. 4 Secondly, this process has involved extracting 5 evidence relevant to the compilation of the Inquiry's 6 list of issues and compiling a provisional list of 7 witnesses who may give evidence on systemic matters of 8 relevance to the Inquiry's terms of reference and who 9 may, in due course, be sent rule 8 requests for Inquiry 10 witness statements, from which group certain patients or 11 patient representatives will be called to give oral 12 evidence in the section 2 hearings. 13 And, finally, this process has informed further 14 lines of enquiry, including the drafting of questions to 15 be addressed to later witnesses in rule 8s or section 21 16 notices. 17 Publicly circulated materials, including the CTI 18 note issued in connection with the Inquiry's preliminary 19 hearing, set out the provisions of the Inquiry's 20 generics order on the restrictions on publication of 21 medical records generally and the Inquiry's processes 22 related to its approach to anonymity and restriction 23 orders relating to extracts from medical records which 24 may require to be published. 25 It should also be noted that the Inquiry approach to Page 52

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1 the recovery, disclosure and publication of medical 2 records is set out in detail in its protocol on the 3 approach to evidence and witness statements from 4 paragraph 57, which involves the minimum amount of 5 medical evidence necessary being disclosed and published 6 for the purposes of our work and that of the ICR. 7 The Independent Clinical Review. In terms of 8 the Inquiry's reference 16, the Inquiry is obliged it 9 take account of the ICR's finding in its work. As 10 I have said, the intention is that the ICR will set out 11 what went wrong clinically. The Inquiry's role will 12 then be to investigate what systems should have existed 13 to detect and prevent those things going wrong and harm 14 occurring and whether those systems were in any way 15 defective. 16 Given this important relationship between the two 17 processes, an invitation has once again been extended by 18 you, sir, to the Chair of the ICR in connection with 19 this opening statement hearing. The ICR has not been 20 invited to make an opening statement, but it has been 21 offered the opportunity to make written submissions on 22 procedural matters and to make an oral statement on 23 them. The ICR has provided a written submission and 24 an oral submission on its behalf will be delivered 25 tomorrow. Page 53	1 they do not, "non-consent cases". 2 As it is possible in cases where no such consent has 3 been provided that the Inquiry will ultimately use its 4 statutory powers to recover the ICR's materials anyway, 5 it is important that the same procedure is followed for 6 the production of applicant statements in all cases. 7 The Inquiry has agreed the standard form letter of 8 instruction with the ICR which will be sent to the 9 independent expert neurosurgeons, in particular to 10 ensure that the questions they are asked will cover the 11 range of matters on which the Inquiry requires the ICR's 12 clinical evidence. Again, there are two versions 13 covering consent and non-consent cases, the questions 14 are the same in each. In cases of particular complexity 15 which may involve the need to instruct more than one 16 expert, the processes have agreed that the ICR will seek 17 assistance from the Inquiry in framing an appropriate 18 letter of instruction. 19 The completion of the draft letters of instruction 20 benefited from suggestions made by Inquiry core 21 participants as to matters which should be included in 22 them. 23 A shared operational guide has now been agreed as 24 between the two processes. This sets out the various 25 stages which will be followed in what is a complex Page 55
1 The ICR was given a copy of the note by counsel to 2 the Inquiry at the same time as core participants. It 3 was given access to the opening statements submitted by 4 core participants when these were shared. Relevant 5 matters raised by core participants in their written 6 submissions on procedural matters have been or will be 7 shared with the ICR by the Inquiry to enable concerns 8 and suggestions to be addressed appropriately, as was 9 the approach at the preliminary hearing. 10 The two processes have continued to work together to 11 achieve their mutual aims in the period since the 12 preliminary hearing. The following is an indication of 13 the progress that has been made: the Inquiry and the ICR 14 have finalised the applicant statement requests which 15 will be used in the ICR to allow applicants to input 16 their experiences to the neurosurgical reviews in their 17 case. 18 The applicant statement request contains a number of 19 questions for applicants relevant to matters which will 20 be the subject of those neurosurgical reviews. There 21 are two versions of the applicant statement request. 22 These contain the same questions but have different text 23 in parts, as they apply respectively to cases in which 24 the applicant consents to materials being shared with 25 the Inquiry known as "consent cases" and cases where Page 54	1 operation to process the cases which are being removed 2 by the ICR, along with mechanisms for tracking progress 3 to ensure that case reviews are finalised in an orderly 4 fashion. 5 The two processes have required to have particular 6 regard to the complexities and sensitivities related to 7 data protection, in light of the nature of the medical 8 information which will pass between them. That has 9 required a number of matters to be addressed and 10 appropriate systems designed. The two processes have 11 now agreed the terms of a data sharing agreement between 12 them which, as far as the Inquiry is concerned, will 13 allow information to be shared between the two processes 14 in early course about ICR registrations and 15 the Inquiry's nominated priority cases. 16 It will also allow the regular flow of data between 17 the two processes which has been planned to commence to 18 enable each process to keep the other aware of the 19 progress it has made and to allow plans to be made and 20 updated accordingly. The two processes still need to 21 finalise the terms of a data protection impact 22 assessment but this too is nearly in final form. 23 Priority cases. The two processes have agreed 24 systems whereby the cases which appear to the Inquiry to 25 be of greatest systemic significance, priority cases, Page 56

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1 will be processed to review first. As was announced at 2 the preliminary hearing in September, the Inquiry has 3 created a list of priority cases which it will ask the 4 ICR to process first so that the evidential material 5 created by the ICR for applicants and for the Inquiry 6 can be processed by the Inquiry as early as possible to 7 allow progress to be achieved as per the Inquiry's 8 ambitious timetable. 9 The signature of the data sharing agreement and the 10 imminent completion of the DPIA will permit the details 11 of those 50 priority cases to be shared. Those who 12 represent applicants who fall into this top 50 list will 13 also be informed as soon as that has happened. If it 14 transpires that any of those in the top 50 list have not 15 registered as applicants to the ICR, they will be sent 16 an invitation to do so. If they do not, those cases 17 will proceed as referral cases as per the terms of the 18 memorandum of understanding. 19 The Inquiry has commenced the compilation of the 20 next batch of cases which it will ask the ICR to 21 prioritise. This will be shared with the ICR and 22 representatives of those whose cases fall into that 23 category at an appropriate juncture. 24 Those who represent the patient core participants 25 will not be asked to contribute to the top 50 cases, Page 57	1 to the Inquiry by Levy & McRae and their counsel and 2 publicly available materials relating to some of their 3 clients. Thus, submissions about their clients' 4 experiences have already featured in the top 50 5 assessment. 6 It must also be stressed that in the allocation of 7 priority cases the Inquiry will retain a role in all 8 cases which progress through the ICR. All of the ICR 9 evidence will become evidence in the Inquiry which will 10 be considered by the Chair in the compilation of his 11 report. Thus, to talk about cases as priority ones is 12 simply an administrative assessment and not one which 13 makes any premature assumptions about the value of any 14 case to the Inquiry's work. All cases are important to 15 the ICR and to the Inquiry, as they will all contribute 16 to the evidence base of what went wrong and what might 17 reasonably have been done to prevent it. 18 What might be helpful at this stage is to provide 19 some greater clarity about the process which the Inquiry 20 has used to compile this list of priority cases. The 21 process has been dictated to an extent by the materials 22 to which the Inquiry currently has access which have 23 been recovered as a means of providing a way to make 24 this judgment. In its assessment of those materials, 25 the Inquiry has created the following triage process to Page 59
1 a point they raise at paragraph 9 of their submission. 2 They could hardly have been because as we understand it, 3 they were not formally instructed in the ICR on behalf 4 of those clients until recently, pending completion of 5 funding arrangements being put in place for them to 6 accept those instructions, a point to which I will 7 return. 8 In any case, we have not yet been able to share the 9 list even with the ICR due to data protection 10 restrictions, an impediment which will soon be resolved. 11 To do so at this stage would cause inevitable 12 unnecessary delay. The priority list must be selected 13 by the Inquiry as part of its planning and ability to 14 have access to materials from all patients. 15 The Levy & McRae opening statement rightly 16 recognises that though its client group represents 17 a significant cohort of Eljamel patients, it does not 18 represent them all. It would be difficult, if not 19 invidious, for the recognised legal representatives of 20 the Levy & McRae group to be asked to rank their 21 clients' cases, given that they owe the same duty to 22 each of them. That responsibility must fall and had to 23 fall to the Inquiry team. 24 In any event, as a matter of fact, the compilation 25 of the top 50 cases has had regard to materials provided Page 58	1 arrive at the top 50: 2 As the top 50 cases are about the clinical 3 assessment which the ICR will offer, priority is given 4 to those cases which appear, on the face of them, to 5 offer the most apparently clinically controversial 6 decisions which merit early, further investigation based 7 on the information available to us. 8 Those which appear on the face of them to be 9 potentially egregious examples of alleged sub-standard 10 clinical performance as defined by reference to matters 11 the ICR experts will be asked to review, for example, 12 lack of consent, incorrectly performed surgery, or 13 surgery not performed at all -- all by way of example -- 14 reflective of wider alleged experiences, rank higher in 15 the analysis. 16 Cases which involve surgery or treatment earlier in 17 the period of Mr Eljamel's employment at NHS Tayside are 18 generally given priority. This is based on the 19 principle that if something was going on wrong earlier, 20 something could have been done earlier, with the maximum 21 protective effect and the fact that other previous 22 investigations hampered by lack of records appear to us 23 to have paid little regard to cases the more historic 24 they were. 25 The Inquiry thus has an important role in looking Page 60

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1 back as far as its terms of reference require that it 2 does. 3 As the Inquiry primarily concerns systems in the 4 NHS, priority is given to those cases which come from 5 the NHS. Though as private cases also require to be 6 looked at under term of reference 3, not all of the 7 cases for priority clinical review come from NHS 8 patients. 9 When things go wrong, people tend to complain. 10 There is a reasonable amount of evidence available to us 11 from the due diligence review of 2023 and the complaints 12 files about complaints and cases where complaints have 13 been made and upheld are given greater priority than 14 those which have been partially upheld and so on. 15 As the Inquiry will require to investigate the 16 adequacy of complaint systems, we make no assumptions 17 about the correctness of the outcomes of these processes 18 but this approach provides a useful guide. 19 Where the clinical circumstances of cases appear to 20 be particularly relevant to matters falling within the 21 Inquiry's remit within the clinical context of the ICR's 22 processes, they would also be given priority, such as 23 ones involving possible research under 2(e), or claims 24 of inadequate supervision, or bullying of junior 25 colleagues under term of reference 2(b) or falling Page 61	1 The applicant statement. Again, the Inquiry 2 understands that the next step will be that the 3 applicants in the top 50 will be sent an applicant 4 statement request with questions to answer, following 5 a stepwise approach to the compilation of the materials 6 needed for the review. It is important that applicant 7 statements are completed in an efficient manner to allow 8 the work of the ICR to progress and for the evidence 9 which will be contained within them to be assimilated 10 into the work of the ICR and the Inquiry as soon as 11 possible. 12 As I have said, lack of progress in the work of the 13 ICR was an issue ventilated at the preliminary hearing. 14 A question was raised about it at First Ministers 15 Questions. Despite what I thought were clear assertions 16 about the need for the remaining issues to be resolved 17 both at the hearing and in subsequent communication 18 between you, sir, and the Cabinet Secretary, the Inquiry 19 has remained concerned about the lack of finalised plans 20 in relation to a number of aspects of the work of the 21 ICR. In particular, connected to the completion of 22 applicant statements, the next substantive step in its 23 process. 24 The Inquiry has consistently issued plans to the ICR 25 with regard to the timetabling of when work will need to Page 63
1 within the period of Mr Eljamel's clinical supervision 2 under term of reference 8. 3 In order to allay concerns in this regard, we can 4 say that we would be amenable to hearing representations 5 on behalf of the patient core participant group for 6 inclusion in the next batch of priority cases for the 7 ICR which, as I say, the Inquiry is already compiling. 8 It may be that some of those suggested in the list 9 appended to the patient group opening statement fall 10 into this category, if not already in the top 50. 11 Neurosurgical instruction. The expert neurosurgeons 12 selected for instruction will be so selected by the ICR. 13 Professor Wigmore, the Chair of the ICR is taking the 14 lead in that process, ensuring the genuine independence 15 of the experts, in particular from NHS Tayside. 16 Though these are matters on which his 17 representatives may address you further, sir, it is 18 understood that Professor Wigmore has conducted further 19 work in finalising the instruction of the experts, not 20 least by liaising with the Society of British 21 Neurosurgical Surgeons. He will be finalising these 22 arrangements and has asked the Inquiry to continue to 23 assist in providing information about what the Inquiry 24 will expect for the neurosurgeons who are instructed. 25 The Inquiry will be happy to do so. Page 62	1 be done to allow the Inquiry to proceed with its own 2 investigations. The ICR requires to produce its work in 3 a way which accords with the Inquiry's timetable as per 4 the provisions of the memorandum of understanding 5 between the two processes. These plans have had to be 6 revised and postponed. 7 In order to try to draw up a clear plan for the way 8 forward, the Inquiry has recently met with 9 Professor Wigmore in order better to understand what 10 stage the ICR has reached in its preparations and its 11 readiness to proceed with its work. 12 As a result of those helpful discussions, for which 13 the Inquiry is grateful, it was apparent that there were 14 a number of matters on which further clarity was 15 required which fall within the remit of the 16 Scottish Ministers as the sponsors of the ICR process. 17 Therefore you, sir, wrote to the Cabinet Secretary on 18 20 November raising outstanding queries with him about 19 the ICR. The Inquiry intimated the note by counsel to 20 the ICR sponsor team last week requesting that the 21 Scottish Ministers provide an update on the matters 22 raised either in a written submission in response to the 23 note or at the opening statement hearing and that they 24 instruct appropriate representation at this hearing to 25 allow matters to be addressed today. Page 64

