

1 Thursday, 27 November 2025 2 (10.30 am) 3 Housekeeping 4 LORD WEIR: Good morning, please be seated. 5 To those who were with us before, welcome back, and 6 to those attending or joining for the first time, 7 welcome also to the second of two days set aside for 8 the Inquiry's opening statements hearing. 9 I propose to go straight to the agenda from which 10 you will have seen that the first item on that agenda 11 involves opening statements being delivered by Mr Dundas 12 on behalf of Healthcare Improvement Scotland and 13 NHS Education for Scotland and I will invite Mr Dundas 14 to come forward and give those statements now. 15 Opening statement by MR DUNDAS 16 MR DUNDAS: Thank you, sir. 17 My name is Shane Dundas and along with Mr Stewart, 18 Ms McCabe and Ms Davidson of the NHS Central Legal 19 Office, I represent two core participants in this 20 Inquiry: NHS Education for Scotland, NES; and 21 Healthcare Improvement Scotland, HIS. 22 At the outset, both NES and HIS wish to recognise 23 that many of Mr Eljamel's former patients and their 24 families are participating in this Inquiry or are 25 watching these proceedings remotely. They wish to Page 1	1 training and workforce development for those in NHS and 2 social care sectors in Scotland. It is responsible for 3 facilitate a skilled, capable and well-supported health 4 and social care workforce by developing and delivering 5 educational programmes, leading national projects and 6 utilising technology-enabled learning and digital 7 services. 8 NES was established in 2002 under the 9 NHS Education for Scotland order. It brought together 10 three existing bodies: the Scottish Council for 11 Postgraduate Medical and Dental Education, the 12 Post-qualification Education Board for Pharmacists and 13 the National Board for Nursing, Midwifery and Health 14 Visiting for Scotland. 15 These bodies were originally instituted to meet the 16 growing need for structured postgraduate medical, dental 17 and other healthcare education and to ensure that the 18 quality of educational programmes met the regulatory 19 standards imposed by the relevant regulator, so, for 20 example, the GMC. And upon its institution, NES assumed 21 these overarching responsibilities. 22 So NES focuses on education and training, whereas 23 other health boards, known as "territorial health 24 boards", are responsible for the delivery and management 25 of local health services to the public. Page 3
1 acknowledge the harm which has been sustained by them 2 either directly or indirectly due to the actions of 3 Mr Eljamel and they wish to express their deepest 4 sympathies to them in respect of that. 5 NES and HIS further wish to offer their thanks to 6 the Inquiry for being afforded core participant status 7 and express both their willingness to assist the Inquiry 8 in any way that they can and their commitment to taking 9 forward what lessons may emerge from these proceedings 10 which relate to the work undertaken by them. 11 NES and HIS are conscious that some people listening 12 to this opening statement may not be familiar with the 13 work which they do and it is important to NES and HIS to 14 explain who they are, what they do and how they can 15 assist the Inquiry this going about its task. I will 16 therefore divide my opening statement into five 17 chapters. 18 First, I will consider the background to NES. 19 Secondly, I will turn to consider NES's participation in 20 this Inquiry. Thirdly, I will consider the background 21 to HIS. I will then turn to consider HIS' participation 22 in this Inquiry and then finally, I will address other 23 matters relating to the Inquiry's work. 24 I turn first to address NHS Education for Scotland. 25 NES is a special health board that provides education, Page 2	1 In April 2014 the Scotland Deanery was established 2 which forms part of NES and its responsibility is to 3 manage the education and training of all resident 4 doctors in training in Scotland, ensuring that their 5 training meets the regulatory standards of the GMC and 6 that they progress appropriately through their training 7 pathway. 8 And prior to the formation of the Scotland Deanery 9 in 2014, medical education and training was managed by 10 four separate regional deaneries across Scotland and NES 11 combined these deaneries into a single national Scotland 12 Deanery in 2014 to oversee all postgraduate medical 13 education and training programmes across the four 14 regions, and the move to merge the four regional 15 deaneries was undertaken to streamline the management of 16 medical education and training across Scotland. 17 By creating a single unified deanery the aim was to 18 ensure greater consistency in standards, improve 19 efficiency and facilitate better sharing of resources 20 and best practice across Scotland. 21 In its capacity, NES is therefore responsible for 22 the recruitment of all resident doctors in training in 23 Scotland and the Scotland Deanery works in partnership 24 with territorial health boards, hospitals and 25 GP surgeries to train resident doctors to be the senior Page 4

1 clinicians that Scotland needs to treat its population 2 in the future. And NES ensures that doctors are given 3 the right training opportunities and experiences to 4 equip them to be effective and capable practitioners. 5 NES also undertakes annual reviews of resident 6 doctors in training to ensure that they're gaining all 7 competencies required by their training programme at 8 an appropriate rate and through appropriate experience. 9 NES is also responsible for making revalidation 10 recommendations to the GMC and managing procedures 11 related to any performance concerns which arise in 12 relation to resident doctors. 13 And quality management visits are also a key element 14 of the work undertaken by NES. NES's quality management 15 team will visit an institution, so, for example, a GP 16 surgery or a hospital, to assess the quality of the 17 training environment and assess whether it 18 satisfactorily meets the GMC standards for medical 19 education and training. 20 And these visits assess training environments rather 21 than individual trainees. And the quality of their 22 training is reviewed through surveys, questionnaires and 23 interviews with staff, trainers and trainees to identify 24 strengths and areas for improvement. 25 And the goal is to promote good practice and enhance Page 5	1 The incumbent senior medical team at NES can impart 2 knowledge of the systems currently in place for 3 education and training and how the landscape has 4 developed in recent years. 5 In addition, previous NES post-holders can provide 6 relevant information relating to the education and 7 training systems in place at the time of Mr Eljamel's 8 practice in order to understand the environment in which 9 he operated, and NES has provided the Inquiry with 10 a list of relevant witnesses separately. 11 Another area for investigation is the identification 12 of any lessons and implications for the future and the 13 making of recommendations if the Inquiry considers them 14 to be appropriate. And the participation of NES in this 15 Inquiry is not only about explaining historical 16 processes but also about ensuring that the education, 17 supervision and quality systems operated today are safe, 18 connected and responsive. 19 And as the special health board responsible for the 20 provision of education and training in Scotland, this is 21 an aspect of the Inquiry which NES considers to be of 22 vital importance so as to learn from the past to 23 strengthen Scotland's system of training and governance 24 for the future. 25 And NES considers that it can assist the Inquiry in Page 7
1 the quality of medical education and training across 2 Scotland. So, in summary, NES is different from other 3 health boards because it is a national health board with 4 statutory functions for providing, coordinating, 5 developing, funding and advising on education, training 6 and workforce development for the NHS rather than the 7 direct delivery of frontline healthcare services. 8 Finally, looking to the future, the 9 Scottish Government is considering implementing a plan 10 to merge NES with NHS National Services Scotland to 11 create a single organisation which would continue to 12 undertake the responsibilities of NES in conjunction 13 with other statutory functions under a new name: 14 NHS Delivery. 15 Turning, now, to chapter 2 and NES's participation 16 in the Inquiry. One of the areas of investigation is 17 other bodies which played or could have played a role in 18 the care provided by Mr Eljamel to his former patients. 19 In particular, the roles of the Scottish Council for 20 Postgraduate Medical and Dental Education and NES, 21 relating to the maintenance of standards in the training 22 of doctors and surgeons. This is an area of 23 investigation for the Inquiry which is central to NES 24 and in respect of which NES considers it can contribute 25 considerable knowledge and experience. Page 6	1 identifying any areas of learning which emerge and 2 recommendations which face the future. For example, one 3 broad area which the Inquiry could consider is how 4 further integration between education and safety systems 5 across NHS Scotland could improve the early detection of 6 and response to clinical risk. And by drawing on the 7 knowledge and experience it possesses, NES can 8 contribute constructively to the Inquiry's objective of 9 fostering a culture of continuous improvement, ensuring 10 that lessons learned are both evidence-based and 11 relevant to the evolving needs of the health service in 12 relation to the training of future doctors. 13 Turning, now, to considering 14 Healthcare Improvement Scotland. HIS is a health body 15 which was constituted by legislation in 2011. HIS is 16 a unique combination of a range of statutory duties and 17 other functions including quality assurance, 18 improvement, service redesign and strategic planning. 19 It also provides evidence-based advice, guidelines and 20 standards for health and care professionals and 21 resources for NHS boards to conduct community engagement 22 for service change. 23 HIS is also responsible for the registration and 24 regulation of independent healthcare, which was 25 conducted by the Care Commission until HIS was Page 8