1 Clarity was sought on a number of substantially 2 financial matters, which seemed to us to be the logical 3 impediments to getting the ICR underway. It is our 4 understanding that those major impediments to the 5 progress of the ICR project lie with the 6 Scottish Government. It should be borne in mind that 7 the ICR was the Scottish Government's invention. It 8 funds it, it requires, it would appear, to put in place 9 contracts and systems to enable it to work. Detailed 10 procedural systems and operational timetables have been 11 devised by the Inquiry and ICR processes to allow the 12 ICR to work as it was intended to do. The progress 13 which has been made by the time the CTI note was drafted 14 was welcome, but it was not sufficient. 15 Whilst it is disappointing that the 16 Scottish Government has once again not sought to engage 17 with us today or instruct representation for today's 18 hearing on behalf of the Cabinet Secretary in his 19 capacity as ICR sponsor, I am pleased to say that 20 a letter was received from him by you yesterday with 21 an update on these important matters, to which I now 22 turn. 23 The Inquiry understands there to be an agreement in 24 principle that clients of Levy & McRae will be funded to 25 receive legal support from their lawyers and that Page 65	1 Support Service Scotland, also known as PASS, and 2 a separate psychological support service will also be 3 offered via the ICR. There remained to us no clarity 4 around what support services would be offered and how 5 patients would engage with them. It has been clarified 6 by the Cabinet Secretary that the PASS service will be 7 provided by an amendment to an existing contract with 8 the Scottish Government, that the PASS service are 9 experienced in providing such support and that they will 10 receive training and part of their agreement will be 11 that statements will need to be in the words of the 12 applicant. As far as we are concerned, the PASS service 13 is available from now. 14 It was clarified that the psychological support 15 service will, in fact, be provided by funding by 16 NHS Tayside. This position is also set out at 17 paragraph 26 of NHS Tayside's written opening statement 18 and paragraph 8 of their written submission. Reference 19 to this is made, as I say, in that opening statement. 20 We understand that this is now ready to proceed, though 21 those in attendance today may benefit from some 22 reassurance that this is an independent service. The 23 Cabinet Secretary has assured you, sir, that it is. 24 The Inquiry understood that there also remained 25 outstanding arrangements within the gift of the Page 67
1 similar support for other applicants otherwise 2 represented will be funded at the same level. There 3 appeared to us to be no clarity or finality surrounding 4 the process by which legal services were to be engaged 5 by the Scottish Government, both for the clients of 6 Levy & McRae and otherwise, the anticipated timescale 7 for this to be put in place, or even the ambit of what 8 legal service would be covered, so as to allow the work 9 of applicant statements being provided to the ICR to 10 commence as soon as possible. 11 The Cabinet Secretary has now confirmed that the 12 ambit of the legal work for Levy & McRae clients and 13 others will be support to draft the applicant statement, 14 advice on any legal issues arising and on the final 15 neurosurgical report. It is clarified that while no 16 legal contract is in place with Levy & McRae, they have 17 been told that they are covered to respond to live 18 queries. 19 We assume that this cover must also cover any other 20 solicitors instructed to whom applicants will be 21 directed via the Law Society. We understand therefore 22 that this legal support aspect of the plan is thus in 23 place. 24 The Inquiry understands that some of the support 25 services will be offered by the Patient Advice and Page 66	1 Scottish Government relating to the involvement of the 2 consultant neurosurgeons in the ICR process. The 3 details of these arrangements and the timescales for 4 them to be completed remained unclear, but you have now 5 been assured by the Cabinet Secretary, sir, that all 6 such matters have been resolved. 7 There is no further time for delay. Even with 8 the Inquiry's revised timetable, the work of the ICR 9 must be allowed to get underway immediately. The 10 evidential requirements of the Inquiry demands that this 11 happens now. Those who have waited years for the 12 process to commence cannot be expected to wait any 13 longer. It is our understanding that there are now no 14 impediments to the work of the ICR getting underway, 15 other than one minor remaining matter in the data 16 protection impact assessment which I anticipate can be 17 ironed out this week. 18 There appears to the Inquiry to be no logical reason 19 why the ICR cannot issue applicant statement requests to 20 the top 50 patients next week. As per previously 21 intimated timetables, this should allow the applicant 22 statements to be completed by early in the new year, 23 perhaps allowing some, based on a four week period to 24 complete them, which Professor Wigmore, we understand, 25 intends to use, inclusive of the opportunity for Page 68

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1 the Inquiry to input into their content to run further. 2 That should enable the expert reports to be 3 completed with Inquiry input during February. If the 4 50 reports are completed by early March, that leaves 5 six months to our section 2 hearings. This will enable 6 the work of the Inquiry which needs to follow to be done 7 to have things in place for those hearings. 8 That work will involve rule 8 requests being 9 prepared and further Inquiry statements being taken, as 10 well as preparations for those hearings to be done. It 11 will also take some account of those who will have 12 an interest in the section 1 hearings, which will need 13 to be done in the period from January through February 14 and March to the hearings in April, by which time the 15 patient applicant statements will be complete for the 16 top 50 cases at least. 17 Those in the next priority list can then follow and 18 also be taken into account as far as possible. If there 19 are any issues with any of that on behalf of any party 20 represented at this hearing, I would urge those present 21 to raise it here. Otherwise, that will remain 22 the Inquiry's expectation. As I have said to you, sir, 23 the Inquiry will give consideration to holding another 24 hearing, possibly at the time of the February slot which 25 we had, to ventilate any issues arising from that Page 69	1 section 1, though possibly beyond. 2 NHS Tayside raised a similar issue relating to the 3 disclosure of the identity of the ICR's experts. This 4 is a matter which has not yet been agreed with the ICR, 5 but the identities of the ICR experts will become known 6 soon enough when the neurosurgical reports start to be 7 completed and disclosed to core participants. 8 There is a standing request with the ICR by 9 the Inquiry to provide CVs for their neurosurgical 10 experts which the Inquiry would intend to peruse and 11 disclose. 12 The Inquiry has provisionally identified a number of 13 specialist areas in relation to which expert witnesses 14 are likely to be giving evidence in section 1. These 15 areas will include neurosurgery. In order to supplement 16 the significant body of expert neurosurgical evidence 17 which the Inquiry will have available to it from the 18 ICR, the Inquiry intends to seek expert evidence on 19 matters including: background to types of surgery 20 performed by Mr Eljamel; the responsibilities of 21 consultant neurosurgeons; issues raised about problems 22 with surgery or care, terms of reference 4 and 5; 23 management of surgical lists; workload, under term of 24 reference 2; and the training of junior staff. 25 Medical ethics. An expert or experts will be Page 71
1 hard-fought plan. 2 The instruction of the Inquiry's expert witnesses. 3 As set out previously, the Inquiry will itself also 4 instruct qualified experts, in particular fields of 5 expertise as experts to the Inquiry. They will insist 6 the Inquiry, either individually or as part of a group 7 of such persons, by way of the provision of written 8 reports and opinions and, where appropriate, the giving 9 of oral evidence at a public hearing. Such experts will 10 have the appropriate expertise and experience for the 11 particular instruction. They will be independent and 12 objective and subject to an overriding duty to assist 13 the Inquiry on matters within their expertise. 14 The appointment of experts to the Inquiry and 15 whether they are assigned to a group of experts 16 considering particular issues are matters exclusively 17 for the Inquiry. Although it will consider suggestions 18 from core participants as to who should be appointed. 19 Core participants will be informed of who has been 20 instructed at an appropriate juncture in the process, as 21 queried by NHS Tayside at paragraph 10 of their written 22 submission. 23 They will, of course, also have the expert reports 24 to consider in the proposal of questions for the experts 25 at Inquiry evidential hearings, in particular in Page 70	1 instructed to address the peculiarities of surgery and 2 neurosurgery; consent issues; duties of candour; the 3 pressures of private practice; obligations relating to 4 research and other roles; training of junior staff and 5 associated obligations; clinical supervision and 6 suspension; duties when things go wrong; and obligations 7 with regard to keeping notes and records. 8 And, finally, health administration and management, 9 including the responsibility of health boards or other 10 health bodies with regard to: appointments and induction 11 and training; management of workloads; clinical 12 governance; the separation between professional and 13 corporate clinical governance; private hospital 14 coordination; requirements relating to complaints and 15 feedback systems; investigative responsibilities of 16 health bodies; duties of reporting to other health 17 bodies; and document management systems and associated 18 obligations. 19 Draft letters of instructions for these experts 20 containing the questions and issues that the expert 21 witnesses will be asked to address will be disclosed to 22 the core participants before the expert reports are 23 instructed. Core participants will therefore be 24 provided with an opportunity to provide observations on 25 the scope of the matters which the experts are being Page 72

1 asked to address. Core participants are also invited in 2 paragraph 13(h) of the guidance note, sent to them for 3 this hearing on 29 October, to make any proposals in 4 their opening statements relating to the identity of 5 expert witnesses on matters which core participants 6 thought should be put to experts, including the proposed 7 section 1 experts. 8 The Inquiry team looks forward to considering any 9 such additions in the aftermath of this hearing. 10 Letters have been drafted to go these potential experts 11 or bodies to assist with the identification of the 12 section 1 experts. Counsel have started the process of 13 drafting the section 1 experts letters of instruction 14 which will, as I say, be disseminated for their comment 15 to core participants during December. 16 Consultation and the Inquiry's trauma-informed 17 approach. Given that the Inquiry was in a transitional 18 phase at the time of the preliminary hearing as regards 19 how it communicated with those with an interest in its 20 work, the Inquiry invited contributions from core 21 participants at, or in connection with, the preliminary 22 hearing as to the their views on how they would wish 23 the Inquiry to communicate with them about the multiple 24 matters on which they may come into contact with its 25 work. Page 73	1 Mr Eljamel and may include others who will be invited to 2 help shape the way that the policy will operate in 3 practice. 4 The results of this exercise will be fed into 5 the Inquiry's wider engagement strategy, which will set 6 out the means by which the Inquiry intends to engage 7 with those with an interest in, and a role to play in, 8 the Inquiry's important work. It will be launched in 9 due course as the Inquiry moves into its evidential 10 phase, as a means of seeking to promote the Inquiry's 11 principles of collaboration, listening and clarity. 12 In the guidance sent out to core participants 13 relating to this opening statement hearing, at 14 paragraph 13(k), input on the Inquiry's trauma-informed 15 policy was invited in core participants opening 16 statements. Any contribution via this route is 17 gratefully received and will be considered, along with 18 the contributions to the public consultation itself. 19 The Inquiry is committed to finding effective ways 20 to communicate and to its trauma-informed approach, not 21 only in principle but also in the ways it actually works 22 on a day-to-day basis. The public consultation, led by 23 the deputy secretary of the Inquiry, is designed to 24 offer collaboration and empowerment to enable this 25 commitment to be fulfilled to the best of our ability. Page 75
1 This was and is part of the Inquiry's ongoing 2 commitment to listening to those with an interest in its 3 work as to how they wish it to operate. 4 The Inquiry had little response in this regard, 5 though remains committed to trying to get communication 6 right. In order to seek to improve the ways that 7 the Inquiry engages with those with an interest in its 8 work, including its core participants, the Inquiry has 9 launched an online public consultation on its 10 trauma-informed policy which it intends to implement in 11 its work. The consultation paper contains an outline of 12 the approach which the Inquiry intends to take in this 13 regard. 14 The Inquiry's trauma-informed policy will play 15 an important part in its engagement strategy given the 16 number of key stakeholders in our work who have 17 experienced trauma as a result of their experiences. 18 The policy will be built around the trauma-informed 19 principles of safety, trustworthiness, choice, 20 collaboration and empowerment and will seek to create 21 a bespoke approach for a trauma-informed public inquiry, 22 based on the principles to which the Inquiry has already 23 committed itself and the reasonable requirements of 24 those who have suffered trauma who are engaged in our 25 work. This will certainly include former patients of Page 74	1 Connected to our trauma-informed policy, the Inquiry 2 has now arranged for a tender process to be commenced, 3 inviting bodies to run the Inquiry's support service for 4 those who engage with our work. That service will 5 ultimately involve support being available to those who 6 are participating in the work of the Inquiry from 7 trained counselors. The tender process stipulates that 8 those who wish to bid for the work must be independent 9 of NHS Tayside given the importance of the independence 10 of that service to those who may wish to use it, having 11 trust and confidence in the support that it will 12 provide. 13 As was the case in connection with the Inquiry's 14 public consultation events and the preliminary hearing, 15 support services are available at this hearing today, 16 provided by The Spark, a Scottish-based charity which 17 provides counselling and mental health support for 18 individuals, couples, families, children and young 19 people and which has provided such services for 20 59 years. 21 Many thanks indeed, sir, for the opportunity to 22 provide this update which I hope those with an interest 23 in our work have found informative and which I hope will 24 lead to further progress and productivity in 25 the Inquiry's work. The hearing, as I have said, is Page 76

1 predominantly about the contribution of core 2 participants to various important aspects of our work to 3 which we will now turn. 4 LORD WEIR: Thank you very much indeed, Mr Dawson. 5 Now, Ms Cherry, I'm going to turn to you next. I'm 6 conscious that we're now at 12 o'clock. If your 7 submission encroaches into lunchtime, I will just rely 8 on you to find an appropriate place that's convenient to 9 stop. Thank you. 10 Opening statement by MS CHERRY 11 MS CHERRY: Thank you, sir, and good morning to everyone who 12 has gathered here today. My name is Joanna Cherry and 13 I appear together with my learned junior Euan Scott for 14 the group of core participants including former patients 15 of Mr Eljamel and their personal representatives. 16 We are very grateful for the opportunity to make 17 this opening statement to the Inquiry and we're also 18 very grateful for the update we have had from counsel to 19 the Inquiry this morning. 20 The group which we represent comprises former 21 patients and personal representatives of former patients 22 who received treatment from Mr Eljamel prior to his 23 suspension from NHS Tayside in 2013. At present, the 24 number of core participants, as we have heard, within 25 that group is 159. The number has continued to grow as Page 77	1 and trauma-informed, but we stress that this will 2 necessitate a full understanding of the experience 3 endured by patients and their loved ones. The voice of 4 the patients and their loved ones must be heard and 5 I would like to preface what I have to say this morning, 6 sir, with just a small flavour of the human cost of 7 Mr Eljamel's actions and his inactions, drawing on what 8 some of the individuals within the group have been able 9 to tell me as we have consulted in recent months. 10 Some patients in this group, sir, have undergone 11 multiple surgeries at the hands of Mr Eljamel. One 12 patient describes how on the morning of her third 13 surgery at Mr Eljamel's hands she was so scared that she 14 vomited. She told a nurse that she had changed her mind 15 and wanted to go home, but the next thing she remembers 16 is waking up having had the surgery. The long-term 17 implications of that spinal surgery which was botched 18 have been so severe that she has lost her marriage as 19 well as her job and her home. She has been through some 20 very dark times and has come very close to taking her 21 own life. 22 The mess that Mr Eljamel left her spine in is such 23 that it is inoperable and she suffers constant falls and 24 broken limbs. 25 Another patient was told by Mr Eljamel that she was Page 79
1 the true nature and extent of Mr Eljamel's practice 2 becomes more widely known. 3 That group is represented by Levy & McRae, but it 4 should be acknowledged from the outset that there are 5 many other former patients or patient representatives 6 who do not form part of the group but who, nevertheless, 7 have a keen interest in this Inquiry's work. 8 I speak only for those who are part of the group 9 represented by Levy & McRae. 10 That group appreciates, sir, that the focus of this 11 Public Inquiry is on the systemic failures that led to 12 Mr Eljamel being in post for so long. The systemic 13 failures that led to him being in post notwithstanding 14 his shocking record, his appalling behaviour which 15 sometimes verged on the malicious and numerous 16 complaints about him and widespread knowledge about his 17 record and behaviour. 18 This Inquiry has to find out why, notwithstanding 19 all those things, he was able to continue treating 20 patients for years. 21 However, in order to understand the systemic 22 failures, it is necessary first to appreciate the extent 23 of the experiences that patients and their loved ones 24 have endured and continue to endure. We welcome the 25 recognition that this Inquiry is to be patient centred Page 78	1 the perfect candidate for an experimental procedure 2 involving the use of glue instead of sutures. He did 3 not warn her of the risks of this procedure including 4 the increased risk of contracting meningitis. He did 5 not tell her that she was part of a study, just that he 6 had invented the glue that was being used. 7 She went on to suffer appalling complications 8 including the contraction of meningitis and had to have 9 further multiple surgeries. She has lost the 10 opportunity to have children and to run her small 11 business which she loved. 12 Another patient was told by Mr Eljamel that she was 13 the first person in Europe to be treated using a new 14 glue. The outcome of her surgery was so bad that she 15 lost her job, but the most upsetting thing for her was 16 that for a significant period of time she was unable to 17 pick up her baby or her toddler when they were very 18 small and young at a time they most needed their mum. 19 Years later, her general practitioner wishes to send 20 her back to Ninewells for further treatment, but she is 21 afraid to go and she told us that NHS Fife have said she 22 could go to a hospital in Edinburgh with her general 23 practitioner's support, but sadly that support has not 24 been forthcoming. 25 Another patient had a titanium plate inserted into Page 80

1 her spine by Mr Eljamel despite it being clear from her 2 medical records and what she had told him that she had 3 a metal allergy. She has not worked since the operation 4 in 2013. 5 Mr Eljamel told another patient who was the victim 6 of spinal surgery that had gone badly wrong -- meaning 7 that she lost her bladder function for a significant 8 period of time -- he told her that it was her fault 9 because she had chipped a bone in her back. 10 Of course, it's not just spinal surgery that 11 Mr Eljamel carried out; there was also brain surgery. 12 We have another patient in our group who underwent three 13 operations on their brain within the space of two weeks 14 and was left with epilepsy and blindness in the right 15 side of both eyes. This gentleman was left unable to 16 read and write and had to take early retirement. 17 Another patient was left paralysed from the neck 18 down. One patient describes appalling histrionics by 19 Mr Eljamel when the results of the surgery that had gone 20 wrong came to light. And this patient has told us that 21 he was told by a nurse that Mr Eljamel had actually come 22 to physical blows with another surgeon who had 23 challenged him about the severity of this patient's 24 outcome. 25 Many patients, sir, have found that other clinicians Page 81	1 long search for truth and justice. That report was 2 entitled "The patronising disposition of unaccountable 3 power". That phrase was chosen to describe the systemic 4 attitude of the authorities towards the Hillsborough 5 families and to highlight how those with power displayed 6 a dismissive and condescending attitude, while avoiding 7 responsible for failures that prolonged the suffering of 8 those affected by the disaster. 9 That phrase, in my respectful submission, "the 10 patronising disposition of unaccountable power" is also 11 apt to describe the experience of the group and their 12 loved ones, not just at the hands of Mr Eljamel, but 13 also at the hands of NHS Tayside, the 14 Scottish Government and other authorities whose actions 15 will be examined by this Inquiry. 16 The group and their loved ones need recognition, 17 accountability and justice for years of suffering and 18 years of deceit. They are seeking answers not just for 19 Mr Eljamel's actions but also for the subsequent 20 cover-ups and the impact that these cover-ups have had 21 upon them. 22 As is well-known, members within the group have 23 campaigned tirelessly for the establishment of this 24 Public Inquiry. Campaigners first called for a public 25 inquiry in 2014, following Mr Eljamel's suspension from Page 83
1 refused to operate on them because they were previously 2 patients of Mr Eljamel and because of the condition in 3 which they have been left by Mr Eljamel. 4 One patient poignantly recalls the dying words of 5 her mother who supported her through years of trauma at 6 Mr Eljamel's hands and that lady said: 7 "It was a shame that she would not be alive to see 8 Mr Eljamel brought to justice." 9 Sir, that is just a flavour of the evidence that we 10 have heard from those we represent. 11 Now, when a patient consents to treatment from 12 a surgeon, particularly a neurosurgeon, they are 13 literally putting their life in that surgeon's hands. 14 It's really quite hard to imagine a surrender which is 15 more complete and which renders a patient more 16 vulnerable and therefore the bond of trust in that 17 situation is of the utmost importance and this Inquiry 18 is about how the betrayal of that trust was allowed to 19 happen repeatedly and why it was allowed to happen for 20 so long. 21 It is also about the way patients and their loved 22 ones have been treated simply for daring to seek answers 23 and redress. 24 You, sir, will be familiar, as many will in this 25 room, with the report about the Hillsborough families' Page 82	1 NHS Tayside, which is, of course, is now more than 2 a decade ago. The Scottish Government repeatedly 3 resisted calls for a full public inquiry, insisting that 4 internal NHS reviews were sufficient. 5 Following a series of unsatisfactory internal 6 reviews and in the face of continued procrastination, 7 delays and obstructions by NHS Tayside and the 8 Scottish Government, the campaign for a public inquiry 9 gathered momentum, with patients staging a series of 10 public protests throughout 2022 and 2023. 11 Whilst every patient's treatment and circumstances 12 is unique, as will become clear, the evidence before 13 the Inquiry will reveal a common experience, both in 14 terms of the treatment received from Mr Eljamel, but 15 also in terms of the actions and inaction of NHS Tayside 16 in response to reasonable concerns. A common experience 17 is that the systems in place designed to protect and 18 promote a patient's well-being were wholly adequate and 19 members of the group have thus been left with little or 20 no trust in the NHS. 21 One hopes that this Inquiry might be able to restore 22 that trust if not for all the NHS Tayside's the group 23 but perhaps more for the general public. 24 Now, in my statement this morning, I'm going to 25 address five chapters. First of all, the purpose of Page 84

1 this Public Inquiry and its terms of reference. 2 Secondly, the group's experiences at the hands of 3 Mr Eljamel and the NHS. Thirdly, the group's 4 experiences trying to get justice. Fourthly, learning 5 from the process of setting up the Public Inquiry and 6 the Independent Clinical Review. And fifth and finally, 7 expectations and the future. 8 So I turn to the first chapter of my oral statement, 9 the purpose of this Public Inquiry and its terms of 10 reference. And for the assistance of those who have had 11 the benefit of seeing the written statement which I and 12 my learned junior lodged on behalf of the patient group, 13 I will be largely following the layout in that written 14 statement. 15 LORD WEIR: Thank you. 16 MS CHERRY: Turning first to the purpose of this Inquiry. 17 As I said, its purpose is to establish facts, ensure 18 accountability and make recommendations for the future 19 and that purpose could not be more important considering 20 that the concerns raised involve the 21 National Health Service and how healthcare is delivered 22 to the people of Scotland. 23 The Cabinet Secretary for NHS Recovery, Health and 24 Social Care recognised this when he announced the 25 Inquiry and he said, and I quote: Page 85	1 basically nothing can be done for them or clinicians are 2 reluctant to provide further treatment due to concerns 3 over what Mr Eljamel has done, so the suffering 4 continues. 5 Too many patients also received a wholly inadequate 6 response to their concerns when raised with NHS Tayside. 7 They believe that NHS Tayside have evaded both moral and 8 legal accountability and despite placing their trust and 9 well-being with the NHS, patients have experienced, at 10 the hands of NHS Tayside, poor communication, a lack of 11 candour, evasiveness and, at times, dishonesty. 12 For the group, their concerns are not limited solely 13 to Mr Eljamel and NHS Tayside. They extend to other 14 institutions involved in or responsible for their care 15 because despite concerns existing over the practice of 16 Mr Eljamel, it seems to the group that these 17 organisations sat silent. Patients were still 18 continuously referred to Mr Eljamel for treatment. He 19 was permitted to train and teach future clinicians that 20 continue to work in the NHS today and the importance of 21 investigating that lasting impact that Mr Eljamel has 22 had on the NHS cannot be overstated. 23 Accordingly, this Inquiry must ensure that 24 organisations designed to provide oversight are 25 scrutinised to ensure the accountability of individuals Page 87
1 "Few things are more important than the safety of 2 patients in our health service. Perhaps equally 3 critical is the trust that we, as individuals and 4 communities, can have on our healthcare. Patients must 5 also trust that any concerns that are raised about their 6 care and treatment will be investigated and that the 7 necessary actions will be taken. They must be able to 8 trust that their concerns will be investigated and 9 scrutinised and will be subject to robust governance and 10 due diligence at the time, not several years later. 11 "When trust is broken and weakness in governance is 12 identified, it is imperative that we do all that we can 13 to investigate why that has happened and to prevent 14 others having the same kinds of distressing and 15 traumatic experiences." (As read). 16 And I end there the quote from the 17 Cabinet Secretary. 18 So to summarise, sir, put shortly, this Inquiry is 19 absolutely necessary to restore trust in our NHS and the 20 various other institutions that are designed to protect 21 patients. 22 Too many people have suffered both physically and 23 mentally due to the actions of Mr Eljamel. Many have 24 been left with life-changing injuries and, as I said, 25 some have found themselves to be in a situation where Page 86	1 within these organisations for allowing Mr Eljamel to 2 continue to practice in the manner that he did for as 3 long as he did and it's only with proper scrutiny that 4 the public can be satisfied that these organisations are 5 fit for purpose, notwithstanding their failures in 6 relation to Mr Eljamel. 7 It is apparent, sir, from our discussions with 8 members of the patient group, that Mr Eljamel was not 9 simply a rogue surgeon acting without the knowledge and 10 tacit approval of colleagues: other healthcare workers 11 were aware. Some appear to have challenged the conduct 12 but elected to take it no further. Others appear to 13 have simply permitted the conduct to continue. 14 The systems that were in place within NHS Tayside 15 require very close scrutiny. The details of a number of 16 individual clinicians and employees of NHS Tayside from 17 whom we believe evidence should be sought, have been 18 provided to the Inquiry this morning. It has taken us 19 some time to compile that list because it's quite 20 lengthy, but we feel it's also incumbent upon 21 NHS Tayside to identify such witnesses and we hope 22 pressure will be brought upon them to do so. 23 The group expects the Chair and counsel to the 24 Inquiry to scrutinise clinicians and management employed 25 by NHS Tayside, as well as NHS Tayside itself, without Page 88

22 (Pages 85 to 88)

1 fear or favour and we have confidence that they will 2 strive to do so. 3 There is an expectation that the relevant facts are 4 fully and fairly investigated so that recommendations 5 can be made to avoid similar issues arising in the 6 future, but first and foremost, what the group expects 7 is accountability. Accountability from the 8 organisations that failed to put the patients' interests 9 first. Accountability from individuals who turned 10 a blind eye. Accountability from those individuals who 11 permitted Mr Eljamel to continue practising when 12 concerns were evident, and accountability for both the 13 individuals and organisations that are responsible for 14 what has happened to the patients and the lasting 15 effects. 16 The group expect truth and justice and that, in my 17 submission, is the purpose of this Inquiry. 18 Now, turning to the terms of reference, following 19 a public consultation exercise, those have been fixed 20 and the group were very grateful for the opportunity to 21 provide comment on the terms of reference and the list 22 of issues and we were particularly grateful that so many 23 of our suggestions for the list of issues were taken on 24 board. 25 Now, you, sir, are already familiar with the Page 89	1 they wish to see Scottish Government ministers held to 2 account for their choices. 3 We note that counsel to the Inquiry very helpfully 4 clarified at the preliminary hearing that evidence will 5 be sought from the GMC and the HSE to help inform the 6 discharge of the terms of reference and that, in 7 particular, the GMC will be called upon to produce 8 evidence relating to the role of NHS Tayside under term 9 of reference 11 in the voluntary removal by Mr Eljamel 10 of his name from the Medical Register. 11 And we also note that while the Inquiry cannot make 12 findings about the role of the Health and Safety 13 Executive, it can make findings about the role of Health 14 Improvement Scotland, in relation to their functions of 15 inspection and regulation of clinical services to ensure 16 they meet safety and quality standards. We understand, 17 sir, that Health Improvement Scotland have a memorandum 18 of understanding with the Health and Safety Executive 19 and we should like to hear evidence about this and 20 understand how it works in practice. 21 Turning to the issue of private healthcare, we note, 22 of course, that the Inquiry requires, under term of 23 reference 2(a), to investigate whether Mr Eljamel's 24 private practice commitments contributed to adverse 25 outcomes for his NHS patients. Under term of Page 91
1 concerns of the group about what has been excluded from 2 the terms of reference. It is, of course, appreciated 3 that the terms of reference have been determined by the 4 relevant Scottish Government minister. However, there 5 remains a very strong feeling within the group that, A, 6 the Inquiry ought to fully examine the role of the 7 private healthcare sector, and, B, that it is very 8 unfortunate that the Inquiry does not have jurisdiction 9 to determine any fact or make any recommendation which 10 is not wholly or primarily concerned with a Scottish 11 matter. 12 These are not criticisms of the Inquiry; they are 13 criticisms of the way in which the Inquiry has been set 14 up. So the group hopes that when the Inquiry comes to 15 investigate the creation of the Inquiry itself under 16 term of reference 12, both the decision to exclude 17 a fuller examination of the role of the private 18 healthcare sector and the decision not to hold a joint 19 Inquiry with the UK government, will be interrogated 20 because, of course, a joint Inquiry would have enabled 21 full investigation of organisations such as the 22 General Medical Council and the 23 Health and Safety Executive, which are the 24 responsibility of the UK government. 25 The group cannot understand why this wasn't done and Page 90	1 reference 3, the Inquiry will require to look at whether 2 there were clues from what was going on in his private 3 practice that should perhaps have been detected so as to 4 protect NHS patients from harm. 5 We believe it will also be necessary to consider 6 issues relating to the granting of practising privileges 7 to Mr Eljamel at Fernbrae Hospital under term of 8 reference 2(a). 9 The group contains patients, sir, who have reason to 10 believe that they were encouraged by Mr Eljamel to "go 11 private", in the colloquial term, for unnecessary 12 surgeries, patients who were made to wait for private 13 care when their condition was so grave they should have 14 been fast-tracked on the NHS lists, and patients who 15 believe they underwent unnecessary procedures simply 16 because Mr Eljamel knew that they had private health 17 insurance. 18 We note, as has been emphasised this morning, that 19 the experience of private patients will be captured by 20 the Independent Clinical Review and available to 21 the Inquiry and these matters are also, of course, 22 within the purview of Health Improvement Scotland, whose 23 remit includes enabling the people of Scotland to 24 experience the best quality of health and social care in 25 both public and private sectors. Page 92

23 (Pages 89 to 92)

1 While it is acknowledged, sir, that the Independent 2 Clinical Review is going to permit examination of 3 Mr Eljamel's clinical work within the private sector, we 4 fear that the absence of such examination by the Inquiry 5 could respectfully result in an incomplete and skewed 6 analysis of the full extent of Mr Eljamel's actions and 7 how he was able to continue for so long. This could, in 8 due course, limit the effectiveness of any 9 recommendations made and this is particularly so given 10 the extent that the private healthcare sector interacts 11 with the NHS within Scotland. 12 It is hoped, sir, that you might consider whether 13 you should make representations to the relevant minister 14 to widen the scope of the terms of reference in relation 15 to the private healthcare sector in due course. 16 I turn, now, to an important issue regarding 17 Mr Eljamel's supervision of NHS colleagues within the 18 NHS which is covered by term of reference 2(b). 19 We believe it's very important to consider what 20 impact, if any, his role at the University of Dundee had 21 on trainee or student doctors challenging his behaviour 22 or raising clinical concerns within NHS Tayside. 23 Separately, the partner of one patient within the 24 group overheard junior doctors discussing the potential 25 need for them to repeat their rotations undertaken under Page 93	1 what counsel to the Inquiry said earlier this morning, 2 that the extent of their representation is, of course, 3 a matter for the university, but it goes without saying 4 that financial constraints will be no answer to their 5 compliance with orders made by the Inquiry for the 6 recovery of evidence. I am glad we're all on the same 7 page about that. 8 Lastly, under the first chapter of my submission, 9 I want to mention briefly the position of NHS Fife. 10 You, sir, will have seen from our written opening 11 statement that we would wish the Inquiry to consider 12 under term of reference 6 why clinicians and GPs, 13 including those within NHS Fife, continued to refer 14 patients to Mr Eljamel, notwithstanding concerns raised, 15 or concerns which should have been self-evident from the 16 results of his treatment of his patients. 17 I turn, now, to chapter 2, the group of their 18 experiences at the hands of Mr Eljamel and the NHS. 19 I have said a little about this already in my 20 introduction, but I want to say a little more about it 21 now. 22 The group contains patients or relatives of patients 23 who were treated by Mr Eljamel between 1995 and 2013 and 24 there is, rightly, a lot of focus on the period in 2013, 25 but the group does contain people who were operated on Page 95
1 Mr Eljamel's supervision when he was finally suspended. 2 I respectfully suggest that the Inquiry should 3 investigate whether this occurred and what steps were 4 taken to ensure that trainees under his supervision were 5 prevented from replicating his suboptimal practices in 6 their own professional practice. 7 Also in relation to term of reference 2(d) and (e), 8 one member of the group, with contemporaneous 9 professional experience of the University of Dundee, has 10 told us of the awe in which Mr Eljamel was held at the 11 university, the impression that he was untouchable and 12 concerns about his role in helping the university get 13 research funding and his relationship with organisations 14 promoting research on new or experimental techniques. 15 As we have heard this morning from counsel to the 16 Inquiry, the University of Dundee is, of course, a core 17 participant in this Inquiry. We note that their written 18 opening statement refers to the severe financial 19 constraints under which the university currently finds 20 itself. 21 It's not clear, sir, but from the brevity of that 22 opening statement we suspect those financial constraints 23 are being raised in order to indicate that the 24 university may be constrained in its participation in 25 this Inquiry and I would wish to associate myself with Page 94	1 long before that and right back at the beginning of the 2 relevant period. 3 Many of them have suffered life-changing injuries, 4 as I have said, for example, loss of sight and 5 paralysis, but they have also been left with injuries 6 which are not just physical, but also psychological, 7 mental and emotional. Some have suffered suicidal 8 ideation, some have lost their jobs, their ability to 9 access work and education, their homes, their marriages 10 and their families. The impact on their families and 11 their loved ones has also been profound and these are 12 not just historic experiences. Members of the group 13 live daily with life-limiting injuries at the hands of 14 Mr Eljamel. 15 Some of the group are representatives of patients 16 who have succumbed to their injuries or died without 17 seeing justice and at least one member of the group is 18 the relative of a patient who recently died from another 19 condition, but the procurator fiscal requested 20 a post-mortem because the deceased had been a patient of 21 Mr Eljamel with all the consequent additional distress 22 that that occasioned. No criticism of the 23 procurator fiscal is intended, but it's just another 24 example of the long-term effects of Mr Eljamel's 25 actions. Page 96