1 established. And HIS' key duties, as set out in 2 legislation, are as follows: a general duty of 3 furthering improvement in the quality of healthcare; 4 a duty to provide information to the public about the 5 availability and quality of services provided under the 6 health service; and when requested by the 7 Scottish Ministers, a duty to provide to the 8 Scottish Ministers advice about any matter relevant to 9 the health service functions of HIS. 10 And to fulfil its functions, certain statutory 11 duties are conferred upon HIS. For example, powers of 12 access and entry for the purposes of inspection. 13 HIS works with over 100 partner health and social 14 care organisations taking a quality management systems 15 approach in a range of different ways to strategically 16 redesign and continually improve services. It provides 17 advice and shares knowledge that enables people to get 18 the best out of the services they use and to help 19 services improve, making the best use of resources. 20 HIS is not a healthcare provider and it is not 21 responsible for the performance management of any NHS or 22 social care body or individual practitioner which does 23 provide care. HIS scrutinises the safety and quality of 24 NHS services in Scotland, but it does not act as 25 regulator. In Scotland, health boards are ultimately Page 9	1 provided to individuals, which is a process known as 2 clinical governance. 3 The Clinical Standards Board for Scotland was 4 dissolved in 2003 and NHS Quality Improvement Scotland 5 was thereafter established. And it was constituted as 6 a special health board with a remit to improve the 7 quality of healthcare in Scotland. NHS 8 Quality Improvement Scotland was tasked with improving 9 the quality of healthcare by delivering on six key 10 functions: 11 Providing advice and guidance on effective clinical 12 practice; setting clinical and non-clinical standards of 13 care; reviewing and monitoring NHS services; supporting 14 staff in improving services; promoting patient safety; 15 and the implication of clinical governance. 16 NHS Quality Improvement Scotland was dissolved in 17 2011 and replaced by HIS. HIS and NHS 18 Quality Improvement Scotland are separate bodies. 19 However, HIS has taken over some of the functions which 20 NHS Quality Improvement Scotland previously delivered. 21 Turning, now, to consider HIS' participation in this 22 Inquiry. One of the areas of investigation is the role 23 other bodies played or could have played in the care 24 provided by Mr Eljamel to former NHS patients and, in 25 particular, the roles of the Clinical Standards Board Page 11
1 accountable to the Scottish Government Cabinet Secretary 2 for health and social care through well-established and 3 rigorous performance management and escalation 4 processes. 5 Now, as I have already said, HIS was established as 6 a health body in 2011 and the Inquiry's investigations 7 will consider events prior to then, and for that reason, 8 HIS thought it may be of assistance to make brief 9 comments about two predecessor bodies. In particular, 10 the Clinical Standards Board for Scotland and NHS 11 Quality Improvement Scotland. 12 The Clinical Standards Board for Scotland was 13 a special health board established in 1999 and its 14 objectives related to quality assurance and 15 accreditation. It had two overarching statutory 16 functions: promoting public confidence that the services 17 provided by the NHS were safe and that they met 18 nationally agreed standards, and demonstrating that the 19 NHS was delivering the highest possible standards of 20 care based on the resources available. 21 And to do so, the Clinical Standards Board developed 22 a standard setting and purview process in partnership 23 with healthcare professionals and the public. And this 24 process complemented the legal duty of each NHS body to 25 monitor and improve the quality of healthcare which it Page 10	1 for Scotland, NHS Quality Improvement Scotland and HIS 2 in relation to the maintenance of healthcare standards 3 over the relevant period. 4 Now, this is a matter central to HIS' participation 5 in this Inquiry because it relates to the statutory duty 6 which it fulfils. And there are several functions of 7 HIS where HIS considers it can contribute considerable 8 knowledge, experience and expertise to assist 9 the Inquiry with its investigation of the matters which 10 fall for consideration. 11 For example, it provides the expertise and resources 12 to coproduce standards which are developed, informed and 13 shaped by people who commission, deliver and use health 14 and/or social care services, and it uses 15 well-established, robust methodology to underpin 16 standards development. 17 NHS Scotland has a statutory duty to ensure that the 18 quality of care that it delivers is improved 19 continuously and HIS will undertake inspections against 20 standards or appropriate framework for assuring the 21 quality of service provision. And this is one of the 22 key areas where HIS can assist the Inquiry, because it 23 can provide evidence about how healthcare standards are 24 devised, how they are communicated and how they're 25 ultimately fulfilled. Page 12

1 The conditions in place now can be compared to the 2 conditions in place over the relevant period to 3 understand the environment in which Mr Eljamel was 4 operating. 5 HIS has also provided a separate list of witnesses 6 to the Inquiry detailing individuals who may be able to 7 speak to the historical processes implemented under 8 predecessor bodies as well as the systems now in place 9 under HIS. 10 Another core issue for this Inquiry is to identify 11 any lessons and implications for the future arising out 12 of its investigations and the making of recommendations. 13 HIS considers this to be an important part of the 14 Inquiry process and will provide such assistance that it 15 can, based on the evidence heard, as to how matters of 16 clinical governance may be capable of being improved 17 upon in the future. 18 HIS occupies an important statutory function in 19 maintaining and improving quality and health services 20 and it considers that it is well placed to assist 21 the Inquiry in looking to the future by providing 22 evidence about the underlying purpose and aims of 23 healthcare standards and how these may be best 24 fulfilled. 25 Finally, turning to chapter 5, NES and HIS consider Page 13	1 which NES and HIS not only support but one which they 2 are committed to participating in. 3 And due to the nature of the work undertaken by 4 them, NES and HIS are both familiar with the principles 5 upon which a trauma-informed approach operates. The 6 National Trauma Transformation Programme is funded by 7 the Scottish Government and delivered in partnership 8 with NES and other bodies. So NES plays a key role in 9 the development of a wide range of learning resources, 10 guidance and implication support for all sectors of the 11 workforce to up-skill staff to the appropriate level of 12 trauma-informed and responsive practice and, critically, 13 to embed and sustain this model of working. 14 NES can bring this knowledge and experience to 15 the Inquiry. 16 HIS also recognises the prevalence and impact of 17 trauma and is familiar with the principles which 18 underpin a trauma-informed approach, prioritising 19 safety, trustworthiness, choice, collaboration and 20 empowerment through its work. 21 In line with the Scottish trauma-informed practice 22 framework, all members of staff at HIS must complete, as 23 a minimum, foundation level mandatory trauma-informed 24 practice training on induction and they must refresh and 25 renew that training every two years, and it is designed Page 15
1 that the terms of reference and list of issues are 2 thorough. They have not identified any areas beyond 3 those already identified which they consider should be 4 investigated relative to their involvement in these 5 proceedings. NES and HIS have both received rule 8 6 requests from the Inquiry and are in the process of 7 responding to them and NES and HIS have undertaken 8 a considerable amount of work in that regard. 9 They understand the importance of producing 10 statements which are comprehensive, clear and which will 11 be of assistance to the Inquiry. With a view to 12 producing those, both NES and HIS anticipate seeking 13 a short extension from the Inquiry to allow them to 14 complete the work which has already been undertaken, 15 ingather the relevant documentation which they hold and 16 thereafter, respond in full to the rule 8 requests in 17 such a way that will assist the Inquiry in effectively 18 fulfilling its terms of reference. 19 Finally, sir, turning to the trauma-informed 20 approach. NES and HIS recognise that the subject matter 21 of this Inquiry is likely to be traumatic for those who 22 have been directly and indirectly affected by 23 Mr Eljamel's actions and the Inquiry has indicated that 24 it intends to adopt a trauma-informed approach to the 25 matters that it will examine and that is an approach Page 14	1 to increase the understanding of what psychological 2 trauma is, how it can affect individuals and how people 3 can be supported to recover. 4 HIS can bring this knowledge and approach to the 5 Inquiry with the aim and intention of creating 6 physically and emotionally safe environments and 7 actively involving people with lived experience. And 8 this approach demonstrates sensitivity to the risk of 9 re-traumatisation, reflecting HIS' commitment to 10 a trauma-informed culture that values dignity, respect 11 and recovery, ensuring that engagement with the Inquiry 12 is not only procedurally fair but also psychologically 13 safe and inclusive. 14 Both NES and HIS are carefully considering the 15 trauma-informed approach proposed by the Inquiry. 16 Whilst they have no specific comments to make at present 17 beyond an indication of general support for that which 18 has been proposed, they wish to emphasise that such 19 assistance as is provided by them to this Inquiry will 20 be done so through this important lens. 21 NES and HIS look forward to working with and 22 assisting the Inquiry in fulfilling its terms of 23 reference. They will share any relevant knowledge and 24 experience they have in relation to the Inquiry's areas 25 of investigation and they conclude by renewing their Page 16

1 commitment to supporting the Inquiry with its work. 2 Thank you, sir. 3 LORD WEIR: Thank you very much indeed. 4 It may be that although the agenda makes for a break 5 at this time, we can perhaps proceed directly to the 6 next item on the agenda in which I'm going to invite 7 Mr McGillivray to address the hearing on behalf of the 8 Independent Clinical Review. 9 Mr McGillivray. 10 Oral submission by MR MCGILLIVRAY 11 MR MCGILLIVRAY: Thank you, sir, and good morning. My name 12 is Ewan McGillivray and I'm appearing for 13 Professor Wigmore, who is the Chair of the ICR, the 14 Independent Clinical Review. Professor Wigmore is 15 grateful for this further opportunity to address 16 the Inquiry and provide an update. 17 I would, sir, adopt the written submissions which 18 were lodged on Monday of this week, subject to some 19 change to the figures which I will come on to very 20 shortly. 21 There are three brief chapters to my submissions 22 this morning. First of all, registrations with the ICR. 23 Secondly, support for patients and, thirdly, future 24 procedure. 25 So, first of all, regarding the figures about Page 17	1 week the applicant statements might be sent out to the 2 first 50 patients or their representatives which have 3 been identified by the Inquiry as being an immediate 4 priority. 5 Other than completing the work on the data sharing 6 agreement and the data protection impact assessment 7 between the ICR and the Inquiry which Mr Dawson referred 8 to, there is one small hurdle to be overcome on the ICR 9 side before those applicant statements can be sent out. 10 The ICR awaits feedback from a small group of 11 patients whom it's asked to check over the terms of the 12 questionnaire to be completed by participants in the ICR 13 who are seeking support from the Association of Clinical 14 Psychologists. 15 I would submit, sir, that seeking this feedback from 16 patients is consistent with the trauma-informed approach 17 which the ICR's own terms of reference mandates. 18 The closing date for this feedback is tomorrow. 19 Once it has been received and due consideration has been 20 given to it, the final versions of the questionnaire 21 will then be posted on the website and those applicant 22 statements can be sent out. 23 I will turn now briefly, sir, to further procedure. 24 I would start by saying that Professor Wigmore shares 25 the frustration at the destruction of the surgical log Page 19
1 registrations and consent forms, the position, as at 2 close of business on Tuesday of this week, is that there 3 have been 474 registrations. This has led to 4 354 consent forms being completed and of those 5 354 consent forms, all of them except for three have 6 authorised the sharing of the information with this 7 Inquiry. 8 The ICR is very grateful to all those who have 9 participated so far. The ICR is still receiving 10 registrations, although in the past month or so the 11 volume has decreased, no more than a handful each week. 12 The closing date for ICR registrations is 1 December 13 this year and that date was made public on 27 October 14 this year. However, in the event there are any 15 extenuating or unforeseen circumstances which lead to 16 a delay in registration taking place until after 17 1 December, sympathetic consideration will, of course, 18 be given to enable such late registrations to be 19 received and a review to be given there as well. 20 I turn, now, to the second of my three chapters: 21 support for patients. Professor Wigmore is pleased to 22 note the assurances given by the Cabinet Secretary in 23 the recent letter to you, sir, which senior counsel to 24 the Inquiry spoke about yesterday. 25 Professor Wigmore shares Mr Dawson's view that next Page 18	1 books which were discussed yesterday. He does regard 2 this as quite a loss. 3 I turn, now, to the instruction of the neurosurgeons 4 who will be assisting the ICR. This week 5 Professor Wigmore will be writing to 450 consultant 6 neurosurgeons who have been identified by the Society of 7 British Neurological Surgeons as suitable experts for 8 ICR purposes, so it will contain information and 9 a request that they consider preparing a report and 10 becoming involved in the ICR. 11 I would take this opportunity, now, to add that 12 Professor Wigmore has been grateful for the support 13 provided by the Inquiry's legal team in finalising the 14 terms of the letter of instructions to be sent to the 15 neurosurgeons and indeed also for the help in finalising 16 the terms of the applicant statements. The terms of 17 both those documents were agreed on 28 October. 18 Sir, I think it was NHS Tayside who raised the 19 question of core participants being advised of the 20 identity of the neurosurgeons who are helping the ICR. 21 Professor Wigmore's instinct is to publish the identity 22 of all those neurosurgeons on the ICR's website in the 23 interests of transparency. 24 However, the position about that will be confirmed 25 once the neurosurgeons have been identified and they Page 20