24 (Pages 93 to 96)

1 The group have been impacted, as I said, not just by 2 what Mr Eljamel did to patients in the operating 3 theatre, but also how he behaved towards them when they 4 sought follow-up. The words most frequently used to 5 describe him are evasive, arrogant and chauvinist, and 6 at least one member of the group describes vividly their 7 dismay at realising that Mr Eljamel had absolutely no 8 idea what to do in their case. 9 The impact on the group extends beyond the physical 10 and psychological consequences of their treatments at 11 the hands of Mr Eljamel, to distress about the way they 12 were treated by other NHS staff. Many patients describe 13 being referred to as "season ticket holders" or 14 "frequent flyers" because of their need for continuing 15 treatment and some describe feeling gaslit by NHS staff 16 and made to feel confused, anxious and unable to trust 17 their own instincts. This behaviour has exasperated the 18 suffering of members of the group at Mr Eljamel's hands. 19 I was pleased to hear the acceptance this morning 20 that the remit of the Inquiry must extend beyond 21 Mr Eljamel's practice at Ninewells Hospital into other 22 NHS hospitals where he might have practised or referred 23 patients for procedures connected with his treatment and 24 that includes Dundee Royal Infirmary and possibly also 25 Perth Royal Infirmary. Page 97	1 good to hear that those instructing me will be consulted 2 about further additions to the priority cases. There 3 have been difficulties over the ICR. I don't intend to 4 go into them in any great detail this morning, but it's 5 important to realise that because of the delays on 6 behalf of the Scottish Government, mentioned by counsel 7 to the Inquiry earlier this morning, that those 8 instructing me are still not formally instructed in 9 relation to the Independent Clinical Review because 10 there's no final agreement in place and that is through 11 no fault of those instructing me, but we are very 12 grateful to the Inquiry team for the pressure that has 13 been brought on the Scottish Government to try and get 14 things moving. 15 One practical point of concern which I should 16 mention in passing just now is that I heard what my 17 learned friend had to say about the plan for the next 18 few weeks and I very much hope that it's going to 19 proceed with the expedition which my learned friend has 20 striven so hard to get. I was just slightly concerned 21 that those instructing me and, more importantly, the 22 patient group, might find themselves in the situation 23 where the four-week period that was referred to falls 24 over the holiday period and that might make things 25 slightly difficult for people, but that's a procedural Page 99
1 Now, whilst it is fully understood that 2 the Inquiry's terms of reference largely focus on 3 systemic issues, the group is grateful that 4 an opportunity is going to be afforded to some of them 5 to tell their story in section 2 of this Inquiry. It 6 is, in my respectful submission, essential that this 7 happens because it's only by listening to members of the 8 group and other patients affected that systemic issues 9 can be properly identified and highlighted so as to 10 fulfil the Inquiry's terms of reference. 11 To that end, the group are grateful to the Inquiry 12 for adopting a trauma-informed approach to the taking of 13 their evidence and we look forward to being consulted on 14 what is proposed, as counsel to the Inquiry has outlined 15 earlier today. 16 I was also grateful to hear counsel to the Inquiry 17 give some clarity about the methodology that had been 18 used to select priority cases for the Independent 19 Clinical Review and the triage system that had been 20 followed and the fact that members of the group which 21 I represent and other patients should not assumed, if 22 they're not included within the initial list of priority 23 cases, that their case is not being treated with equal 24 importance. 25 It's good to have that clarification. It's also Page 98	1 matter which I'm sure I can iron out behind the scenes 2 with my learned friend. 3 As I say, I'm grateful to him and you, sir, for all 4 the work that has been put into getting the Independent 5 Clinical Review off the ground. I'm also grateful to 6 Professor Wigmore for the benefit of the meetings that I 7 have had. Some members of the group I represent remain 8 cautious about the Independent Clinical Review. They 9 have, however, been encouraged to engage with the 10 Independent Clinical Review with its importance being 11 emphasised and will now, of course, have the support of 12 their solicitors to do so. 13 My learned friend spoke about some of the themes 14 that emerge from Mr Eljamel's practice. I would wish to 15 say that every patient experience is unique, but from 16 the information I have to date I have been able to 17 identify some common themes. These include: the absence 18 of informed consent; warnings about underlying 19 conditions in medical records which were ignored; 20 surgeries performed by junior colleagues without 21 adequate supervision; the use of experimental techniques 22 and medical devices which were new to the market; the 23 lack of expertise to perform specific surgeries; 24 surgical mistakes which could have been avoided; wrong 25 site surgeries; ghost surgeries, where the surgery for Page 100

1 which the patient was consented was not actually carried 2 out; the absence of basic oversight and investigation; 3 the awareness of concerns that were not acted upon; 4 bullying and intimidating behaviour; the absence of 5 meaningful communication; the lack of transparency; and 6 the lack of candour. That is by no means meant to be 7 an exhaustive list, but is a pattern that I and my 8 junior have been able to identify from the information 9 we have. 10 I want to turn now to chapter 3 of my submission 11 which relates to the group's experiences as they 12 attempted to get justice. The conduct of Mr Eljamel and 13 its impact on patients, as I have said, must be 14 examined, but the wrongs inflicted upon members of the 15 group did not end there. Each and every member of the 16 group put their trust and faith in Mr Eljamel, but also 17 our National Health Service when they were at their most 18 vulnerable and they trusted all the healthcare employees 19 involved in their care and they trusted that they would 20 act with expertise and honesty and with their best 21 interests at the forefront of their minds. 22 That trust was broken not just by allowing 23 Mr Eljamel to continue practising, but in how 24 NHS Tayside has sought to address the concerns that have 25 since arisen and the group want answers to why that has Page 101	1 We have heard examples of NHS Tayside refusing or 2 claiming to be unable to provide patients with their 3 medical records. 4 Of particular concern is where further treatment 5 and/or investigations have been refused due to the 6 historic involvement of Mr Eljamel. Patients within the 7 group feel that they have, in effect, been blacklisted 8 for daring to raise concerns. Accordingly, it is vital 9 that when listening to the former patients, the Inquiry 10 consider to what extent institutions have contributed 11 and are indeed still contributing to the wrongs 12 originally inflicted by Mr Eljamel. 13 In this connection, sir, I wish to raise a very 14 serious matter which has come to light in the last few 15 days. Members of the group and the legal team were 16 appalled to read in NHS Tayside's written opening 17 statement that the board has recently discovered that 18 around 40 hard-copy theatre log books, which would have 19 contained information relating to Mr Eljamel's surgeries 20 in the period 1995 to 2013, were destroyed by 21 NHS Tayside employees this summer on 24 July 2025. 22 It beggars belief that this should have occurred, 23 notwithstanding everything that has gone before. 24 Patients and their representatives have repeatedly 25 raised concerns that their medical records may have been Page 103
1 happened in order to ensure it doesn't happen again. 2 Now, we understand that individuals within the group 3 as well as at least one whistleblower raised complaints 4 or concerns about Mr Eljamel's practices prior to 2012 5 and we have given the name of that whistleblower in our 6 list of witnesses. 7 The Royal College of Surgeons (England) report dated 8 6 December 2013 records that there were four complaints 9 about Mr Eljamel in 2012 and three in 2011. And in the 10 undated report by Mr Donald Campbell on the Gillies 11 report, it is recorded, and I quote: 12 "This surgeon had three and a half times as many 13 complaints in the space of two years than the average 14 number of complaints made in a whole professional 15 lifetime for the average surgeon. This is an obvious 16 pattern and should have raised queries in 2013 if not 17 before." (As read). 18 That's the end of the quote. 19 I'm sure more information about all of this will be 20 captured by the Independent Clinical Review patient 21 statements, but it's important to emphasise that the 22 group's experiences are not just historic. Members 23 within the group continue to experience difficulties in 24 how NHS Tayside address their complaints and their 25 continued care. There have been data protection issues. Page 102	1 tampered with or be incomplete and in these 2 circumstances, it should have been obvious that these 3 log books might have provided vital evidence for this 4 Inquiry to fill gaps in patient records. 5 You, sir, of course issued formal "do not destroy" 6 notices on 11 October 2024. We fail to see how this 7 wanton destruction of vital evidence could have happened 8 if NHS Tayside had put proper systems in place to comply 9 with that "do not destroy" notice. That's particularly 10 so given the terms of the protocol on the production 11 handling and retention of documents, which you, sir, 12 issued on 8 May. 13 It seems to us that the only explanation for what 14 has occurred must be gross negligence or indeed possible 15 malice. 16 Now, of course, offences may have been committed 17 under section 35 of the Inquiries Act 2005, but at the 18 preliminary hearing, sir, you said that you wouldn't 19 hesitate to use your statutory powers to call for or 20 recover evidence and in due course to compel the 21 attendance of witnesses in order to exhaust the terms of 22 reference. 23 We would hope that, as I think was indicated by 24 counsel to the Inquiry this morning, that witnesses will 25 be called upon to give evidence on oath about how these Page 104

26 (Pages 101 to 104)

1 documents came to be destroyed and in our view, such 2 witnesses should include NHS Tayside's Chief Executive 3 and Chief Operating Officer, together with the chain of 4 command, right down to those who destroyed the evidence. 5 I heard that we might be having further preliminary 6 hearings and I would hope that perhaps the time that was 7 originally set aside in February, some of it might be 8 used to get to the bottom of why it was possible for 9 this vital evidence to be destroyed. 10 Now, turning to the examination of previous reviews 11 and investigations. The group wish the Inquiry to 12 investigate concerns about a number of issues. One of 13 those is the extent of the supervision afforded in 2013. 14 Another is why the Royal College of Surgeons (England) 15 were instructed only to investigate spinal surgery and 16 not brain surgery. 17 A third concern is why no thought was given to 18 a potential conflict of interest when at least one known 19 internal review of a complaint by NHS Tayside in 2015 20 was carried out by the same clinician who had been 21 responsible for supervising Mr Eljamel. 22 Another concern is Mr Eljamel's failure to attend 23 routine multidisciplinary meetings and his alleged 24 failure to carry a bleep. We also would wish 25 the Inquiry, in this connection, to look at the Page 105	1 However, when the Independent Clinical Review was 2 originally announced, many patients thought that the 3 Government's emphasis on their needs meant that it would 4 provide an avenue to explore future treatment. That's 5 clearly not the case and they have been left 6 disappointed and in some cases angry after learning that 7 that is not, now, the purpose of the Independent 8 Clinical Review. It was, of course, designed to be 9 an adjunct to the Inquiry as matters evolved. It 10 doesn't have the same powers that are available to 11 the Inquiry, for example, it cannot compel organisations 12 to provide relevant documentation. 13 Members of the group have, in the past, experienced 14 significant difficulty in obtaining their medical 15 records. Some have obtained medical records which are 16 partial and some have been told that medical records 17 have been destroyed. One member of the group has told 18 us of how Mr Eljamel kept her child's medical records in 19 a locked drawer in his room. So I think it's very fair 20 to say that members of the group have legitimate 21 concerns that medical records are not as they should be, 22 that they may be incomplete, they may have been 23 falsified and they may have been deliberately destroyed. 24 Now, of course, as we know, the Independent Clinical 25 Review is reliant on the Inquiry for the purposes of Page 107
1 circumstances surrounding a complaint we believe to have 2 been made by the Tayside local medical committee 3 regarding Mr Eljamel and we have provided witness names 4 who might be able to assist the Inquiry with that. 5 I turn now to chapter 4: learnings of the process 6 with setting up the Public Inquiry and the Independent 7 Clinical Review. 8 Members of the group are very glad, of course, that 9 the Scottish Government eventually acceded to their 10 request to establish the Public Inquiry to examine the 11 issues with which we are concerned today. However, they 12 do have some concerns over the manner in which these 13 issues will be explored and as I have stressed, or tried 14 to stress today, careful examination of the patient 15 experience is necessary before we can properly identify 16 systemic issues and such identification is obviously 17 necessary for the Inquiry to fulfil its stated remit. 18 The Scottish Government have, however, elected to 19 largely outsource examination of clinical issues to the 20 Independent Clinical Review with difficulties about 21 limited support being afforded to that review and also 22 to the group to interact with it. I'm hoping that we're 23 getting over some of those issues now and I was 24 comforted by some of what counsel to the Inquiry had to 25 say earlier this morning. Page 106	1 recovering those medical records. This has meant 2 something of a delay, I think, but we were comforted 3 this morning by what counsel to the Inquiry had to say 4 about that. But the extent of issues associated with 5 the medical records and the absence of proper 6 accountability of organisations to the Independent 7 Clinical Review in that regard remain a concern to the 8 group. 9 As noted by counsel to the Inquiry at the 10 preliminary hearing back in September, progress with the 11 ICR's work is vital and we are grateful to 12 Professor Wigmore for the time he has given to us, as 13 legal representatives of the group, to explain what was 14 happening and we are pleased to hear about the progress 15 that we have heard about this morning. 16 However, it goes without saying that the patient 17 group are disappointed about the cancellation 18 of February's hearings and the postponement of section 1 19 to April. This means, of course, that the voices of 20 patients and their representatives will not be heard by 21 this Inquiry in section 2, now, until the autumn and 22 it's incumbent upon me to say that the group would like 23 to have assurances that there will be no further 24 delays and to know exactly what the section 2 hearings 25 will take place. Page 108

1 Now, I know that we are going to have four weeks 2 in September and I'm very grateful to counsel to the 3 Inquiry for telling us that this morning, but I suspect 4 there will probably need to be more than one diet of 5 hearings to deal with the section 2 hearings. 6 Now, Chair, I'm coming to part 5 and my conclusion. 7 I can do one of two things. I can finish, which 8 I anticipate doing in about 15 minutes, or I'm in your 9 hands, sir, as to whether or not you might wish to take 10 a break now, but I'm very happy to finish, if that's 11 what you would prefer. 12 LORD WEIR: I think we will just press on, unless there's 13 any pressing concern that we shouldn't. 14 MS CHERRY: Excellent, thank you. 15 So, I'm coming, now, to chapter 5 and chapter 5 of 16 my submissions this morning relates to expectations and 17 the future. 18 The group accept that a number of hearings will be 19 required to properly explore the issues with which this 20 Inquiry is concerned and that it will take time. Their 21 trust in the NHS has been broken and it is anticipated 22 that the trust placed in the NHS by the wider public 23 will be tested once the conduct of Mr Eljamel, together 24 with the systems and individuals that enabled that 25 conduct, comes under the microscope. Page 109	1 findings and recommendations from which criminality 2 might be inferred. 3 Equally, it has the power to undertake 4 investigations and to make findings and recommendations 5 from which civil liability might be inferred. There's 6 an ongoing police investigation into Mr Eljamel's 7 actions. Some members of the group have been denied 8 compensation by NHS Tayside, citing legal technicalities 9 relating to the passage of time. 10 The group would like to see NHS Tayside and the 11 Scottish Government act to override these 12 technicalities. They would like to see this done, not 13 on a case by case basis as has been suggested by the 14 Government to date, but across the board for all 15 patients damaged by Mr Eljamel so that all may be 16 compensated. 17 We hope that it might be possible for 18 recommendations to be made which will encourage this to 19 happen. In particular, it is hoped that the Inquiry 20 will investigate whether failures on the part of any 21 relevant organisation to inform people who are affected 22 timeously impacted on the opportunity of patients to 23 seek redress or compensation and to make findings in 24 this regard and consequent recommendations. 25 Under term of reference 18, the Inquiry, we submit, Page 111
1 Some members of the group accept that they may not 2 be alive to see the Inquiry fulfil its purpose, but to 3 properly identify the systemic issues and to leave 4 a legacy of change it's imperative that the perspective 5 of the patient is taken into account. Public confidence 6 in the NHS requires to be rebuilt. Public confidence in 7 other institutions which may have failed to address 8 Mr Eljamel's behaviour, or indeed sought to minimise it, 9 needs to be restored. 10 But even then, members of the group will continue to 11 be distrustful of the NHS. They have faced obstacles in 12 having their concerns listened to. As I said, some feel 13 ignored, others feel blacklisted and despite assertions 14 to the contrary, NHS Tayside continues to adopt 15 an overly defensive stance to both complaints and legal 16 claims made by members of the group, and the perception 17 of members of the group is that NHS Tayside is more 18 concerned with protecting its image than it is concerned 19 with patient safety and well-being; and there, I'm 20 talking about the institution rather than its employees. 21 So whilst it is fully appreciated that this Public 22 Inquiry's function is not to determine any person or 23 body's civil or criminal liability, we note that counsel 24 to the Inquiry said at the preliminary hearing that 25 the Inquiry can undertake investigations and make Page 110	1 could make recommendations as to treatment, care and 2 support for the group in the future and it is submitted 3 that these could be made by way of interim 4 recommendations after the section 2 hearings. 5 Finally, it is a small point, but perhaps important. 6 A member of the group has brought to our attention that 7 Mr Eljamel has written a textbook entitled "Problem 8 Based Neurosurgery", which was published in 2011 and 9 which is still available to purchase and may be in some 10 university libraries. The group would like to see 11 the Inquiry consider recommendations about what should 12 be done about this book. 13 To conclude, sir, this Inquiry has been a long time 14 coming and very hard-fought for. The group are fully 15 intent on supporting the Inquiry so that it may fulfil 16 its remit, but the former patients of Mr Eljamel must be 17 at the heart of this Inquiry. Without their efforts it 18 would not be happening and they and their 19 representatives require to be listened to for any 20 lessons to be learned. 21 Although the substantive part of the Inquiry has not 22 yet begun, the group are confident that the Inquiry will 23 strive to uncover the truth and to shine a light on what 24 has, for too long, been shrouded in secrecy. They have 25 every confidence that the Chair, counsel to the Inquiry Page 112

1 and his team will explore these issues without fear or 2 favour. 3 We remain grateful to the Chair and counsel to the 4 Inquiry and their team for the empathy and compassion 5 shown to date. We remain committed to working further 6 with the Inquiry, knowing that those we represent will 7 finally be afforded an opportunity to tell their story 8 and to see justice and accountability. 9 Thank you. 10 LORD WEIR: Thank you very much indeed. 11 Now, we will move after lunch to the next statement, 12 which will be an oral opening statement given by 13 Ms Doherty on behalf of NHS Tayside, but perhaps you 14 will leave that, Ms Doherty, until 2 o'clock and we will 15 take lunch now. Thank you. 16 (12.58 am) 17 (The luncheon adjournment) 18 (2.00 pm) 19 LORD WEIR: Now, for entirely administrative reasons 20 I thought over lunchtime it might be expedient just to 21 adjust the order of events this afternoon and in 22 reaching that view, what I am going to do is invite 23 Ms O'Neill, who would otherwise have spoken tomorrow 24 morning, to come to the lectern and address you on 25 behalf of the Royal College of Surgeons of Edinburgh. Page 113	1 of Surgeons in Ireland. It is a charity registered with 2 the Office of the Scottish Charity Regulator. 3 The college notwithstanding being the Royal College 4 of Surgeons of Edinburgh is a global network of more 5 than 34,000 professionals comprising fellows, members, 6 associates and affiliates. The majority are surgeons 7 but the college also contains sizeable faculties of 8 dental surgeons and of pre-hospital care professionals, 9 including paramedics and emergency care practitioners. 10 Membership includes people at every stage of their 11 career, from medical students through to trainees, 12 consultants and those who have retired from practice. 13 I want to say a little, sir, about the Royal College's 14 interest in and participation in the Inquiry's work. 15 A key objective of the Royal College of Surgeons of 16 Edinburgh is the promotion of high standards, of 17 clinical competence and conduct among surgical 18 professionals. In pursuing that objective, the 19 Royal College is an integral part of the healthcare system 20 within the UK and internationally. It promotes high 21 standards in a variety of ways, including through 22 providing education and training to surgeons throughout 23 their careers and by setting and assessing postgraduate 24 surgical examinations. 25 It offers surgical and dental courses for surgeons Page 115
1 Opening statement by MS O'NEILL 2 MS O'NEILL: I'm grateful, sir. This opening statement is 3 made on behalf of the Royal College of Surgeons of 4 Edinburgh. The Inquiry already has the written 5 statement submitted in advance of today's hearing and 6 I adopt that written statement without reading it 7 verbatim, sir. 8 The statement contains a degree -- 9 LORD WEIR: Sorry, Ms O'Neill, I'm going to ask you to 10 pause. We have a few coming back from the break. 11 (Pause). 12 Perhaps just start again. 13 MS O'NEILL: Sir, this opening statement is made on behalf 14 of the Royal College of Surgeons of Edinburgh and 15 the Inquiry already has my written statement. That 16 written statement, sir, includes some contextual 17 material to give a bit of background to the 18 Royal College, which dates from 1505 and was formally 19 established by royal charter in 1851. The Royal College 20 of Surgeons of Edinburgh is one of four independent 21 royal colleges of surgeons in the United Kingdom and 22 Ireland. 23 It collaborates with but is separate from the Royal 24 College of Surgeons of England, the Royal College of 25 Physicians and Surgeons of Glasgow and the Royal College Page 114	1 at all stages of their careers in relation to clinical 2 and other aspects of their practice. The college has 3 five vice-presidents, each with a specific portfolio of 4 responsibilities; one of those portfolios is to oversee 5 the college's work on clinical standards and quality 6 assurance. 7 The college has, for some years, had a professional 8 standards committee to oversee standards issues, but 9 this has been recently disbanded as the part of wider 10 governance changes within the college. A quality 11 assurance committee is in the process of being set up to 12 replace that former professional standards committee and 13 to support the work of the vice-president in this area. 14 In addition, the Royal College has a patient safety 15 group whose role is to ensure that the Royal College's 16 core professional standards, training and educational 17 activities are focused on continuously improving patient 18 safety and reducing harm. The PSG is 19 a multidisciplinary group whose membership is drawn from 20 all faculties of the college and includes 21 representatives from both the wider surgical team and 22 patients with lived experience. It's engaged in a wide 23 range of activities in support of patient safety, 24 including providing members and fellows with expertise 25 and advice on patient safety issues, promoting good Page 116

1 practice and coordinating training and increasing 2 awareness of clinical human factors to improve the 3 safety of surgical care. 4 The group also works with medical educators, NHS 5 bodies and other royal colleges. It has engaged in work 6 to improve the surgical workplace environment by 7 supporting surgical teams and helping to address 8 conflict within those teams. It also provides resources 9 to support surgical teams when adverse outcomes or 10 errors happen in surgery. 11 The Royal College of Surgeons therefore has 12 a particular interest in paragraph 6 of the Inquiry's 13 terms of reference which concern the role of any other 14 bodies which played or could have played a role in the 15 care provided by Mr Eljamel to his former NHS patients. 16 It is keen to understand whether and to what extent 17 there were deficiencies in regulation across the 18 healthcare system that caused or contributed to patient 19 harm. 20 In relation to providing assistance to the Inquiry 21 and in making this opening statement the Royal College 22 has had regard to the guidance for core participants 23 that was issued in advance. There are a number of 24 matters in respect of which the Chair invited 25 submissions, that the Royal College does not address Page 117	1 and regulators to those failings. The Royal College is 2 keen to listen to and to understand the evidence that 3 will be given to the Inquiry about the failings in 4 Mr Eljamel's practice and the response of the wider 5 medical community to those failings. 6 The Royal College does carry out invited reviews of 7 surgical services and of individual surgeons' practice 8 and supports Scottish health boards in conducting what 9 are known as "Annex B and C reviews". It has also 10 recently agreed to provide 11 Healthcare Improvement Scotland with access to experts 12 to help them assess concerns about service provision 13 raised with them. 14 The Royal College therefore wants to learn from the 15 work of the Inquiry with a view to providing better 16 support to the NHS in respect of these areas of work. 17 You have, sir, though, invited core participants to 18 indicate where they think that they can contribute to 19 the work of the Inquiry and where they might be of most 20 assistance to the Inquiry. The Royal College of 21 Surgeons of Edinburgh can assist the Inquiry in 22 providing its perspective on matters of good 23 professional and clinical practice. 24 In particular, it can provide evidence on what 25 constitutes good practice in the training and Page 119
1 because of the very limited direct engagement that the 2 Royal College had with Mr Eljamel and his patients. 3 By which of explanation, while Mr Eljamel was 4 a surgical fellow of the Royal College between 2003 and 5 2015 and acted as an examiner in certain examinations 6 during that time, the Royal College did not receive, to 7 the knowledge of the current management team, any 8 complaints about Mr Eljamel's practice while he was 9 a fellow. 10 The Royal College does not regulate surgeons' 11 licences or fitness to practice in the way that 12 statutory regulators such as the General Medical Council 13 do. 14 While the Royal College has a code of conduct and 15 disciplinary scheme for members, Mr Eljamel was not 16 subject to any disciplinary action by the Royal College 17 and the Royal College of Surgeons of Edinburgh was not 18 involved in the clinical review that was carried out by 19 the Royal College of Surgeons of England and was not 20 made aware of the findings of that review other than by 21 way of media reporting. 22 At this stage of the Inquiry's work, the Royal 23 College of Surgeons of Edinburgh does not have access to 24 detailed information about Mr Eljamel's clinical 25 failings or the response of his employers, colleagues Page 118	1 supervision of junior staff, by reference to paragraph 2 2 of the terms of reference, and the duty of candour, by 3 reference to paragraph 7 of the terms of reference. 4 The Royal College has already sought to assist 5 the Inquiry by reviewing and commenting on the draft 6 expert letter of instruction in relation to the clinical 7 review. 8 More generally, the Royal College can provide 9 evidence about its role in setting and maintaining high 10 standards of surgical practice. 11 The Royal College will seek to assist the Inquiry in 12 any other ways the Inquiry considers appropriate. 13 Thank you, sir. 14 LORD WEIR: Thank you very much. 15 Now, let's return to the agenda and I will now 16 formally invite Ms Doherty to address the hearing on 17 behalf of NHS Tayside. 18 Ms Doherty, when you're ready. 19 Opening statement by MS DOHERTY 20 MS DOHERTY: Sir, my name is Una Doherty. I appear today on 21 behalf of NHS Tayside, along with Cat MacQueen and 22 instructed by Tracey Turnbull of the Central Legal 23 Office. 24 NHS Tayside welcomes this Inquiry which has been 25 established to investigate the professional practice of Page 120

30 (Pages 117 to 120)

1 Mr Eljamel, a consultant neurosurgeon who was working in 2 NHS Tayside between 1995 and 2014 and the adequacy of 3 governance systems that were in place to protect his NHS 4 patients. 5 NHS Tayside recognises the importance of this 6 Inquiry for many patients of Mr Eljamel and their 7 families. It understands that the Inquiry will be 8 a difficult time for many people. NHS Tayside wishes to 9 extend its sincerest apologies to all patients who have 10 suffered because of the treatment they received from 11 Mr Eljamel. 12 Many patients of Mr Eljamel have experienced injury 13 and distress and have been left with an enduring 14 distrust of healthcare professionals and the NHS. At 15 a time when many patients were faced with frightening 16 diagnoses and had the reasonable belief and trust in 17 NHS Tayside to keep them safe, they were let down. 18 NHS Tayside is very sorry for the events that happened 19 and fully acknowledges that in many cases the situation 20 was exacerbated by the way in which it managed patients' 21 complaints and concerns. 22 NHS Tayside knows that it failed to react 23 appropriately and at an adequate pace when there were 24 concerns raised about Mr Eljamel's clinical practice. 25 Again, in this regard, it let down its patients. Page 121	1 an opportunity for an independent assessment of what 2 went wrong and why. It recognises that it is 3 accountable for its failures and does not shrink from 4 that. It welcomes recommendations from this Inquiry as 5 to further changes which should be made. 6 The Inquiry's conclusions will be of great 7 importance to NHS Tayside, as the safety, well-being and 8 trust of patients is at the heart of its work. 9 As a learning organisation, it wants it hearing from 10 patients and families, those best placed to advise and 11 share their experiences, as to how it can consistently 12 improve and build confidence in the services it 13 delivers. 14 Today, we have listened carefully to the opening 15 statement made on behalf of the patient group including 16 the powerful patient experiences described. NHS Tayside 17 welcomes the opportunity for the serious matters raised 18 by the patient group in relation to NHS Tayside to be 19 investigated in this Inquiry. 20 NHS Tayside is fully committed to assisting 21 the Inquiry and will work collaboratively with 22 the Inquiry team. It welcomes the Inquiry's 23 trauma-informed approach and is keen to ensure that this 24 is adhered to. It recognitions its systems and 25 processes are a significant focus of the Inquiry's Page 123
1 NHS Tayside understands that patient trust and 2 confidence has been eroded because of the actions of 3 Mr Eljamel and its own failures to ensure its systems of 4 oversight and supervision of Mr Eljamel were adequate. 5 NHS Tayside regards it as fundamentally important 6 that its patients have confidence in the quality of care 7 and treatment that they receive. It has made many 8 changes in the intervening years since Mr Eljamel worked 9 in NHS Tayside to strengthen clinical and professional 10 governance. 11 Changes have been made to systems and processes to 12 ensure that NHS Tayside is alerted at an early stage 13 when there are escalating concerns relating to clinical 14 practice. 15 It has also ensured that there are many ways in 16 which people can speak up about any concerns they have 17 and that when complaints and concerns are raised they 18 are managed in a consistent and timely way, with 19 openness and transparency. 20 All of these changes have been made with the intent 21 of avoiding a similar situation occurring. NHS Tayside 22 recognises that openness and transparency is fundamental 23 in order to rebuild the trust of patients and the wider 24 public. 25 NHS Tayside very much views this Inquiry as Page 122	1 investigations. It will closely review relevant 2 materials and will listen carefully to the evidence to 3 understand the perspectives of those directly affected, 4 all with an openness and a willingness to get things 5 right for its patients. 6 This opening statement is in seven chapters 7 addressing the following areas: the role of NHS Tayside 8 as a health board; NHS Tayside's due diligence review 9 2023, its findings, recommendations and actions; support 10 to those directly impacted by the Inquiry; assistance to 11 the Independent Clinical Review; data protection 12 breaches; preliminary comments on the Inquiry's 13 approach; and time-bar for civil claims by patients of 14 Mr Eljamel. 15 Dealing with the first chapter, I'd like to explain 16 briefly the role of NHS Tayside as a health board. 17 Tayside health board, commonly known as NHS Tayside, is 18 one of 14 total health boards in Scotland and was 19 established in 1974. Health services in Tayside have 20 operated under different legal and governance 21 arrangements from the period 1974 to date. 22 A health board is a public body, constituted by the 23 Secretary of State. Each health board is responsible 24 for its respective region. NHS Tayside is responsible 25 for health services in Angus, Dundee City and Perth and Page 124