1 have been given notice of this matter. 2 I conclude, sir, by reiterating that 3 Professor Wigmore and the ICR staff will continue to 4 seek to assist the Inquiry in any way it can and they 5 all look forward to continuing to work with you and your 6 team. 7 So, sir, those conclude today's submissions, unless, 8 of course, you have any questions about these matters 9 and I will be happy to do my best to address them. 10 LORD WEIR: Thank you very much. 11 Ladies and gentlemen, the next stage in today's 12 proceedings involves a response from counsel to the 13 Inquiry to various statements that have already been 14 made and which you have heard. And against the 15 possibility that he may wish to respond to any matters 16 that have been raised this morning, it might be 17 a convenient moment for us to take the promised break at 18 this time and let's aim to start again in half an hour's 19 time. Thank you. 20 (11.11 am) 21 (A short break) 22 (11.41 am) 23 LORD WEIR: Thank you, please be seated. 24 The final item of the agenda requires me to invite 25 Mr Dawson to address the hearing in response to the Page 21	1 what has been said can and ought to be incorporated into 2 our planning as we move further into the evidential 3 phase of our work. 4 We will certainly do so carefully as we have 5 undertaken that we will. For the avoidance of doubt, 6 aspects of what colleagues have mentioned in their 7 statements may give rise to us considering a further 8 update on to the list of issues which the Inquiry is 9 willing to entertain and will review. 10 It has also been beneficial to be able to use the 11 public nature of these important hearings as a means of 12 ventilating, in public, certain areas of concern. In 13 some areas, this has allowed progress to be achieved 14 which is a positive development. 15 At this stage, there are a number of areas on which 16 I feel I can usefully make further submissions to you, 17 sir, as follows: first of all, aspects of the terms of 18 reference. Secondly, NHS Tayside log books. Thirdly, 19 documentary production times. Four, the NHS Tayside 20 admissions. Five, matters relating to civil litigation. 21 Six, procedural planning. Seven, Inquiry experts. 22 Eight, the search for Mr Eljamel, before closing. 23 I turn, then, to aspects of the terms of reference. 24 I think it is important to reiterate at this stage that 25 the terms of reference of an Inquiry are an important Page 23
1 submissions and statements that have been made. 2 Mr Dawson. 3 Response statement by MR DAWSON 4 MR DAWSON: Thank you very much, sir. The Inquiry team is 5 very grateful to our colleagues who have made oral 6 opening statements at the hearing and to those who have 7 provided written opening statements and submissions on 8 the counsel to the Inquiry note. 9 We are also very grateful to the clients who have 10 clearly taken the time to provide detailed instruction 11 to enable these statements to be made. The 12 contributions have been very valuable. Your efforts and 13 those of the clients whom you represent are greatly 14 appreciated. 15 In the outline for these hearings set out some 16 months ago, in the Inquiry's public hearings protocol, 17 we said that we wished to have a separate hearing slot 18 at this point in our procedural planning so as to allow 19 our core participants to make active contributions to 20 our work, both on matters of substance and process, 21 consistent with the Inquiry's principles of 22 collaboration and listening. 23 The detail of much of what has been said and written 24 is undoubtedly valuable and informative and the Inquiry 25 will require to take time to reflect on how aspects of Page 22	1 document. They define not only what the Inquiry has to 2 look at, but what it is empowered to look at. 3 The Inquiry's powers of investigation and compulsion, 4 the Chair's right to hold hearings and spend public 5 money, are all only permitted if they relate to matters 6 covered by the terms of reference. 7 We are not only required to look at things that are 8 reasonably deemed to be covered in them, we are not 9 allowed to look any further. It would be wrong for to 10 us give the impression that there are matters which 11 individuals want us to look at into which we do not 12 think are reasonably covered by the terms of reference 13 which define our duty to investigate and our right to do 14 so in this way. 15 Even inadvertently to create a misleading impression 16 in that regard would not be consistent with our 17 principles of clarity and openness. It would certainly 18 not be trauma-informed. It is in that spirit and with 19 those principles in mind that I feel I must make some 20 observations about the Inquiry's terms of reference and 21 the remit which they create for us. 22 In that context, I observe that it is a consistent, 23 though not universal, feature of the patient group's 24 opening statement insofar as it related to the terms of 25 reference that it seeks to assert that matters should be Page 24

1 included within the Inquiry's investigation which would 2 be necessary so that the Inquiry represents 3 an investigation of, to quote "the full extent of 4 Mr Eljamel's actions." 5 That aspiration, however valid in general terms, is 6 not, I'm afraid, the touchstone by which our remit and 7 your powers, sir, must be determined; the terms of 8 reference are. 9 This is why I said at the public consultation event 10 in October 2024 that it is important that the terms of 11 reference are clear. I said that we and those who are 12 listening at the time needed to know what we are looking 13 at and what we are not. 14 I said that this would allow the work of the Inquiry 15 to proceed with a clear purpose and its work to be 16 focused on achieving it, as well as allowing all those 17 who participate to know what we are here to achieve. 18 A major part of the preliminary hearing was devoted to 19 providing an explanation of what we interpreted the 20 final terms of reference to mean, what was included but 21 also what was not. 22 The patient group states at paragraph 3 of its 23 written opening statement that the voice of the patients 24 must be heard. That is absolutely accepted. Means by 25 which those voices can and will be heard are to be found Page 25	1 small part on their thoughtful, evidence-based and 2 ultimately very helpful contributions to date. The 3 patient opening statement consistently identifies the 4 importance of listening to patients and patient evidence 5 in the Inquiry's work. We agree. This is part of the 6 reason why, as I explained yesterday, the timetable for 7 the Inquiry has been postponed, resulting from delays in 8 the ICR, to seek to ensure that all manifestations of 9 that evidence called for is gathered sensitively and 10 carefully. 11 The result of this important context is that there 12 are aspects of the patient submissions about our 13 approach which we accept and others we feel we are 14 unable to. It is apt to recognise in this regard 15 aspects of the patients' approach and their 16 interpretation of the remit as set out in the patient 17 group's written submission with which we agree. 18 It is acknowledged and appreciated that despite 19 inevitable hesitation about doing so, the patient group 20 has been encouraged to engage with the ICR, as the 21 statement points out at paragraph 31. We are required 22 by our terms of reference to seek to assist the ICR to 23 thrive. We have consistently done so. 24 For this aim to be achieved requires a considerable 25 leap of faith on the part of the patients. We Page 27
1 throughout the planning for this Inquiry. What cannot 2 be said, however, is that the undeniable requirement 3 that the voices of patients be heard and that the 4 Inquiry should serve as a form of learning, and 5 hopefully of catharsis, can be accepted by the Inquiry 6 as a means of defining its remit when that is the 7 function of the terms of reference. 8 To do so would, as a matter of law, constitute 9 a violation of the Inquiry's legal powers and 10 limitations. What the Inquiry is and will remain 11 committed to is allowing the patient voice to be put at 12 the centre of the Inquiry in relation to the matters 13 which are within its remit. 14 As you, sir, have consistently said in your public 15 statements about the Inquiry, we have an already wide 16 remit and a consequently considerable task ahead of us. 17 The breadth of that task was informed by opportunities 18 afforded to patients and others to help to fix our remit 19 in our public consultation exercise. We will set about 20 that task with tenacity and enthusiasm for what we are 21 empowered to investigate. We will do so in the hope 22 that patients will join us in that endeavour, focused on 23 what we are empowered to do, as opposed to what we are 24 not. 25 We have every faith that they will do so based in no Page 26	1 appreciate this commitment to that process which, I am 2 sure, Professor Wigmore does also. 3 It is recognised, as is set out in the statement at 4 paragraph 5, that the Inquiry is about not only the 5 failure which led to alleged harms in the first place 6 but also the compounding features of what is 7 characterised in the submission as how those with power 8 displayed a dismissive and condescending attitude while 9 avoiding responsibility for failures that prolonged the 10 suffering. 11 Terms of reference 4 and 5, complaints and response; 12 8 to 11, supervision, suspension, resignation, removal 13 of Mr Eljamel's name from the GMC register; term of 14 reference 12, investigations; 13, institutional candour; 15 and 14, document management systems, all have elements 16 which post-date the alleged original harm for many. 17 The ability of failures in this regard to pile harm 18 on harm is not underestimated by the Inquiry, though 19 the Inquiry is also about things that may have gone 20 wrong at the time of the original treatment which, if 21 done differently, may have prevented harm, for at least 22 some, ever occurring at all in any form. 23 We note with interest that patients have campaigned 24 from 2014 for a Public Inquiry -- patient group opening 25 statement at paragraph 6 -- a matter which will receive Page 28