1 Kinross. It provides health services to those in its 2 geographical area and they also do so for patients from 3 other health board areas. 4 NHS Tayside is required under legislation to fulfil 5 certain duties and functions. It plans, commissions and 6 delivers NHS services to its local population. This 7 involves a delivery of frontline NHS services including 8 primary care, secondary care and tertiary care in 9 hospitals within its geographical area. Like other 10 health boards, NHS Tayside is funded by and reports 11 directly to the Scottish Government. It is accountable 12 to the Scottish Ministers, who, in turn, are accountable 13 to the Scottish Parliament. 14 The second chapter I address is NHS Tayside's due 15 diligence review 2023. Since 2013, multiple internal 16 and external reviews have been undertaken in relation to 17 Mr Eljamel's practice. These identified and addressed 18 systemic issues within NHS Tayside. The reviews 19 highlighted important points for NHS Tayside to address 20 relating to professional governance, creating a culture 21 for staff and patients to speak up about safety concerns 22 and the importance of clinical effectiveness. 23 As the Inquiry will consider the reviews undertaken 24 under terms of reference 12. In the written opening 25 statement, quite a lot has been said about the most Page 125	1 signs of poor practice could appear, the way in which 2 those signs were considered collectively was lacking and 3 feedback from trainees was not always seen by line 4 managers. 5 Since Mr Eljamel practised in NHS Tayside, the 6 joining up of potential alerts is achieved, now, through 7 an executive director-led safety oversight group which 8 responds to emerging potential issues. 9 Third, it was found that there was variability in 10 the organisational response to signs of poor practice 11 within the system. Some complaints did not lead to 12 formal investigation using governance processes and 13 there was a variation in response times. Once multiple 14 signs of poor practice were considered together, 15 decision-making related to Mr Eljamel's practice was 16 delegated too far down the organisation in 2013. 17 Restrictions placed on Mr Eljamel's practice in 2013 18 were not adequate and decision-making was not 19 sufficiently well documented. The level of supervision 20 decided upon was not proportionate to the concerns being 21 raised at the time and once implemented, were not 22 monitored effectively. 23 During the period of Mr Eljamel's employment, there 24 was an absence of an advanced process of professional 25 governance from concerns being raised to their being Page 127
1 recent review which was this NHS Tayside due diligence 2 review of documentation held relating to 3 Professor Eljamel, dated 25 August 2023. I don't repeat 4 just now all that is set out in the written opening 5 statement about this review. Instead, I summarise by 6 explaining that this review was instructed in 2023 to 7 try to get a better understanding of what had happened, 8 what had gone wrong in NHS Tayside's systems and 9 processes and what actions were needed to strengthen the 10 systems and processes. 11 The review was undertaken by a team led by the 12 associate medical director of clinical governance. The 13 findings of the review included conclusions as to past 14 events and considered the clinical and professional 15 governance arrangements in place in 2023. 16 An non-exhaustive summary of the findings includes, 17 first, that Mr Eljamel was not open and honest with 18 patients and colleagues. Whilst such behaviours are 19 rare within the medical profession, there is a need to 20 have systems in place to detect and act on these if they 21 occur. 22 And since Mr Eljamel practised in Tayside, 23 NHS Tayside has overhauled the governance and alert 24 systems in place for professional governance. 25 Second, while there were multiple ways in which Page 126	1 acted upon and in ensuring clear documentation of 2 decisions made. 3 Now, however, there is a process in place through 4 the establishment of the responsible officer advisory 5 group. 6 Fourth, there was a finding that reliable 7 documentation of actions arising from recommendations 8 from previous reviews from 2013 to 2022 was not 9 consistently present and monitoring and assurance routes 10 for those actions were variable. However, now, revised 11 systems have greatly improved the opportunities connect 12 signs of poor practice and adopt whole system learning 13 from events. 14 Fifth, it was found that the communication with 15 patients affected by Mr Eljamel's practice was of 16 variable quality, fragmented and generally poor. There 17 had been no central coordination to ensure a truly 18 person-centred approach. When concerns were raised by 19 patients, the issue was managed through a small subset 20 of the acute management team. There was a lack of 21 visibility within NHS Tayside, no governance routes to 22 assure and scrutinise and no indications or reporting of 23 improvement through action plans. 24 Since the establishment of the patient liaison 25 response team in early 2023, patients with long-running Page 128

1 concerns have a single point of contact to build 2 improved relationships and understanding of concerns to 3 achieve a more consistent and person-centred approach. 4 At the conclusion of the review, NHS Tayside's 5 executive medical director made nine recommendations, in 6 relation to professional governance, clinical governance 7 and corporate governance which were presented to 8 NHS Tayside. 9 NHS Tayside fully accepted the review's 10 recommendation and developed an action plan to address 11 them. 12 In actioning the recommendations arising from the 13 review, NHS Tayside has sought to achieve improvements 14 in patient safety and the quality of patient care. It 15 considers that its systems are now better placed to 16 respond to any future clinical concerns and potential 17 harm to patients from the practices of individual 18 clinicians. The aim is that the positive changes which 19 have been made will reduce the risk of and prevent 20 events such as those being considered in this Inquiry 21 arising in future. 22 While the systems and processes now in place are 23 very different to those which existed at the time of 24 Mr Eljamel's employment at Tayside, NHS Tayside 25 recognises that there will always be more to learn. It Page 129	1 Scottish Government, but, as set out in the written 2 opening statement, this is not NHS Tayside's 3 understanding of the position and, rather, as I've 4 already said, NHS Tayside has offered these independent 5 psychological support services for ICR applicants. 6 Counsel to the Inquiry this morning has confirmed 7 that it is, in fact, as NHS Tayside had understood, that 8 it is funding the independent psychological support by 9 the Association of Clinical Psychologists, not the 10 Scottish Government. 11 And support to current and former employees of 12 NHS Tayside. In advance of the preliminary hearing on 13 10 September, counsel to the Inquiry asked NHS Tayside 14 to confirm its position in relation to the provision of 15 representation and support to its current and former 16 employees in connection to the Inquiry. NHS Tayside's 17 position was set out in written submissions dated 18 4 September 2025 and have been clarified in its 19 submissions dated 13 November 2025. 20 NHS Tayside wishes to reinforce that it is keen to 21 fully support all of its current and former employees 22 throughout the Inquiry. There is, however, an important 23 distinction between representation and support. 24 NHS Tayside's legal team are not the legal 25 representatives of any individual in this Inquiry. Page 131
1 is keen to learn lessons from this Inquiry to enable it 2 to do what more it can to ensure the safety of its 3 patients. 4 I turn, now, to my third chapter which is support to 5 those directly impacted by the Inquiry. In relation to 6 support to former patients of Mr Eljamel, NHS Tayside 7 wishes to offer its support those directly impacted by 8 the Inquiry. 9 On 3 October this year, the Executive Medical 10 Director of NHS Tayside, Dr James Cotton, sent a letter 11 to the ICR setting out the support options offered to 12 former patients participating in the ICR. Patients are 13 being offered the opportunity of independent, 14 confidential and trauma-informed psychological support 15 and care. Patients participating in the ICR will self 16 refer to this service via the ICR website. 17 NHS Tayside is making the same offer to all former 18 patients of Mr Eljamel regardless of their participation 19 in the ICR and this can be accessed through the patient 20 liaison response team. 21 Counsel to the Inquiry had indicated in his note 22 that the ICR had secured agreement in principle for 23 psychological support services for applicants to the 24 ICR, organised via the Association of Clinical 25 Psychologists UK, which was to be funded by the Page 130	1 They're instructed by and represent the public body 2 NHS Tayside. In terms of the Inquiry rules, they are 3 the recognised legal representatives of NHS Tayside, not 4 any individual. This does not mean that NHS Tayside 5 will not provide support to current and former employees 6 of NHS Tayside. Its intention has always been to 7 provide as much support to individual employees as is 8 considered acceptable by the Inquiry. 9 Steps have already been taken by NHS Tayside to 10 provide a range of pastoral and practical support to its 11 current and former employees as set out in its written 12 submissions dated 4 September 2025. In those 13 submissions, NHS Tayside sought guidance from 14 the Inquiry in relation to the nature of legal support 15 which it ought to offer its current and former 16 employees. This guidance was sought because NHS Tayside 17 fully appreciated the distrust felt by some of the 18 former patients of Mr Eljamel towards it. Considering 19 this, the concern was that issue may be taken with 20 NHS Tayside and its legal team being too closely 21 involved in the provision of written and oral evidence 22 by its current or former employees. 23 NHS Tayside does not want to cause any further 24 trauma or distress to the patient group. It is also 25 important that current or former employees of Page 132

1 NHS Tayside feel able to provide their best evidence. 2 Those individuals may not feel comfortable with 3 NHS Tayside's legal team being involved in the provision 4 of their evidence to the Inquiry. 5 NHS Tayside also considers that it would not be 6 appropriate for its legal team to have any involvement 7 in the preparation of an individual current or former 8 employee's evidence in circumstances where the 9 individual's position diverges from that of NHS Tayside. 10 It is anticipated that a conflict of interest will not 11 likely occur in most cases, but such a situation could 12 nevertheless arise. 13 At the preliminary hearing, oral submissions by both 14 counsel to the Inquiry and counsel for the patient group 15 indicated that the expectation is for NHS Tayside to 16 provide legal support to individual current and former 17 employees in connection with the preparation of their 18 evidence. NHS Tayside is grateful for this confirmation 19 and has set out, in its submissions dated 20 13 November 2025, a proposed approach to the provision 21 of legal support for current or former employees in 22 connection with their evidence to the Inquiry. 23 Counsel to the Inquiry has indicated that the 24 proposed arrangements are broadly acceptable. He did 25 seek some further clarification, which was provided, as Page 133	1 access to the necessary information of patient names and 2 addresses. 3 To help the ICR progress its investigations without 4 unnecessary delay, NHS Tayside therefore wrote out to 5 the Eljamel patient cohort as requested. 6 My fifth chapter is data protection breaches. 7 Regrettably, there have been some data breach incidents. 8 These have been dealt with by NHS Tayside and reported 9 appropriately to the Information Commissioners' office 10 which is the regulatory body for data protection. 11 NHS Tayside also sent letters to the individuals 12 affected to inform them of this error relating to their 13 personal data, explaining what had happened and to offer 14 its sincerest apologies. 15 NHS Tayside would like to sincerely apologise again 16 to those affected. It recognises that these incidents 17 may have compounded patients' distress and further 18 eroded confidence in NHS Tayside. 19 Following the data breaches, the chief executive 20 commissioned a learning review. This sought to evaluate 21 the systems and processes in place in relation to 22 information governance, identify improvements required 23 to data security across NHS Tayside and make 24 recommendations for organisation-wide learning. 25 The learning review has identified areas for Page 135
1 he confirmed in his opening address this morning. Today 2 he has sought some further clarification and we will 3 come back to the Inquiry with the clarification sought. 4 It is hoped that the suggested approach will be 5 acceptable to both the Inquiry and the core 6 participants. 7 Turning, now, to the fourth chapter, which is 8 assistance to the ICR, the Independent Clinical Review. 9 NHS Tayside wishes to offer its assistance and support 10 to the work of the ICR. It has previously provided 11 assistance to the ICR by contacting those patients who 12 had advised NHS Tayside's PLRT that they would like to 13 be engaged with the ICR. This communication was to 14 advise them of the online public engagement session to 15 be held by Professor Wigmore of the ICR on 16 26 February 2025. 17 NHS Tayside's intention in assisting in this way was 18 simply to allow the ICR to make progress with its 19 important work. 20 The ICR also sought assistance from NHS Tayside to 21 write out to the whole Eljamel patient cohort to advise 22 of its work. As the Inquiry had not yet been formally 23 set up when this assistance was sought, the ICR had no 24 means of compelling NHS Tayside to provide the required 25 information. NHS Tayside was the only organisation with Page 134	1 improvement relating to organisational data protection 2 awareness and its consistent application in practice and 3 the requirement to strengthen information governing 4 structures. An improvement plan will now be developed 5 and will report, for security and assurance, to 6 NHS Tayside's clinical governance committee. 7 Turning, now, to my sixth chapter which is 8 preliminary comments on the Inquiry's approach. Counsel 9 to the Inquiry has produced a very detailed and 10 comprehensive list of issues. NHS Tayside is grateful 11 to have been afforded the opportunity to input into this 12 document. It welcomes the close assessment by 13 the Inquiry of the matters contained within the list of 14 issues and considers that all the listed issues are 15 important and merit detailed attention in the Inquiry's 16 investigations. 17 There are a number of comments which NHS Tayside 18 makes in an attempt to assist the Inquiry at this stage. 19 First, the scope of Mr Eljamel's practice within the 20 NHS in Scotland. NHS Tayside supports a broad and 21 thorough investigation by the Inquiry into Mr Eljamel's 22 practice within the NHS in Scotland. Neurosurgery 23 within NHS Tayside was originally established as 24 a purpose built unit in Dundee Royal Infirmary in 1966. 25 Whilst Ninewells Hospital officially opened in 1974, Page 136

1 neurosurgery services remained at Dundee Royal Infirmary 2 until its closure in 1998. 3 Mr Eljamel will therefore have worked at 4 Dundee Royal Infirmary for a period. The Inquiry may 5 therefore wish to investigate Mr Eljamel's practice at 6 Dundee Royal Infirmary. 7 As far as NHS Tayside is aware, Mr Eljamel did not 8 practice in any other health board in Scotland. It has 9 noted that counsel for the patient group raises the 10 point that some patients of Mr Eljamel were from the 11 NHS Fife area. As NHS Fife does not have its own 12 neurosurgery unit, patients from that health board area 13 may be referred to NHS Tayside for neurosurgery 14 treatment. It is not uncommon for patients from other 15 health boards to receive treatment within NHS Tayside. 16 NHS Tayside considers that any NHS patients treated 17 by Mr Eljamel during his employment with NHS Tayside 18 should come within the scope of the Inquiry. 19 It is noted that if another health board is 20 identified as being of relevance to the Inquiry's 21 investigations, this may require that board to become 22 a core participant in the Inquiry which could result in 23 some delay to proceedings. 24 Next, Mr Eljamel's involvement in research projects. 25 NHS Tayside recognises that Mr Eljamel held, Page 137	1 Previous investigations and reviews relating to 2 Mr Eljamel's practice within NHS Tayside. NHS Tayside 3 recognises that there are some very detailed questions 4 in the list of issues about how the investigations 5 listed under terms of reference 12 were conducted and 6 the outcomes. 7 The due diligence review which I have already 8 mentioned was conducted because of the recognition that 9 previous investigations and reports into Mr Eljamel's 10 practice did not sufficiently address the full range of 11 issues. It is acknowledged by NHS Tayside that there 12 was previously a lack of oversight around the timing and 13 nature of reviews and the actions taken to address 14 review findings. 15 As I've already explained, the focus of the due 16 diligence review was to assess the governance position 17 with recommendations and actions. That review looked at 18 the systems in place and improvements that could be made 19 going forward, rather than individual actions by former 20 employees. NHS Tayside therefore considers that 21 the Inquiry's investigation into previous reviews would 22 benefit from detailed consideration of the rationale 23 behind individual decision-making within NHS Tayside at 24 the relevant time, which was outwith the scope of the 25 due diligence review, as this may give rise to further Page 139
1 concurrently, a research position with the 2 University of Dundee alongside his patient practice at 3 NHS Tayside. It is understood that given his academic 4 position, research projects were a component of 5 Mr Eljamel's workload. As such, this area will likely 6 be of interest to the Inquiry. NHS Tayside does not 7 have access to information about Mr Eljamel's research. 8 Accordingly, this area did not form part of 9 NHS Tayside's internal investigations in relation to 10 Mr Eljamel's practice. 11 NHS Tayside therefore welcomes the Inquiry's 12 investigation in this area, as part of term of 13 reference 2 subsection (e). 14 I now turn to complaints or concerns regarding 15 Mr Eljamel's practice prior to 2012. NHS Tayside's 16 knowledge regarding any complaints made prior to 2012 is 17 limited. This is because its complaints systems were 18 changed in 2012 and the information contained 19 electronically on its old systems was not retained. 20 Notwithstanding the limited information available to it, 21 NHS Tayside would welcome investigation by the Inquiry 22 into any complaints or concerns raised about 23 Mr Eljamel's practice prior to 2012 in terms of 24 reference 4 and 5, some of which will, no doubt, be 25 informed by the work of ICR. Page 138	1 learning points. 2 Possession of documents relevant to the Inquiry. 3 NHS Tayside holds many documents which will likely be of 4 assistance to the Inquiry and is working hard to respond 5 to any requests for evidence it receives from 6 the Inquiry. Given the passage of time, however, some 7 documents have been destroyed in accordance with the 8 contemporaneous NHS Tayside's health records strategy 9 and management policy, its health records operational 10 guidance and service operating procedures and 11 Scottish Government guidance. 12 These indicate a minimum number of years for which 13 documents ought to be retained, after which they're 14 eligible for destruction. Some documents were therefore 15 destroyed long before the setting up of this Inquiry. 16 More recently, however, and as the Inquiry has been 17 advised, NHS Tayside has discovered that a number of 18 hard copy theatre log books, some of which would have 19 contained information relating to Mr Eljamel's surgeries 20 during the period 1995 to 2013, were unfortunately 21 destroyed on around 24 January 2025. It is estimated 22 that there were probably around 40 of these log books 23 which dated from the 1960s onwards. 24 NHS Tayside understands that some log books may have 25 contained information of potential assistance to Page 140