1 attention under term of reference 12. Those who were 2 involved in that campaign will be called upon to provide 3 evidence to the Inquiry about their experiences of it. 4 It is also important to note, not for the first 5 time, the commitment of harmed patients to assisting 6 with the Inquiry's forward-facing function. That 7 commitment cannot be doubted and it is, and it will be, 8 consistently relied upon. The patients say that the 9 harm caused by Mr Eljamel affecting the wider NHS cannot 10 be overstated, at paragraph 21. 11 They express a desire that the Inquiry seek 12 accountability to ensure that organisations charged with 13 responsibility can be deemed fit for purpose as well as 14 individuals within them, at paragraphs 12 and 14. They 15 do so so that recommendations can be made to avoid 16 similar issues occurring in the future, as they say at 17 paragraph 14. 18 We, too, commit ourselves to that forward facing 19 endeavour. 20 One area, however, where I fear there may be 21 a divergence in our interpretation of our remit is in 22 the area of the consequences of the patients' treatment 23 and experience. Though not formally part of the terms 24 of reference, it is important to note, in my view, that 25 the Cabinet Secretary has seen fit to recognise in the Page 29	1 understand the broad outcomes for patients in order to 2 be able to adjudicate on the extent of sub-standard care 3 which is at the root of our systemic investigation. 4 To provide an example, we heard from Ms Cherry 5 yesterday about some of the consequences suffered by 6 patients as a result of their allegedly sub-standard 7 treatment. These were truly harrowing accounts which we 8 are already aware sit amongst many more such patient 9 experiences. We are grateful to her and to the patients 10 involved for allowing these experiences to be shared in 11 this public forum. 12 She told us that one patient tragically contracted 13 meningitis. The contraction of meningitis is a relevant 14 general physical consequence which helps us identify the 15 nature of possible sub-standard treatment which perhaps 16 ought to have been prevented such that the outcome could 17 have been prevented from occurring. 18 We also require to look at how that might have been. 19 If more care had been taken, that adverse outcome -- to 20 use the language of the terms of reference -- might have 21 been avoided. We require to investigate whether, if 22 more care had been taken in overseeing infection or 23 other control, or other aspects of patient care, if 24 these consequences could have been avoided by reasonable 25 steps being taken. Page 31
1 explanatory notes at paragraph (d) to the terms of 2 reference his rightful aspiration, which we share, that 3 the Inquiry will provide an opportunity for public 4 acknowledgement of the suffering of former patients of 5 Mr Eljamel and a forum for public consideration of 6 evidence of their experiences. We know that damage has 7 been done. 8 Aspects of the extent of the harm amongst the group 9 and in individual cases is helpfully set out in the 10 patient group's written submission. We intend to 11 conduct ourselves in a way that will recognise and be 12 respectful of that fact. 13 In my submission, that is not the same as saying 14 that the Inquiry requires to undertake a detailed 15 investigation into the consequences for patients of 16 their experiences. Whilst the terms of reference make 17 clear and make reference to aspects of outcome, these 18 are framed in general terms, such as the reference to 19 how certain factors contributed to adverse outcomes in 20 terms of reference 2. 21 Risks to patient safety, quality of care or 22 experience are referred to in equally general terms in 23 term of reference 5, which relates to the implementation 24 of the outcomes of complaints or feedback processes. In 25 our current interpretation, this means that we need to Page 30	1 That is, in my submission, not the same as saying 2 that the Inquiry requires to undertake a detailed 3 examination of the consequences or loss for individual 4 patients as one would do in a civil litigation. 5 In my submission, no term of reference requires us 6 to do so. 7 Equally, it should be noted that the terms of 8 reference of the ICR are limited in this regard though 9 not equally so, in practice. Those terms of reference 10 require that process to provide a view on physical 11 outcomes and to signpost patients to future care, 12 providing, in its term of reference 7, that the ICR 13 will, where possible, analyse what physical damage was 14 caused to the patient and whether that physical damage 15 resulted from the treatment or lack of treatment by 16 Mr Eljamel or medical colleagues under his supervision, 17 on the balance of probabilities. 18 And analyse the adequacy of follow-up care received 19 by patients beyond the care provided by Mr Eljamel or 20 medical colleagues under his supervision and provide 21 signposting of patients to future care if possible. 22 It should be added that the neurosurgeons will be 23 asked in their letter of instruction to provide 24 an analysis in their reports of the key sequelae, or 25 consequences, for the patient and of those caused by the Page 32

1 surgery or sub-standard care which they have identified. 2 The applicant statement request, which will be sent 3 to those who apply to the ICR, will ask and enable 4 patients to provide details of both physical and mental 5 health consequences of the treatment of the care they 6 received. 7 The ICR does not require to undertake a detailed 8 analysis of the consequences, however. The ICR 9 reviewers will analyse, in broad terms, the physical 10 consequences, the mental consequences and provide 11 a broad outline of the outcome. This will serve 12 the Inquiry's purposes in this regard as I have defined 13 them. 14 In any event, it is noted with interest that the 15 patient group's submission identifies a common 16 experience amongst its sizeable patient group, both in 17 terms of treatment provided, which one would imagine 18 would be represented in a number of the applicant 19 statements provided to the ICR and the actions or 20 inaction of NHS Tayside, an allegation which will be the 21 key focus of the Inquiry's work. 22 As to the former, we note the common experiences 23 identified by the patient group at paragraph 32 of their 24 submission and are pleased to report that in our 25 interpretation all of these are matters on which the ICR Page 33	1 the investigation of private systems, a plea to be found 2 at paragraph 22 of the patient group's submission, that 3 it is accepted by the patient group that they are not 4 part of their current ambit. We agree. This is the 5 natural interpretation of the words read in their 6 context. It should also be borne in mind that the 7 inclusion of private systems was a matter which was 8 raised in our public consultation and so was put to the 9 Cabinet Secretary for his consideration in the final 10 terms of reference. 11 We take it he must logically have considered and 12 rejected their inclusion. 13 It is our interpretation that these private systems 14 are not included within our remit. This is an Inquiry 15 which is predominantly about the NHS and the extent to 16 which systems which existed in that service did enough 17 to protect Mr Eljamel's NHS patients from harm. 18 They do, however, require us to look at aspects of 19 private care through that NHS lens, including whether 20 Mr Eljamel's commitments to private practice contributed 21 to adverse outcomes for his NHS patients; term of 22 reference 2(a), and whether clues from what was going on 23 in his private practice could and perhaps should have 24 been detected so as to protect NHS patients from harm; 25 term of reference 3. Page 35
1 experts will be asked to address their minds in cases 2 where they are relevant considerations. It is that 3 common experience which the Inquiry wishes to capture as 4 a means of fulfilling its systemic remit. 5 It is undoubtedly worthy of recognition and respect, 6 which the Inquiry has tried to incorporate into the way 7 it will do its work, that many people have suffered both 8 physically and mentally and that lives have been 9 changed, as the patient group says at paragraph 10. 10 Signposting to means by which these consequences can 11 be addressed is an important part of the remit of the 12 ICR, as I have said. It is also recognised by 13 the Inquiry that trust has been broken and that 14 a thorough and fearless investigation within this 15 Inquiry of the alleged institutional failings has 16 an important part to play in attempting to restore that 17 trust. 18 I say "attempting" in recognition that for some that 19 may never be possible. Even for those in this position, 20 we hope that our work will go some way to achieving that 21 important aim. 22 I wish also, sir, to address you in relation to 23 matters raised by Ms Cherry relating to private cases. 24 It must be the logical corollary of the plea to you, 25 sir, to seek to extend the terms of reference to include Page 34	1 The Inquiry was provisionally called "The Eljamel 2 and NHS Tayside Inquiry". Though that name was removed 3 to make clear that the role of other bodies were 4 included, as we have discussed, it is our current 5 interpretation that the terms of reference require to us 6 focus on the NHS and care received there. 7 It is, I should add, sir, in theory possible for the 8 sponsoring minister to be asked to change the terms of 9 reference if the public interest required it. However, 10 as I said at the consultation event in October last 11 year, if possible, this is best avoided as changes to 12 the terms of what we are here to investigate will 13 interrupt the efficiency of the Inquiry and inevitably 14 result in delay. 15 In my submission, though it is a matter for you, it 16 is not your role, sir, to seek to make representations 17 to the Cabinet Secretary about an extension of the terms 18 of reference when that course is open to other parties 19 and your understanding of the terms of reference is that 20 they are limited due to the focus which you have been 21 asked to have on public health services. 22 Though a matter for you, sir, it is not as I 23 understand it your current intention to do so. 24 This does not mean, however, that there are no 25 aspects of the private sector which fall to be Page 36

1 considered. It does mean, however, that private 2 practice and the systems within it will not and cannot 3 feature in the Inquiry's findings or recommendations. 4 Aspects of the private sphere which we will examine must 5 necessarily be ancillary to our stated remit, though 6 those ancillary investigations may well shed light in 7 areas related to the private sphere. 8 As was your stated intent throughout this process, 9 sir, we have taken a broad interpretation of the terms 10 of reference where matters relating to private care have 11 been included. Therefore, as regards the patient 12 group's submission in this regard we agree that the 13 Inquiry can competently investigate Mr Eljamel's 14 practising privileges at Fernbrae Hospital as falling 15 within both term of reference 2, relating to his 16 commitments to private practice, and term of 17 reference 3, relating to the interrogation by 18 NHS Tayside of issues in the private sphere. 19 This is why this matter was included in the updated 20 list of issues which is, again, suggested at 21 paragraph 20 in the patient group opening statement. 22 We also accept the suggestion, made at paragraph 17 23 of the patient group statement, that it is within our 24 remit to look at the extent to which private cases 25 featured in decision-making around holding a Public Page 37	1 investigation the following matters raised in the 2 patient group opening statement, though we keep an open 3 mind as to the extent to which these factors require to 4 be investigated pending further evidence. First of all, 5 eagerness to refer patients to private care possibly for 6 unnecessary surgeries. We think that this forms part of 7 the consideration of Mr Eljamel's private practice under 8 term of reference 2 and may form part of the matters 9 which clinical governance systems ought to have picked 10 up under term of reference 3, or involve lack of candour 11 by Mr Eljamel under term of reference 7. 12 Patients who should have received earlier treatment 13 in the NHS due to the gravity of their conditions will 14 also be considered. We consider this to form a part of 15 sub-standard practice which could be addressed by the 16 ICR experts and should be raised by patients in their 17 applicant statements if they wish to do so and which 18 could have been picked up by clinical governance systems 19 under term of reference 3. They may also possibly 20 involve lack of candour under term of reference 7. 21 Sir, I would also like to say something to you about 22 representations that have been made about NHS Fife. The 23 patient body suggests, at paragraphs 6 and 5 of their 24 written submission, that the role of NHS Fife could be 25 explored under term of reference 6, with reference to Page 39
1 Inquiry under term of reference 12, as well as the 2 possibility of a joint Inquiry which could look beyond 3 issues that are primarily related to Scottish matters. 4 It should also be borne in mind that as the 5 Independent Clinical Review will cover private cases as 6 well as NHS ones, individuals will be entitled to have 7 their own cases in private care reviewed and assessed by 8 an independent neurosurgeon. This is, I continue to 9 assert, a generous offer by the Scottish Government 10 which has little, if any, precedent. The results of 11 those reviews will be part of the Inquiry's evidence as 12 well, to inform what was going on and possibly going on 13 wrong in the private sphere broadly, to inform our 14 limited investigations relating to private care, as 15 I have set out under terms of reference 2 and 3. 16 To that extent, those who are treated in private 17 care and who go through the ICR process will also have 18 an impact on the Inquiry's work. As I have said, 19 private cases do appear amongst those in our top 50 20 priority cases which will be sent to the ICR first. 21 A section 1 rule 8 request relating to matters 22 falling within our remit has been sent to 23 Circle Healthcare, the body we understand to have 24 responsibility for treatment at Fernbrae Hospital. 25 At present, we are minded also to include in the Page 38	1 the consistent re-referral of patients to Mr Eljamel 2 from within the NHS Fife area, which meant that they 3 ought to have been aware of poor outcomes within their 4 patient group which could have been acted upon. They 5 call upon the Inquiry to issue a section 1 rule 8 to 6 NHS Fife. 7 It appears to be the case from the NHS Tayside 8 written opening statement that this may not quite be 9 accurate. This seems to suggest that this was 10 a referral route available to those doctors within 11 NHS Fife, as the NHS Tayside neurosurgical service 12 covered Fife as well which had no such service of its 13 own. Referral would, therefore, be made from NHS Fife 14 doctors to Tayside for this sort of care. 15 In such a case, the patient would have been treated 16 within NHS Tayside and the case could potentially be 17 considered, if of significance to the Inquiry's remit, 18 no matter where the patient resided. The 19 Scottish Government submits that NHS Fife is not covered 20 by the terms of reference as it is not named in them. 21 Ms Thomson hypothesised, perhaps with some basis, that 22 if the suggestion was that the importation of work from 23 the Fife area created workload issues within Tayside 24 that affected patient outcomes, that that, too, could be 25 covered under our term of reference 2(c). Our view is Page 40

1 that that possibility would indeed be covered if 2 evidence emerged of it. 3 However, our interpretation of the possibility that 4 NHS Fife should be included as a body under term of 5 reference 6 as one which could have done something about 6 the emerging evidence relating to Mr Eljamel's practice, 7 is one which we will require to give further thought to. 8 At present, our view is that the investigations which 9 are being proposed would involve looking at what 10 individual doctors working within NHS Fife could have 11 done, as opposed to the body itself. 12 Such individuals within NHS Tayside are covered 13 under term of reference 3. It seems to us likely that 14 undertaking investigations to cover such individuals 15 within NHS Fife would be casting the net too wide. 16 This would logically also exclude the inclusion of 17 NHS Fife in the section 1 ambit in any event based on 18 the approach the Inquiry has taken to that section, 19 seeking information about key bodies and their role in 20 matters pertaining to the practice of Mr Eljamel within 21 the NHS Tayside system. 22 This does not mean, I should say, that individual 23 doctors from the NHS Fife area may not have relevant 24 evidence to bring to the Inquiry about what they knew 25 and when. If they do so, the Inquiry wants to hear from Page 41	1 As to the latter, Perth Royal Infirmary, we would 2 appreciate some further information from the patient 3 group as to why they say that work occurred there which 4 should be included within the Inquiry's terms of 5 reference and remit, noting that, at paragraph 10 of 6 their written opening statement, NHS Tayside makes clear 7 that Perth and Kinross is covered within the 8 geographical area covered by NHS Tayside's statutory 9 remit. It therefore remains feasible that Mr Eljamel 10 did work at Perth Royal Infirmary, though as the 11 NHS Tayside statement also provides no suggestion that 12 a neurosurgical service was offered from there, it 13 remains unclear as to what Mr Eljamel could have done 14 there. We will willingly listen to any further 15 explanation that can be provided. 16 Medical records. Concerns were rightly expressed by 17 Ms Cherry on behalf of her clients about the accuracy 18 and completeness of NHS Tayside medical records. 19 A large range of detailed issues about medical records 20 are now contained in the list of issues, drawing in 21 large part from the particular issues raised by the 22 patient group and which I outlined yesterday. 23 These issues can be assessed by the Inquiry on their 24 review of the records, which, as I have said, is already 25 underway. Page 43
1 them. They can apply for anonymity which will be 2 granted if you, sir, deem it appropriate. The evidence 3 of medics like them will be addressed in section 3. If 4 anyone knows who these doctors may be, their names will 5 be welcomed by the Inquiry. Any such potential 6 witnesses listening now or later could choose to engage 7 with us via the legal team or our engagement strategy, 8 which is designed, in part, to attract and liaise with 9 these types of witnesses. 10 Those and any other medics, nurses or other hospital 11 or medical staff who have relevant evidence to give are 12 urged to get in touch with us as soon as possible. 13 Hospitals. We note that it is suggested by the 14 patient group that the remit of the Inquiry should 15 extend to Dundee Royal Infirmary and to 16 Perth Royal Infirmary, though Ms Cherry, I think, added 17 the word "possibly" to the involvement of the latter 18 when she spoke yesterday. 19 We note that NHS Tayside has helpfully also 20 explained that the former, Dundee Royal Infirmary, will 21 need to be included as Mr Eljamel will have worked 22 there; it is accepted that it must be. NHS Tayside will 23 be pursued to explain in the first instance where 24 records are held relating to the neurosurgical services 25 provided at that hospital. Page 42	1 In addition, such issues, of which patients are 2 clearly already aware, can be ventilated insofar as 3 possible and necessary at public hearings. In the 4 applicant statement request for the ICR, patients will 5 be able to raise issues they have with the care they 6 received in a residual question where any such issues 7 with records can be highlighted. 8 The ICR experts who will, of course, have the 9 records are specifically asked to address the question 10 of the accuracy or comprehensiveness of the hospital 11 records including any discrepancies between those 12 hospital records and the primary care records to which 13 they will also have access. 14 They are also asked to provide a view on whether 15 they were prevented in their important work in providing 16 a view on any matters they were asked to cover by any 17 issues with the materials which might also encompass 18 missing medical records. 19 The Inquiry will provide a broad assessment of these 20 issues in its report under term of reference 14. 21 Expectations as regards the management of hospital 22 records will be part of the matters put to the Inquiry's 23 experts in a general sense. This should hopefully 24 provide a benchmark against which any alleged 25 deficiencies can be evaluated. Page 44