1 the Inquiry's investigations. It also recognises that 2 the destruction occurred following a formal "do not 3 destroy" notice for information that may be relevant to 4 the work of the Inquiry issued on behalf of the Chair on 5 11 October 2024. 6 As soon as the incident became apparent, the matter 7 was escalated immediately within NHS Tayside. 8 An internal investigation has taken place. It has been 9 ascertained that the theatre log books were destroyed by 10 members of the department in which they were held. The 11 individual involved were not aware of the connection 12 between the theatre log books and Mr Eljamel. The 13 destruction was carried out in accordance with the NHS 14 and Scottish Government guidance policies already 15 mentioned. 16 The destroyed theatre log books related to surgeries 17 undertaken by Mr Eljamel and by other members of staff. 18 Given the importance of this matter, it has been 19 raised at the senior level within NHS Tayside. Renewed 20 instructions have been communicated to staff in relation 21 to identification, logging and retention of 22 documentation relevant to Mr Eljamel to try to ensure 23 that there is no further destruction of documents in 24 error. 25 NHS Tayside has ascertained that much of the Page 141	1 the Inquiry for allowing it the opportunity to review 2 and input into the draft ICR letter of instruction to 3 expert neurosurgeon and for counsel to the Inquiry's 4 confirmation that it will be given the same opportunity 5 in respect of further experts instructed by the Inquiry. 6 And we are grateful for the confirmation given today 7 by counsel to the Inquiry that the identity of the 8 Inquiry experts will be disclosed to core participants. 9 In relation to the ICR's expert neurosurgeons, we do 10 consider that it would be useful to know the identity of 11 these experts in advance of seeing their reports. 12 And finally in this section, the rule 8 request to 13 NHS Tayside. A rule 8 request for evidence relevant to 14 section 1 of the evidential hearings was received by 15 NHS Tayside on 6 November with a response deadline of 16 4 December 2025, so four weeks later. The request seeks 17 a draft corporate witness statement and disclosure of 18 documents. The information sought is extensive and 19 covers many areas of the Inquiry's terms of reference. 20 Although many people within NHS Tayside are working on 21 the response, the challenge of the short timescale has 22 been increased by the planned annual leave and sickness 23 absence of some individuals. 24 NHS Tayside has already sought an extension of the 25 response deadline of 4 December and is grateful that Page 143
1 information normally contained within the destroyed log 2 books should be contained in patient records if those 3 still exist. It is hoped that much of the information 4 will still be available to the Inquiry, albeit in 5 a different format. 6 NHS Tayside deeply regrets this error and is 7 committed to ensuring that it does not happen again. 8 Next, I turn to identification of witnesses to 9 the Inquiry. NHS Tayside previously provided 10 the Inquiry with a list of individuals it employed in 11 management roles at the relevant time. It is considered 12 that these individuals may be able to assist the Inquiry 13 with the provision of written and/or oral evidence. 14 NHS Tayside does not, however, have witness 15 statements from any individual. Mr Eljamel worked in 16 various wards and clinics for a period of almost 17 20 years. NHS Tayside is providing to the Inquiry 18 medical records sought by section 21 notice which 19 contain information about clinical personnel involved in 20 patient care. This information may be of assistance to 21 the Inquiry's identification of individuals whose 22 evidence may be relevant to its investigations. 23 NHS Tayside offers to further assist the Inquiry as far 24 as it's able to do so. 25 Expert evidence. NHS Tayside is grateful to Page 142	1 the Inquiry is considering this. 2 Turning, now, to the final chapter, time-bar for 3 civil claims by patients of Mr Eljamel. Under 4 section 17 of the Prescription and Limitation (Scotland) 5 Act 1973, a claim for damages for personal injuries must 6 be brought within three years, often described as 7 "time-bar", unless the court exercises its discretion in 8 terms of 19(a) to allow an action to proceed outwith 9 that timeframe. NHS Tayside is aware of a view reported 10 in the press that patients of Mr Eljamel ought to be 11 exempt from the three-year limitation period. 12 In claims for damages for personal injuries by 13 former patients of Mr Eljamel raised outwith the 14 three-year limitation period, NHS Tayside has committed 15 to actively reviewing the facts and circumstances on 16 a case-by-case basis when considering whether to plead 17 that the claim is time-barred. NHS Tayside believes 18 this approach accords with the expectation of the 19 Scottish Government, as stated by the First Minister on 20 2 October 2025 at First Minister's Questions. 21 So, in conclusion, NHS Tayside remains sincerely 22 sorry for the distress experienced by patients of 23 Mr Eljamel. It is acknowledged that NHS Tayside failed 24 to put in place sufficient measures to safeguard 25 patients once concerns were raised about Mr Eljamel and Page 144

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1 this placed the safety and well-being of patients at 2 risk. NHS Tayside recognises that in many cases it has 3 added to the distress and trauma experienced by patients 4 in the way it has handled ongoing complaints and 5 concerns. It is also sincerely sorry for this. 6 As I have already said, the due diligence review in 7 2023 found that NHS Tayside's communication with 8 Mr Eljamel's former patients was poor. This was not 9 appropriate nor acceptable. NHS Tayside understands 10 that all of these factors have undermined the trust and 11 confidence of patients, families and staff and has been 12 working hard to rebuild that trust. It has sought to 13 understand and learn lessons from the events surrounding 14 Mr Eljamel. It has taken seriously and acted upon the 15 findings and recommendations arising from internal and 16 external reviews. 17 The clinical and professional governance processes 18 within which NHS Tayside's teams operate today are 19 demonstrably different to those which were in place more 20 than a decade ago. Positive changes have been made to 21 systems and processes within the organisation to seek to 22 safeguard against the possibility of any such incidents 23 arising again in the future. 24 Nonetheless, it is recognised that there's always 25 room for further learning and improvement. NHS Tayside Page 145	1 NHS Education for Scotland and 2 Healthcare Improvement Scotland. There will also be 3 a submission on behalf of the Independent Clinical 4 Review and after all of that has been done, I will 5 invite Mr Dawson to respond, as he sees appropriate, to 6 the matters that have been raised during the course of 7 the statements today. 8 So that is, I hope, a steer as to what happens next. 9 We will be starting again tomorrow at half past 10. 10 I mention that now just in case I forget to tell you 11 when we reach the conclusion of today's proceedings. 12 But with that in mind, may I invite Ms Thomson to 13 address the hearing on behalf of the Scottish Ministers. 14 Ms Thomson. 15 Opening statement by MS THOMSON 16 MS THOMSON: Thank you, sir. My name is Laura Thomson. 17 I represent the Scottish Ministers, assisted by 18 David Blair and instructed by Harper Macleod. 19 I'm grateful to counsel to the Inquiry for making 20 clear that I represent the Scottish Ministers in their 21 capacity as core participants and that I do not 22 represent the sponsored team. 23 At the outset, the Scottish Ministers wish to thank 24 you, sir, for affording them core participant status. 25 The Scottish Ministers welcome the opportunity to Page 147
1 is keen to continue to learn lessons for the future. It 2 is hoped that any recommendations arising from this 3 Inquiry will lead to further organisational improvement 4 which will positively impact on the quality of patient 5 care. 6 NHS Tayside wishes all the former patients of 7 Mr Eljamel and their families to know that it is 8 entering this Inquiry with openness and transparency at 9 the forefront of its participation. NHS Tayside will 10 contribute openly to this Inquiry. It will be 11 accountable for the decision-making and actions taken 12 while Mr Eljamel was working in NHS Tayside and for its 13 handling of complaints and investigations thereafter. 14 As a learning organisation, NHS Tayside is committed 15 to improving services. It wishes to take whatever steps 16 are necessary to ensure that its systems and processes 17 are the best that they can be to provide safe, effective 18 and patient-centred care for the population of Tayside. 19 Thank you, sir. 20 LORD WEIR: What I propose to do now is to invite one 21 further statement this afternoon and that will be given 22 by Ms Thomson on behalf of the Scottish Ministers. 23 Those who have an agenda will be aware -- and if 24 not, I will tell you anyway -- that that will leave for 25 tomorrow's hearing oral opening statements on behalf of Page 146	1 participate in this Inquiry and to assist the Inquiry in 2 its work. The Scottish Ministers recognise that 3 legitimate questions and concerns exist regarding their 4 responsibility to secure the effective provision of 5 national health services in Scotland and in particular, 6 oversight of NHS Tayside and the handling of complaints 7 about Mr Eljamel. 8 They welcome both the scrutiny and the opportunity 9 for learning that this Inquiry will bring. The 10 Scottish Ministers wish to ensure the Inquiry of their 11 commitment to learning lessons and to taking positive 12 steps to improve the experience of all who receive 13 treatment and care within the NHS. Patient safety is 14 the ministers' priority. 15 The Scottish Ministers offer their sincere sympathy 16 to all patients who have suffered at the hands of 17 Mr Eljamel and wish to repeat the sentiments expressed 18 by the Cabinet Secretary for Health and Social Care in 19 his speech to Parliament on 29 February 2024, where he 20 recorded his regret and sorrow that the search for 21 answers by patients and their families had taken so 22 long. 23 The Scottish Ministers are therefore pleased that 24 this Inquiry and also the clinical review intend to 25 adopt a patient-centred and trauma-informed approach to Page 148

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1 their investigations. 2 The Scottish Ministers are grateful for the guidance 3 issued by the Inquiry on 29 October in respect of 4 matters that could most usefully be addressed in opening 5 statements. Having regard to that guidance, I propose 6 to address the following matters: I will begin by 7 providing an outline of the remit and responsibilities 8 of the Scottish Ministers in relation to the NHS. 9 I will then provide a brief chronology of the 10 Scottish Ministers' principal involvement in respect of 11 the complaints made against Mr Eljamel. I will then 12 address you, sir, in relation to the terms of reference 13 of particular relevance to the role of the 14 Scottish Ministers and in respect of which they are 15 likely to be well placed to assist the Inquiry in its 16 work, and, finally, I'll make certain observations in 17 respect of matters arising from paragraph 13 of the 18 guidance note. 19 The remit and responsibilities of the 20 Scottish Ministers. The Scottish Ministers are 21 established as the devolved Government of Scotland in 22 terms of section 44 of the Scotland Act 1998. Health, 23 and in particular the operation and administration of 24 the National Health Service in Scotland, are matters 25 devolved to the Scottish Ministers. Page 149	1 for the 14 territorial and seven special health boards 2 that collectively form NHS Scotland. Their 3 responsibility is discharged through the 4 Scottish Government's health and social care 5 directorates. Directors General are responsible for 6 families of directorates within the Scottish Government. 7 The Director-General Health and Social Care is also 8 the Chief Executive of NHS Scotland and has overall 9 responsibility for the work of the health and social 10 care directorates, with directors and senior clinical 11 advisers such as the chief medical officer and chief 12 nursing officer, taking responsibility for particular 13 directorates. 14 The Director-General delegates, through a scheme of 15 delegation, financial responsibility for particular 16 budgets and expenditure incurred against these budgets 17 to individual directors. 18 The health and social care directorates that sit 19 within the portfolio of the Director-General and 20 contribute to the delivery of policy for health and 21 social care, as well as the administration of the NHS in 22 Scotland, include the directorate of the chief medical 23 officer, the directorate of the chief nursing officer, 24 the directorate of the chief operating officer NHS 25 Scotland, the directorate for health and social care Page 151
1 In terms of section 1 of the National Health Service 2 (Scotland) Act 1978, the Scottish Ministers are subject 3 to a statutory duty to promote, in Scotland, 4 a comprehensive and integrated health service designed 5 to secure, A, the improvement in the physical and mental 6 health of the people of Scotland and, B, the prevention, 7 diagnosis and treatment of illness, and for that purpose 8 to provide or secure the effective provision of 9 services. 10 Section 1(a) imposes an obligation on the 11 Scottish Ministers to promote the improvement of the 12 physical and mental health of the people of Scotland. 13 Whilst the 1978 Act provides for the establishment of 14 individual geographical and thematic health boards for 15 the delivery of health services to patients across 16 Scotland, the Scottish Ministers retain ultimate 17 responsibility for the NHS in Scotland. 18 The Scottish Minister with portfolio responsible for 19 the NHS in Scotland is the Cabinet Secretary for Health 20 and Social Care. During the period since it appears 21 concerns were first reported by NHS Tayside to the 22 Scottish Ministers regarding the practice of Mr Eljamel 23 in December of 2013, there have been six 24 Cabinet Secretaries. 25 The Scottish Ministers hold ultimate responsibility Page 150	1 finance, the directorate for health workforce, the 2 directorate for mental health, the directorate for 3 primary care, the directorate for population health and 4 the directorate for social care and national care 5 service. 6 The Scottish Cabinet is the Scottish Minister's main 7 decision-making body. It comprises the first minister 8 and all Cabinet Secretaries, all of whom are bound by 9 the Scottish ministerial code and the doctrine of 10 collective responsibility. 11 The primary role of the health and social care 12 directorates in relation to Cabinet is to provide advice 13 to the Cabinet Secretary and to draft and advise on 14 papers going to Cabinet in the Cabinet Secretary's name. 15 The Scottish Government's health and social care 16 management board is the main decision-making body of the 17 health and social care directorates. The board is 18 accountable for the strategy and performance of the NHS 19 and health and social care directorates, ensuring that 20 resources are best used to respond to the priorities set 21 by Ministers and deliver the best services possible for 22 the people of Scotland. 23 The permanent secretary holds the Director-General 24 to account with the board being used as the vehicle by 25 which the Director-General discharges their functions. Page 152