1 It is hoped that these systems provide some 2 reassurance that the Inquiry's investigative mechanisms 3 will enable it to reach a clear position on the various 4 issues relating to medical records which have been 5 raised and which have, quite reasonably, been of 6 considerable concern to the patient group. 7 As regards other matters which were raised, 8 Ms Cherry stated that her clients would like to see the 9 memorandum of understanding which existed between 10 Healthcare Improvement Scotland and the 11 Health and Safety Executive. The nature of the 12 relationship between these two bodies and any such 13 documentation, which may include such an MOU, has been 14 investigated as part of the rule 8 request for section 1 15 sent to both organisations. 16 It would be useful to have more information from the 17 patient group about the underlying medical conditions 18 which they claim were ignored by Mr Eljamel, as referred 19 to at paragraph 32 of the patient group opening 20 statement, to ensure, as I think it is, that this is 21 indeed part of the remit of the instruction going to the 22 experts in the ICR. 23 Sir, I turn, now, to the subject of the NHS Tayside 24 log books. It is indeed troubling that NHS Tayside has 25 admitted to potentially important theatre log books Page 45	1 documents they know they held in the past but do not 2 hold now. 3 In such cases, they are asked to explain how the 4 documents they once held came not to be available in 5 response to the request. Thus, it will be necessary for 6 NHS Tayside, as part of its corporate statement in 7 response to the section 1 request, to provide such 8 an explanation. 9 Though NHS Tayside's candour in bringing this event 10 to the Inquiry's attention should be commended, I should 11 say that the explanation provided in the materials 12 presented to the Inquiry will not suffice. More will be 13 expected. If the corporate position is not sufficient, 14 further explanation will be sought from individuals 15 responsible. 16 At paragraph 52 of their opening written statement, 17 NHS Tayside says that the individuals involved were not 18 aware of the connection between the theatre log books 19 and Mr Eljamel. Blaming the individuals will simply not 20 do when those individuals were acting in the course of 21 their employment with the board. The board has 22 a responsibility to ensure that the obligations placed 23 on it by the Inquiry are adhered to in its work. 24 The matter can be ventilated publicly and questions 25 asked, if appropriate, at the section 1 hearings. It is Page 47
1 relating to Mr Eljamel's practice having been destroyed. 2 I do not go as far as Ms Cherry did when she described 3 these revelations as "beggarly belief". The Inquiry 4 requires to take a more objective approach. 5 What I would observe is that the written opening 6 statement by NHS Tayside is replete with statements to 7 the effect that it is a learning organisation which 8 wishes to rebuild of trust of patients both in this 9 group and more widely and that at times committed to 10 doing so, in particular in light of admitted data 11 protection breaches which, it has rightly admitted, have 12 further undermined patient trust. 13 This is a most unfortunate event to have occurred in 14 that context. Equally, for the Inquiry's evidential 15 purposes, we will expect that the measures which 16 NHS Tayside have said they will put in place to prevent 17 any recurrence are more robust from now on. 18 The Chair has asked me to make clear that these 19 events will be the subject of careful further scrutiny 20 by the Inquiry. Such logs had been asked for as part of 21 the disclosure expected to come along with the section 1 22 rule 8 request. In that request, as in all such 23 requests, NHS Tayside have been asked generally to 24 provide an explanation of what documents they have 25 produced, including addressing the question of what Page 46	1 asserted in the written opening statement by NHS Tayside 2 that it is hoped that the information contained in the 3 logs, spanning the entirety, as I understand it, of 4 Mr Eljamel's practice with them, may be found in other 5 places, such as patient medical records. 6 It is for the reason that those records themselves 7 have been found to have been inaccurate and incomplete 8 that the Inquiry has been charged with investigating 9 document management systems under term of reference 14. 10 The Inquiry, and no doubt patients who harbour these 11 concerns about their records, will approach 12 NHS Tayside's claim that the evidence will be found in 13 them with a degree of scepticism. It is noted by 14 the Inquiry in that context that this is an admitted 15 failure of document management which has occurred in 16 real time rather than historically. 17 The legal position is that this occurrence can have 18 potentially serious consequences in terms of both 19 sanction under section 35 of the Act and evidentially. 20 As such, I will say nothing more on the matter. 21 As I have said, the Inquiry will have to gather 22 evidence about how this breach has been allowed to 23 happen in order to assess what steps to take and the 24 apparent evidential impact and will do so in early 25 course, by seeking clear explanations in the form of Page 48

1 necessary written statements in the first instance. Any 2 such evidence will, of course, be disclosed to core 3 participants for their consideration in the normal 4 course. 5 Sir, I turn, now, to documentary production times. 6 It is understood to be the case that the main material 7 providers to this Inquiry in terms of the volume of 8 documents to be produced will be NHS Tayside and the 9 Scottish Government. Both of these material providers 10 have received, or will receive, separate general 11 disclosure requests in short order, separate from their 12 section 1 rule 8s. 13 This approach has been designed to allow the 14 evidence associated with section 1 to be recovered 15 separately to allow progress to be made toward the 16 section 1 hearings including disclosure before it, but 17 also for the recovery of the general documentary 18 disclosure held by these bodies to be made early in the 19 life of the Inquiry. 20 This will allow that documentation to be assessed, 21 assimilated, disclosed and published in an orderly 22 fashion, reducing the potential for delay to impact upon 23 our process. In this regard, it is concerning to note 24 that in the written opening statement of the 25 Scottish Government reference is made to particular Page 49	1 production, both to stall an Inquiry's progress and cost 2 huge sums of public money. This Inquiry will tolerate 3 neither. 4 As I have said before, the documents produced and 5 received for sections 1 and 2 should be relatively 6 self-contained. The general document discovery will be 7 required for analysis and disclosure for section 3 8 onwards. 9 As regards the expectation that documents will be 10 available and capable of being produced in an orderly 11 manner, we note that it is NHS Tayside's position that 12 they created an information log relating to the Eljamel 13 affair as part of the 2023 due diligence review. 14 Though we do not accept that the database contained 15 everything that we will need or, indeed, that should 16 have been compiled at that time, this starting point, we 17 reasonably anticipate, will make finding and cataloguing 18 many of the relevant documents far easier than in most 19 Public Inquiries as this bulk is already encapsulated in 20 a self-contained space. 21 Equally, we note the Scottish Government's position 22 that their involvement in the Eljamel affair stems only 23 from late 2013 and revolved largely around calls for 24 external review, as opposed to having had any 25 involvement in the primary matters with which we are Page 51
1 complexities which may result from the nature of the 2 platform on which their documents are stored and that, 3 as they say, full review and disclosure will inevitably 4 take some time. 5 This is a matter for the Scottish Government and 6 will not be accepted as a reason for delay. It is 7 concerning that the Scottish Government, a body 8 frequently subject to Freedom of Information and Subject 9 Access Requests, as well as requests for orders from 10 Public Inquiries or courts, would seek to rely on the 11 apparent inadequacy of a storage system which it has 12 chosen to use. 13 Equally, the Inquiry will expect documents to be 14 produced in an orderly fashion, clearly referenced to 15 the calls made in the requests for them. It will not be 16 tolerable to be given a haystack and the Inquiry and its 17 core participants left to find the needles. 18 Rule 8s will be drafted in an ordered way. It will 19 be expected that discovery will be produced in 20 an ordered way as a result. Internal document retrieval 21 and production mechanisms should be set up immediately 22 in accordance with these reasonable demands. 23 Those who take an interest in how much Public 24 Inquiries cost and why they take so long might have 25 regard to the potential for disorderly documentary Page 50	1 involved relating to Mr Eljamel's career. 2 Equally, we would expect that this limited 3 involvement should mean that documents were collated and 4 catalogued in an orderly fashion. To produce documents 5 from one review to a subsequent review, ie the Inquiry, 6 should be a more straightforward exercise. These 7 circumstances should mean that there can be no good 8 reason for delay in the production of documentary 9 material. We will expect deadlines to be adhered to, as 10 is the case with all recipients of evidential requests. 11 It should not be expected that the forced 12 postponement of the evidential hearings which had been 13 scheduled for February will be repeated. Deadlines will 14 be set to make sure that it is not. 15 We note with appreciation that NHS Tayside commits 16 fully to assisting the Inquiry. Similarly, and with the 17 same degree of appreciation, with regard to the same 18 approach which is being taken by the 19 Scottish Government, who also commit to working 20 collaboratively with us. Such full assistance we expect 21 will involve adherence to the reasonable standards and 22 expectations I have set out. 23 It would be ironic in the extreme if the 24 Scottish Ministers were to set the Inquiry the task of 25 reporting as soon as reasonably practicable under term Page 52

1 of reference 19, only then to frustrate the Inquiry in 2 meeting that requirement by not producing documents on 3 time and allowing progress to be made. 4 I turn now, sir, to the NHS Tayside admissions. 5 The Inquiry is not a civil litigation. It is not 6 confined in its investigations or evidence it can 7 ventilate by admissions made by those who might be 8 criticised, as would be the case where such admissions 9 made in a civil court. 10 It is, however, relevant to the necessity for, or 11 the proportionality of, those investigations and that 12 evidence, especially in extent, where criticisms which 13 are made are already accepted. 14 Indeed, it is both encouraged and appreciated that 15 this is acknowledged where this is the case. Such 16 concessions will inevitably assist with the sense of 17 justice so rightly demanded by those who have suffered 18 harm. The earlier they are made the better, in order to 19 try to offer what, for many, has been a long road to 20 justice, as Ms Cherry set out very amply yesterday. 21 Such concessions represent a constructive and 22 responsible approach to the public work of an Inquiry 23 such as this, both in terms of achieving justice and 24 also limiting the amount of time and money which might 25 be needed to achieve it, in particular, where they are Page 53	1 the Inquiry can progress. 2 Though I think it would be fair to say that this 3 applies to all such concessions or apologies which have 4 been offered as part of their written opening statement 5 or beyond, consideration might be given to their 6 position on the following matters: 7 They say, in paragraph 2 of the opening written 8 statement, that they wish to extend their sincerest 9 apologies to all patients who have suffered because of 10 the treatment they received from Mr Eljamel. What are 11 they apologising for here? What part of their role in 12 that treatment, with which the Inquiry is primarily 13 concerned, do they accept merits an apology on their 14 part and why? 15 They say, in paragraph 3 of the opening written 16 statement, that patients were let down when they put 17 their belief and trust in NHS Tayside to keep them safe. 18 How do they accept they were let down? At what times 19 and in what ways? Who was responsible and why? 20 They say, in paragraph 3 of the opening written 21 statement, that the situations in which patients found 22 themselves were exacerbated by the way in which 23 NHS Tayside managed patients' complaints and concerns. 24 What failure of management of complaints or concerns, if 25 any, do they accept? Noting that the 2023 due diligence Page 55
1 made by public bodies with public facing 2 responsibilities. A similar approach to apologies might 3 be said to be appropriate. 4 However, in order for sessions or admissions to be 5 of value for these reasons, they must be unequivocal and 6 they must be clear. Clarity is one of the Inquiry's 7 principles, after all. It is my submission that the 8 concessions made by NHS Tayside in its opening statement 9 are not clear. The Inquiry will endeavour to clarify 10 them by evidence in light of our position on them. The 11 concessions made by NHS Tayside are matters for them and 12 not matters for the Inquiry to seek to define. However, 13 it may be of value for NHS Tayside to use their 14 corporate response to the section 1 rule 8 which they 15 have received to provide needed greater clarity in this 16 regard. 17 They are asked in that rule 8 request to provide the 18 main conclusions of the various investigations listed 19 under term of reference 12, for example, as well as 20 being asked to define the nature of the apology which 21 was given on their behalf via the media in advance of 22 our preliminary hearing. 23 In doing this, they may be able to define with 24 greater clarity what they accept and what they do not as 25 a clear basis from which further investigations within Page 54	1 review appears to be limited when considering patient 2 complaints at least by their failure to look further 3 back than complaints received in 2011, 2012 and beyond. 4 Over what time period do they accept any such 5 failures occurred? Who was responsible and why? To 6 what extent do they accept that patient outcomes were 7 exacerbated as a result? 8 They say, at paragraph 4 of their statement, that 9 NHS Tayside knows that it failed to react at an adequate 10 pace when there were concerns raised about Mr Eljamel's 11 clinical practice and in that regard, that it let 12 patients down. What concerns do they say they failed to 13 react adequately to? With what pace do they say that 14 they did react and what pace would have been adequate? 15 Who was responsible and why? 16 They say, at paragraph 4 of their statement, that 17 patient trust has been eroded by NHS Tayside because of 18 its failures to ensure its systems of supervision and 19 oversight were adequate. In what way and to what extent 20 do they accept that their systems of supervision and 21 oversight were inadequate? What would adequate systems 22 have looked like and why? How would current systems, to 23 which they refer, ensure that they would be alerted at 24 an early stage, as they say they would be now at 25 paragraph 5? Who was responsible and why? How do they Page 56