1 The Scottish Ministers are also assisted in relation 2 to matters of medical policy and clinical standards by 3 the chief medical officer. There have been four 4 office-holders during the relevant period. 5 A brief chronology of the Scottish Ministers' 6 involvement. On 7 September 2023 the then 7 Cabinet Secretary, Michael Matheson MSP, announced 8 an Independent Clinical Review into the clinical care 9 provided to Mr Eljamel's patients and that a Public 10 Inquiry would be held in respect of the actions of 11 Mr Eljamel and the previous steps taken to investigate 12 his conduct and clinical governance issues arising. 13 The Scottish Ministers anticipate that detailed 14 chronologies setting out the Scottish Ministers and 15 Scottish Government officials' engagement with the 16 issues under investigation by the Inquiry will be of 17 assistance to the Inquiry. They will be pleased to 18 provide detailed chronologies and associated 19 documentation under the Inquiry's direction in due 20 course. 21 What follows is but a high level chronology of the 22 Scottish Government's involvement. 23 On 19 December 2013, the Scottish Government 24 received formal notification from NHS Tayside that it 25 had suspended Mr Eljamel from practice following Page 153	1 On 1 November 2018, the then Cabinet Secretary wrote 2 to health boards, setting out the requirement to share 3 good practice to ensure that boards learn from each 4 other and an event was being set up to facilitate and 5 progress this. 6 On 4 December 2018, a meeting was held attended by 7 senior representatives of the territorial health boards 8 and facilitated by Professor Craig White, then 9 divisional Clinical Lead Director of Healthcare Quality 10 and Improvement and now Associate Director of the 11 directorate, to share good practice and take forward 12 work on what would become the openness and learning 13 commission. 14 The directorate of Healthcare Quality and 15 Improvement now sits within the directorate of the chief 16 operating officer NHS Scotland. 17 On 18 December 2020, the then Cabinet Secretary met 18 with two former patients of Mr Eljamel to discuss their 19 concerns regarding the treatment and care provided by 20 him, together with NHS Tayside's response to those 21 concerns. 22 On 11 March 2021, the Cabinet Secretary commissioned 23 a review of unresolved and outstanding concerns 24 regarding Mr Eljamel to be led by Professor Craig White. 25 Clinical reviews of the treatment and care provided by Page 155
1 concerns raised by 55 separate patients. This followed 2 a report provided by the Royal College of Surgeons to 3 NHS Tayside consequent to its invited review 4 in September 2013. 5 On 24 April 2014, the Scottish Government was 6 informed that Mr Eljamel had indicated his intention to 7 retire at the end of May. He also resigned as a member 8 of the General Medical Council at the end of May 2014. 9 Between 2014 and 2017, the Scottish Government 10 received substantial correspondence from a former 11 patient of Mr Eljamel setting out concerns he had raised 12 with NHS Tayside regarding the treatment and care he had 13 received. 14 On 1 December 2016, the then Chief Medical Officer, 15 Dr Catherine Calderwood, met with the GMC to discuss the 16 frustrations felt by former patients that Mr Eljamel had 17 been able to voluntarily remove himself from the 18 register prior to the conclusion of a fitness to 19 practice investigation. 20 On 1 September 2018, the then Cabinet Secretary, 21 Jeane Freeman MSP, wrote to all NHS health boards in 22 Scotland seeking confirmation from each health board as 23 to the steps they were taking as a matter of clinical 24 governance to properly handle complaints regarding 25 clinicians. Page 154	1 the two patients I have referred to were also 2 commissioned. 3 On 10 May 2022, the report on the review of 4 unresolved and outstanding concerns was published. It 5 made a series of recommendation to NHS Tayside including 6 in respect of complaint handling and measuring the 7 effectiveness of actions taken following previous 8 reviews. 9 Certain recommendations were also made to NHS 10 Scotland in respect of developing national guidelines 11 for consultant supervision and a national neurosurgical 12 audit programme. 13 On 9 February 2023, the then Cabinet Secretary, 14 Humza Yousaf MSP, met with a number of MSPs to discuss 15 their constituents' concerns regarding prior 16 investigations into the actions of Mr Eljamel and the 17 calls which had been made for a Public inquiry. 18 On 20 April 2023, the then Cabinet Secretary 19 Michael Matheson MSP, directed that an independent 20 commission led by an independent legal expert be 21 established to review, one, individual cases in which 22 patients considered they had suffered at the hands of 23 Mr Eljamel and, two, learning systems and governance 24 within NHS Tayside. 25 On 31 August 2023, NHS Tayside published its due Page 156

1 diligence review report identifying various failings in 2 NHS Tayside's handling of the concerns regarding 3 Mr Eljamel. 4 On 7 September 2023, and in light of the findings in 5 the due diligence review report, the Scottish Government 6 announced the establishment of this Public Inquiry and 7 the Independent Clinical Review, replacements for the 8 previously planned Independent Commission. 9 Turning to the Inquiry's terms of reference, sir. 10 The guidance issued to core participants invited them to 11 identify those aspects of the Inquiry's terms of 12 reference, and list of issues as updated, that are of 13 particular importance to them or that they consider 14 merit particular, or particularly detailed, attention on 15 the part of the Inquiry. 16 It is anticipated that the Scottish Ministers can 17 best assist the Inquiry in relation to issues arising in 18 respect of the adequacy of the reviews and 19 investigations carried out since Mr Eljamel's suspension 20 in 2013. 21 Whilst the ministers are committed to assisting 22 the Inquiry in any way they can, they're not currently 23 aware of any information available to them relating to 24 concerns regarding Mr Eljamel until they were advised of 25 his suspension on 19 December 2013. Page 157	1 of issues 234 to 239 and 255 to 261, which relate to 2 term of reference 6, and 299 to 327, which relate to 3 term of reference 12. 4 They also have an interest in issue 75, which asks 5 whether Mr Eljamel held an advisory role with the 6 Scottish Government; issue 266, which relates to 7 NHS Tayside reporting obligations to the 8 Scottish Government; and issue 228, which references 9 reports made by NHS Tayside to the Scottish Government. 10 In due course, it is anticipated that the Inquiry's 11 attention in respect of the Scottish Ministers might 12 reasonably be detected at two broad questions. 13 First, could, or should, the Scottish Ministers have 14 identified issues in respect of Mr Eljamel prior to 15 notification of his suspension being received on 16 19 December 2013? And, second, whether the 17 Scottish Ministers' response to the issues once raised 18 was adequate and timely. 19 Moving on to matters arising from the guidance note 20 of 29 October, sir, that note invited core participants' 21 comments and observations on a variety of matters. In 22 their written submission, the Ministers offer their 23 views on the scope of the terms of reference and explain 24 that they do not, at this time, wish to suggest further 25 lines of investigation or propose additional issues for Page 159
1 In particular, the Scottish Ministers consider that 2 the terms of reference upon which they are most likely 3 to be able to assist the Inquiry are term of 4 reference 6, to investigate the role of any other bodies 5 which played or could have played a role in the care 6 provided by Mr Eljamel to his former NHS patients, 7 including but not limited to the Scottish Executive or 8 Scottish Government relating to its overall 9 responsibility for the NHS in Scotland, and term of 10 reference 12, which includes an examination of all 11 previous reviews or investigations undertaken by or 12 behalf of on the instructions of the Scottish Executive 13 or Scottish Government into the professional activities 14 of Mr Eljamel during the course of his employment with 15 NHS Tayside and to consider the adequacy and timeliness 16 of those reviews or investigations, including the 17 adequacy of steps taken in light of the findings and 18 recommendations of them. 19 A non-exhaustive list of investigations is then 20 provided and this includes the Scottish Government's 21 review of unresolved and outstanding concerns regarding 22 Mr Eljamel, former consultant neurosurgeon at 23 NHS Tayside in 2022. 24 Having regard to the list of issues, the 25 Scottish Ministers have a particular interest in respect Page 158	1 consideration by the Inquiry or suggest possible 2 recommendations, but that they will keep these matters 3 under review. 4 In my oral submission today I wish to restrict 5 myself to saying a few words in relation to documents, 6 witnesses and areas where the Ministers might best 7 assist the Inquiry. 8 Dealing firstly with witnesses, paragraph 13(d) of 9 the guidance note invites suggestions as to the identity 10 of witnesses whom core participants submit the Inquiry 11 should take written statements or perhaps hear oral 12 evidence from and to identify the role which such 13 individuals are expected to be able to play and the 14 areas which and why their involvement in those ways 15 would be beneficial to the Inquiry's fulfilment of its 16 terms of reference. 17 Having regards matters on which the Inquiry might 18 best be assisted by the Scottish Ministers, it is 19 anticipated that the Inquiry may wish to hear evidence 20 from the following witnesses: firstly, the various 21 Cabinet Secretaries in office during the relevant 22 period, who might speak to the dialogue between 23 NHS Tayside and the Scottish Government, dialogue with 24 other key stakeholders including former patients, the 25 decision to initiate the review of unresolved and Page 160

1 outstanding concerns, the decision to convene the 2 Independent Clinical Review and, of course, the decision 3 to announce this Public Inquiry. 4 Then, the various chief medical officers in office 5 during the relevant period, to speak to engagement with 6 stakeholder regarding the clinical care provided by 7 Mr Eljamel. 8 The Inquiry may wish to hear from 9 Professor Craig White, Associate Director of the 10 Scottish Government's Healthcare Quality and Improvement 11 directorate to speak to his role in relation to the 12 review of unresolved and outstanding concerns. 13 The Inquiry may also wish to receive evidence from 14 the two consultant neurosurgeons to speak to the case 15 note review of the care of two patients that was 16 associated with the review of unresolved and outstanding 17 concerns. 18 Next, the various Directors General of health and 19 social care during the relevant period, to speak to the 20 corporate knowledge and responsibilities of the 21 Scottish Ministers during the various period subject to 22 inquiry. And finally, the various Chief Operating 23 Officers of the health and social care directorates 24 during the relevant period to speak to the corporate 25 knowledge and responsibilities of the Scottish Ministers Page 161	1 ingather documentation that it is anticipated 2 the Inquiry will wish to consider and in response to the 3 rule 8 notice intimated on 10 November. 4 However, given the large volumes of data held by the 5 Scottish Ministers and the nature of the platforms on 6 which such information is stored, full review and 7 disclosure will inevitably take some time. 8 Paragraph 13(g) of the guidance note invites comment 9 on those aspects of the Inquiry's terms of reference and 10 list of issues and sectional evidence plan to which core 11 participant groups think they can contribute to the 12 greatest extent. 13 The Scottish Ministers anticipate their principal 14 contributions to the Inquiry being in respect of terms 15 of reference 6 and 12. In that context, the 16 Scottish Ministers' main involvement is likely to arise 17 in respect of the following sections of the Inquiry: 18 section 1, setting the scene. In particular, the 19 Scottish Ministers can provide evidence setting out the 20 roles and responsibilities of the Ministers, the 21 Cabinet Secretary, the Chief Medical Officer, NHS 22 Scotland and the directorates for health and social 23 care, as well as the formal mechanisms in place for 24 sharing of information between those various parts of 25 government. Page 163
1 during the various periods subject to inquiry. 2 It may be, sir, that as the Inquiry's investigations 3 progress, additional former or current Scottish 4 Government officials will be able to assist the Inquiry 5 with the provision of corporate statements or individual 6 witness evidence on particular points of interest. The 7 Scottish Ministers will work collaboratively with 8 the Inquiry to ensure that it has access the most 9 relevant witnesses to assist it in its important work. 10 Turning to consider paragraph 13(f) of the guidance 11 note which references key material which core 12 participant groups hold, the Scottish Ministers hold 13 substantial documentation particularly in relation to 14 the commissioning of the review of unresolved concerns, 15 the Independent Clinical Review and this Public Inquiry. 16 The Scottish Ministers respectfully agree with the 17 proposals set out within the note by counsel to the 18 Inquiry of 10 September 2025 that disclosure should be 19 made by reference to appropriate rule 8 requests and 20 where necessary section 21 notices, that rule 8 requests 21 be issued on an iterative basis, focusing on specific 22 topics or issues. 23 The Scottish Ministers respectfully request that as 24 much notice as possible is given in respect of any 25 rule 8 request. Steps have already been taken to Page 162	1 They can also provide an overview of their 2 involvement in the various reviews that fall within the 3 remit of term of reference 12. 4 Section 5, corporate clinical oversight complaints, 5 the role of the Scottish Ministers' investigations and 6 organisational candour. In particular, the 7 Scottish Ministers can provide detailed evidence in 8 respect of their role and responsibilities and the 9 investigations undertaken by, or on behalf of, the 10 Scottish Ministers during the period from December 2013 11 onwards. 12 Section 6, lessons to be learned. The 13 Scottish Ministers anticipate that, as regards their 14 role, there may be lessons to be learned in respect of, 15 firstly, oversight of health boards by central 16 government and whether the level of oversight provided 17 is adequate or requires to be increased. 18 Secondly, the extent and effectiveness of 19 information sharing between relevant agencies. 20 Thirdly, whether the steps taken by the 21 Scottish Ministers as matters were reported to them was 22 adequate. 23 Fourthly, whether a Public Inquiry should have been 24 convened earlier. 25 Fifthly, the extent to which recommendations of Page 164

1 previous reviews have been implemented. 2 And, sixthly, the extent to which such 3 recommendations might protect against any repeat of the 4 issues that gave rise to this Public Inquiry. 5 In conclusion, sir, the Scottish Ministers are 6 grateful for the opportunity to contribute to 7 the Inquiry's work by making this opening statement. 8 They reiterate their willingness to work collaboratively 9 with the Inquiry and to assist the Inquiry in fulfilling 10 its terms of reference. 11 Thank you. 12 LORD WEIR: Thank you. 13 Ms Thomson, just before you sit down, I wanted to 14 just clarify one matter and that was whether you had any 15 observations in relation to paragraph 13(b) or 13(c) of 16 the guidance that was issued? It's a matter entirely 17 for you, but I wanted to be clear whether these featured 18 as any part of your submissions. 19 MS THOMSON: They did, sir. I read them short, but if I may 20 elaborate, paragraph 13 -- sorry, 13(b) -- sorry, sir. 21 LORD WEIR: 13(b)(ii). 22 MS THOMSON: (b)(ii), I'm sorry. 23 LORD WEIR: 13(b)(vii), 13(b)(x), 13(b)(xi) and 13(c). Now, 24 it may well be that that was intended to be covered in 25 brief and I'm happy if you're content that you have Page 165	1 investigate complaints or concerns about Mr Eljamel's 2 practice prior to 2012 and the nature of any such 3 complaints or concerns. And the Ministers' position is 4 quite simply that the terms of reference are 5 sufficiently broad to allow consideration of those 6 issues. 7 The other subparagraphs to which you drew my 8 attention, sir, were all matters in respect of which the 9 Ministers' position was, ultimately, we have no 10 suggestion to say make at this time in relation to 11 further investigations, additional issues for the lists 12 of issues or draft recommendations. However, we will 13 keep those matters under review and, no doubt, it goes 14 without saying, sir, that in the event that the 15 Ministers wish to contribute in any way to shaping the 16 scope of the lines of investigation, the list of issues 17 or draft recommendations, then they won't hesitate to 18 bring any thoughts or observations or suggestions that 19 they have to make to the attention of your team, sir. 20 LORD WEIR: All right, thank you very much indeed. 21 MS THOMSON: Thank you. 22 LORD WEIR: As I indicated before Ms Thomson addressed the 23 hearing room this afternoon, I don't intend to take any 24 further statements this afternoon. We will resume again 25 at 10.30 tomorrow morning and deal with the matters that Page 167
1 covered them. I just wanted to be clear that -- 2 MS THOMSON: I'm obliged for that opportunity, sir. I chose 3 to read them short. Paragraphs 13(b)(ii) and 13(b) -- 4 I think it was (iii) both related to the scope of the 5 terms of reference. 6 LORD WEIR: Yes. 7 MS THOMSON: Sir, you have the brief comments that were 8 offered by the Ministers in their written submission. 9 In short, in relation to whether the remit should extend 10 beyond Mr Eljamel's practice at Ninewells Hospital into 11 other parts of the NHS, the Ministers' position is that 12 it's ultimately a matter for you, sir, to interpret the 13 terms of reference, but the Ministers would query 14 whether work carried out work by Mr Eljamel for NHS Fife 15 would fall within the current terms of reference, as 16 NHS Fife were not referenced within the Inquiry's terms 17 of reference and are not a core participant to 18 the Inquiry. But notwithstanding that observation, it 19 does not seem to be problematic for the Inquiry to 20 consider the extent to which the workload within 21 NHS Tayside was perhaps increased as a consequence of 22 Mr Eljamel taking on work from other parts of the NHS. 23 The other paragraph that touched on terms of 24 reference was -- I'm sorry, it wasn't (b)(iii), it was 25 (b)(vii), is in relation to whether the Inquiry should Page 166	1 I mentioned some moments ago. 2 Can I thank you all for attending today, whatever 3 your interest is in the Inquiry. As I say, we will 4 start again with Mr Dundas addressing you on behalf of 5 Health Improvement Scotland and NHS Education for 6 Scotland in the morning, after which there will be 7 a final address from Mr Dawson for you to consider. 8 Let me, in the meantime, wish you all a safe journey 9 home and for those who are coming tomorrow, we will meet 10 again tomorrow, but thank you and I wish you a good 11 afternoon. Thank you. 12 (3.21 pm) 13 (The hearing adjourned until 10.30 am on Thursday, 14 27 November 2025) 15 16 17 18 19 20 21 22 23 24 25 Page 168

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