1 accept that this has worsened the outcome for patients? 2 They say, at paragraph 20 of their statement that 3 Mr Eljamel was not open and honest with patients and 4 colleagues and that they have overhauled their 5 professional governance systems. In what ways and at 6 what times do they accept that Mr Eljamel was not open 7 and honest? In what way and to what extent do they 8 accept that their systems of professional governance 9 failed or at least played a part in this failure of 10 honesty with patients and colleagues? What would 11 adequate professional governance systems have looked 12 like and why? How would current systems have made 13 a difference? Who was responsible and why? How do they 14 accept that this has worsened the outcome for patients, 15 if at all? 16 At paragraph 20, they say the way in which some of 17 those signs of poor practice were joined up was lacking. 18 In what way and to what extent do they accept that their 19 systems of triangulation for monitoring poor practice 20 were lacking? What would adequate, joined up systems 21 have looked like and why? Who was responsible and why? 22 How do they accept that this has worsened the outcome 23 for patients, if at all? 24 Similar considerations apply to other such apparent 25 concessions, including: variability in organisational Page 57	1 doctors, nurses, administrative staff, to act on its 2 behalf. It is through that physical interaction the 3 corporate entity discharges its legal responsibilities 4 to patients and others. 5 This Inquiry will expect NHS Tayside to answer for 6 the actions of its agents, the individuals who did 7 things in its name, on its watch and in the discharge of 8 its legal responsibilities. The idea that in some way 9 the corporate entity does not need to answer for the way 10 in which those individuals interacted with the outside 11 world on its behalf will not be tolerated, for the 12 avoidance of any doubt, whatever the position of the 13 board is, as far as its representation of the interests 14 of those individuals is now. 15 I turn, sir, relating to some matters relating to 16 civil litigation. In the NHS Tayside written opening 17 statement they raise their position in relation to 18 time-bar in civil litigations from paragraph 59. As 19 the Inquiry is prevented from making findings of 20 criminal or civil liability, it offers no current view 21 on these matters. 22 It is correct to say, as Ms Cherry did and I have 23 done, that the Inquiry is not prevented from exploring 24 matters within its remit for fear that those 25 investigations may result in findings from which Page 59
1 response; some complaints not leading to formal 2 investigation; decision-making being delegated too far 3 down the organisation; the inadequacy of practising 4 restrictions in 2013; decision-making not being 5 sufficiently well documented; the lack of reliable 6 documentation from earlier reviews; and lack of 7 oversight around the nature and timing of reviews, which 8 can be found at paragraphs 20 and 46. 9 All of these concessions and others are relevant to 10 our remit. We require clarity around what they mean. 11 Similarly, we note that at paragraph 47 of its 12 written opening statement, NHS Tayside informs 13 the Inquiry that the 2023 due diligence review looked at 14 governance and not individual actions of former 15 employees. It states that the Inquiry's investigation 16 into previous reviews would benefit from looking at the 17 rationale behind individual decision-making within 18 NHS Tayside in a more detailed way. 19 One thing in this regard needs to be made clear: 20 NHS Tayside is a corporate entity which is created by 21 statute, as the submission makes clear. As a corporate 22 entity, it has no means of interacting with the outside 23 world. It exists in the abstract, a concept without 24 physical presence. In order to interact with the 25 outside world it requires to rely on physical agents, Page 58	1 criminal or civil liability might be inferred by others. 2 It is important, however, to understand the 3 limitations of that provision. The investigation of 4 matters pertaining to civil or criminal liability, 5 including considerations of time-bar per se, cannot be 6 the primary aim of our work. However, it is permissible 7 if those matters may be inferred incidentally from the 8 product of it. 9 I turn now, sir, to procedural planning. In her 10 opening statement, Ms Cherry made some submissions about 11 her clients' position with regard to the explanation 12 I had set out regarding the Inquiry hearing scheduled 13 for February being postponed until April; a delay of 14 around ten weeks. 15 Ms Cherry was right to point out, from a temporal 16 point of view, that the delay would result in the oral 17 hearings of the patient-focused section 2 of the Inquiry 18 being delayed from April until September. 19 However, she characterised this delay of five months 20 as being a delay in the patients' voices being heard. 21 I disagree with this characterisation of developments. 22 It should, I hope, be evident that in their capacity 23 as core participants, Ms Cherry's clients patient voices 24 are being heard. They have been since before 25 the Inquiry was set up in our public consultation on our Page 60

1 terms of reference. In fact, they were even before 2 that, as our starting point before setting up was with 3 the voices of patients who had raised them in the media 4 about their stories about the issues that they had 5 experienced. 6 From an evidential perspective it would also be 7 wrong to suggest, as she did, that patient voices are 8 not heard until the early hearings in section 2 9 in September. As I set out yesterday, our initial 10 analysis of the evidence available to us has included 11 a careful review of the patients' complaint files, over 12 100 in number, where the patient perspective and patient 13 voices can certainly start to be heard. 14 Equally, the main means by which evidence be 15 contributed to this Inquiry, as I have said before, will 16 be via written statements. As I said yesterday, the 17 voices of the patients will not only be heard but will 18 be actively listened to in an evidential sense via their 19 ICR applicant statements which the Inquiry hopes and 20 expects will be sought from next week and subsequent 21 Inquiry statements taken thereafter. 22 It is set out in the Inquiry protocol on its 23 approach to evidence and written statements at 24 paragraph 12 that evidence contained in documents, 25 including in witness statements provided to the Inquiry, Page 61	1 public acknowledgement and consideration of evidence of 2 the suffering and experiences of former patients of 3 Mr Eljamel and subject to the provisions of 4 the Inquiry's general restriction order and its protocol 5 on disclosure, publication, restriction and anonymity 6 which contain provisions which seek to respect the 7 rights and legitimate wish of certain former patients or 8 their representatives to confidentiality and privacy. 9 And from paragraph 19, the Chair of the Inquiry is 10 aware that for many patients and their representatives 11 providing written statements to the Inquiry is likely to 12 be a traumatic experience. In accordance with its 13 trauma-informed approach, the Inquiry wishes to minimise 14 the number of times such individuals will have to 15 provide written statements containing evidence of their 16 experience. This principle underpins the approach to 17 further written statements which may be requested by 18 the Inquiry. 19 With that important principle in mind and in light 20 of the broadly systemic remit of the Inquiry's 21 investigation, it is considered likely that for many 22 former patients or their representatives, the applicant 23 statement to the ICR about their clinical experience is 24 likely to provide sufficient evidence for the Inquiry's 25 purposes. It is hoped that for certain of Mr Eljamel's Page 63
1 will be deemed by the Inquiry to be evidence in the 2 Inquiry which the Chair of the Inquiry can consider in 3 making findings and recommendations in fulfilment of 4 the Inquiry's terms of reference. 5 Such evidence will be able to be relied upon without 6 the need for it to be spoken to in oral evidence and 7 hearings or otherwise adduced formally. Such formality 8 would be inconsistent with the inquisitorial nature of 9 the Inquiry and likely to involve unnecessary cost. 10 Written evidence will be disclosed to core 11 participants and published, as well as ventilated and 12 explored at evidential hearings as the Inquiry deems 13 necessary in the interests of fairness, thoroughness, 14 economy and consistent with the Chair's obligations 15 under the Inquiries Act 2005. 16 Further, it states at paragraph 17 that by providing 17 written evidence in the form of an ICR applicant 18 statement, all applicants to the ICR who consent to 19 their applicant statements being shared with the Inquiry 20 will, by their applicant statements, have provided 21 evidence to both the ICR and the Inquiry. That evidence 22 will be considered and analysed along with all of the 23 other evidence available to the Inquiry. 24 It will ultimately be disclosed to core participants 25 and published, consistent with the requirement for Page 62	1 patients, and/or their relatives or representatives, 2 their experience will have been adequately set out in 3 those applicant statements and that it will not be 4 necessary for the Inquiry to seek further statements 5 from them, the content of their applicant statements 6 already being evidence in the Inquiry. 7 Given the Inquiry's systemic remit, it will not be 8 feasible or necessary for the Inquiry to examine 9 individual cases of all former patients of Mr Eljamel or 10 even all of those who have suffered harm. The Inquiry 11 will seek to draw conclusions from their collective 12 experiences as reflected in the applicant statements. 13 This is not to undermine the importance of those cases 14 or any individual's experience. It is a recognition of 15 the Inquiry's systemic remit and the obligation 16 the Inquiry has to discharge its terms of reference in 17 an efficient manner in the interests of the public as 18 a whole. 19 Sir, these systems have been carefully designed to 20 make sure that patients' voices are heard, consistent 21 with our obligations, our remit and the commitment we 22 have made to putting patients at the centre of our 23 process. The patient group is right to say that 24 the Inquiry needs to look at individual clinical cases 25 and hear and listen to the voices of the patients as Page 64

1 a basis of understanding and advancing its systemic 2 remit. 3 The Inquiry needs to know what they say went wrong 4 to understand what might have been avoided with better 5 systems. However, to suggest that this remit requires 6 a full examination of every clinical case is not 7 accurate, in my submission. A broad picture, 8 a collective experience of what went wrong and when will 9 suffice in that regard. 10 In any event, undertaking such a clinical 11 investigation within the Inquiry would be to undermine 12 the structure of this Inquiry and its constitutional 13 requirement to rely on the evidence from the ICR. In 14 fact, this Inquiry will have available to it, through 15 that process, a louder expression of the patient voice 16 than perhaps has ever been available to any public 17 Inquiry; a voice much louder than the Inquiry itself 18 would ever have heard had the Inquiry been the only 19 means by which such evidence was gathered. 20 To dismiss the ICR project as mere outsourcing of 21 the clinical analysis and the evidence being gathered 22 is, in my submission, to undersell its true value. 23 A highly eminent surgeon with intimate knowledge of its 24 workings recently described the ICR as the biggest 25 examination of neurosurgical practice in UK history. Page 65	1 paragraph 10. This helpful suggestion is noted and 2 recognised as a distinct medical discipline. Roles, 3 demarcation and the importance of the relevant 4 disciplines will be covered in the section 1 letters of 5 instructions to the Inquiry's experts. We remain open 6 to later involvement of such expertise if this proves to 7 be a significant discipline in issues arising in cases 8 where there has been sub-standard treatment. 9 I move, sir, to the search for Mr Eljamel. At the 10 last hearing in September, I provided an update on the 11 steps which had been taken by the Inquiry to seek to get 12 in touch with Mr Eljamel. I recognised that though the 13 remit of the Inquiry is predominantly systemic in 14 nature, legitimate questions arise in connection with 15 that remit, the answers to which would logically be 16 assisted by evidence from Mr Eljamel himself. 17 It is inevitable that evidence which the Inquiry 18 receives will contain substantial criticism of 19 Mr Eljamel which will, in turn, require consideration of 20 the Inquiry's obligations to serve warning letters on 21 him under rule 12 and subsequent rules of the 2007 22 Rules. 23 Certain comments ventilated in the press shortly 24 after the hearings and more recently appear to have been 25 critical of the adequacy of the steps we had taken. To Page 67
1 The ability of any patient who wishes to make 2 a statement which will ultimately be evidence in 3 the Inquiry and also have an individualised clinical 4 review by an independent expert is an unprecedented 5 offering, as far as I am aware, in any public 6 investigation of this nature. 7 Ms Cherry rightly asked me to provide what clarity 8 I could at this point about the timing of the hearings 9 of section 2 of the evidence. As I have set out, the 10 oral hearings form only part of the way that patient 11 voices will be heard in this Inquiry. The current 12 intention, as per the detailed plan I have set out, is 13 that the patient voice on the matters within 14 the Inquiry's remit will be heard in the four weeks of 15 hearings which we have reserved from the week commencing 16 7 September 2026. 17 Though I have already said at the preliminary 18 hearing that the Inquiry would keep an open mind about 19 the calling of further patient evidence if important 20 testimony was required to be ventilated in public 21 emerges in our investigations, the plan would then to be 22 move to section 3. 23 Sir, as regards Inquiry experts, the possibility of 24 instructing a neuroradiology expert is raised by the 25 patient group in their written submission at Page 66	1 be clear, those steps were taken in the particular 2 procedural context in which the preliminary hearing took 3 place. A window was open for those with a significant 4 interest in the work of the Inquiry, including those who 5 might be criticised in its evidence or its report to 6 apply for core participant status. It was incumbent 7 upon the Inquiry at that stage to seek to engage with 8 Mr Eljamel, if he wished to engage with us. 9 The Inquiry, as it has moved on, has now taken 10 further steps in this regard as it has been called upon 11 to do. A section 21 notice has been served on a body in 12 Scotland seeking information which it is believed to 13 hold about aspects of Mr Eljamel's financial 14 arrangements in this country. 15 Further investigations are being undertaken relating 16 to another aspect of Mr Eljamel's business affairs in 17 this country. I provide that information by way of 18 reasonable update but go no further, in case doing so 19 publicly might frustrate those lines of enquiry. 20 Those who take an interest in this line of 21 the Inquiry's investigation should be aware that these 22 steps could only ever be preliminary ones in an effort 23 to seek to have Mr Eljamel participate in the work of 24 the Inquiry and answer the very reasonable and 25 voluminous questions which we and others would have for Page 68

1 him. 2 Further, any such questions which would be posed to 3 him would be posed as part of a later section in 4 the Inquiry's procedural plan. There is a stepwise 5 approach being taken to understanding the questions and 6 evidence available related to them before putting them 7 to those who may have been responsible for alleged 8 failures. 9 It should be realised that finding Mr Eljamel would 10 only be a very preliminary part of the process. If he 11 were in Libya, where we believe him to be, the Inquiry 12 would have no power to bring him here to answer for what 13 he did. Its jurisdictional reach extends only to 14 Scotland, as I have previously set out. This is not to 15 say that we will not continue to try to engage him in 16 our process; we have done and we will continue to do so. 17 Equally, we will continue to work in our analysis on 18 the assumption that he will not engage with us, as he 19 has not done so far. This is not the end of the story. 20 We will try to recreate a reasonably accurate picture of 21 what happened in his absence by accessing what evidence 22 is available to us. We will invite you, sir, to draw 23 reasonable inferences from the evidence we do have in 24 the fulfilment of our important remit. This is 25 an exercise not unusual in our judicial system where the Page 69	1 continuing to work with our core participants and their 2 legal representatives in that spirit as the evidential 3 phase of the Inquiry progresses. 4 Thank you, sir. 5 LORD WEIR: Those following the agenda will now appreciate 6 that we have reached the end point for that agenda and, 7 with Mr Dawson's remarks concluded, that also brings to 8 a conclusion this opening statements hearing. 9 Cumulatively, the various submissions serve to 10 emphasise and to confirm the wide public interest and 11 importance of this Inquiry's investigations. From what 12 you have heard over the last day and a half or so, it 13 will perhaps be apparent that those investigations, now 14 well underway, are the product of many moving parts and 15 that is why, amongst other reasons, it was thought 16 appropriate to arrange this event as a bespoke hearing, 17 to bring you and the wider public up to date with the 18 point we have reached. 19 Above all, I do hope that this has been a useful and 20 an informative exercise. For my part, I know that 21 the Inquiry team has derived benefit, support, but also 22 learning from the contributions that have been made to 23 its work hitherto. 24 By way of example, the list of issues consultation 25 brought to notice a number of matters which, as counsel Page 71
1 truth can only be found by careful investigation, even 2 from an unhelpful starting point. 3 Sir, there are some aspects of detail in the 4 submissions on which we intend to seek further 5 information from core participants. By way of example, 6 the patient group's reference to a complaint about 7 Mr Eljamel being made by Tayside Local Medical Committee 8 at paragraph 39, and the details of their allegations of 9 conflict of interest in investigations into Mr Eljamel 10 set out in the same paragraph. 11 Sir, we will examine the submissions and opening 12 statements which have helpfully been provided to us with 13 care again and, if any further matters arise, we will 14 not hesitate to engage with those who made them. This 15 is the essence of the active participation we expect and 16 upon which we certainly rely. 17 Having made those closing remarks, I have nothing 18 further to add, other than to thank those who have 19 participated once again for their very helpful 20 contributions in writing and orally at these opening 21 statement hearings. These hearings have been approached 22 by my colleagues in the constructive and collaborative 23 spirit in which they were designed and in accordance 24 with the Inquiry's principles. 25 We and the Inquiry team very much look forward to Page 70	1 mentioned, have been incorporated into what remains 2 a living document and we are greatly appreciative of 3 that. 4 I hope that, for those who are interested in or 5 concerned about it, you will participate in the public 6 consultation on the trauma-informed policy that we 7 intend to implement in our work going forward. There is 8 a consultation document now published on the Inquiry 9 website and, for those interested, I do encourage you to 10 have a look at it and participate if you choose to do 11 so. 12 You can, in any event, expect to hear from us 13 regularly as we take our evidential investigations 14 forward, and you have already heard from Mr Dawson about 15 some of the ways in which your further engagement and 16 assistance will be sought. 17 It only remains for me to reiterate the thanks that 18 have already been expressed to all of you, whether you 19 have attended in person or joined remotely and in 20 whatever capacity you have done so, for the interest you 21 continue to show in our work. 22 The task my team has been set is, on any view, 23 a challenging one, but that engagement genuinely 24 encourages us in what we do and we are very grateful for 25 it. Page 72

1	May I also, then, conclude by thanking all of those	
2	who were involved in the preparation for and delivery of	
3	the opening statements we have now heard. I do not	
4	underestimate the work involved in that exercise; it is	
5	much appreciated.	
6	We will meet again soon. The hearing will now	
7	adjourn. Thank you.	
8	(12.49 pm)	
9	(The hearing concluded)	
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