1 Tuesday, 8 September 2026
2 (10.06 am)
3 THE CHAIR: Thank you. Please be seated.
4 Well, may I begin by welcoming you all to the first
5 of the Eljamel Inquiry's evidential hearings.
6 Many of you are attending in person today at the
7 hearing suite here in Edinburgh. Others are joining
8 remotely and watching via the live feed.
9 But whatever your interest and from wherever you are
10 observing, you are all very welcome.
11 Many of you will also have attended one or other of
12 the public meetings which were organised in October 2024
13 as part of the consultation held in connection with the
14 setting of the Inquiry's Terms of Reference.
15 On those occasions, I addressed myself directly to
16 the former patients of Mr Eljamel, and I said that I was
17 very conscious of the length of time you had already
18 waited for answers to your questions, and I recognised
19 that you may have felt frustrated and worn down by the
20 time it had taken to get to that point.
21 Given the circumstances in which the present
22 hearings were postponed in the spring, I can only think
23 that that frustration will have grown. Indeed it will
24 likely be shared by others who have a different but
25 nonetheless significant interest in the Inquiry's work.

1 Mr Dawson will shortly be providing me, and you,
2 with an update of where broadly our investigations stand
3 and report on our plans going forward. He may also
4 touch on the circumstances which led to the postponement
5 of the hearings originally scheduled for April of this
6 year. And let me be clear, what happened was deeply
7 disappointing, as was the extent to which having to
8 address the issue in advance of the decision to postpone
9 was time-consuming and extremely disruptive to the
10 Inquiry team's focus, a point that has been made
11 forcefully in the recent past.
12 I should nevertheless record my appreciation of the
13 recent efforts that were made to address this, by means of
14 a legal solution, the technical fire safety concerns
15 that had arisen to the point where I can now be
16 satisfied that these hearings can properly and safely
17 take place. The solution device may come with practical
18 and financial consequences for the Inquiry but these
19 will be for me to deal with. What matters is that the
20 hearing suite is now available for its intended use with
21 the result that we are in a position to commence with
22 the evidence in section 1 of the Inquiry's evidential
23 plan today.
24 It is indeed a watershed moment for all those who
25 have suffered or continue to suffer as a result of

1 medical treatment they received and their experiences
2 subsequently. They deserve special mention on what will
3 doubtless be a day of very mixed emotions indeed.
4 It is also a moment of profound significance for all
5 those who have long campaigned for and promoted the
6 necessity for this public inquiry. Im personally
7 recommitting myself today to its very important work, I
8 will do all I can to meet the expectations that so many
9 have invested in it.
10 As has been said before and will likely be
11 reiterated this set of hearings involves to
12 a significant extent, although by no means exclusively,
13 an exercise in context-setting for the later and more
14 involved sections of the Inquiry's evidential plan.
15 The evidence you will hear over the next four or
16 so weeks may well lead to the exploration of further
17 lines of investigation or the revisiting of issues that
18 have arisen which may merit more detailed examination.
19 Witnesses may in due course be recalled to give evidence
20 in later sections if our investigations justify that
21 course of action. We go, as I have said before, where
22 the evidence takes us.
23 But even allowing for the introductory nature of the
24 hearings you should understand they are themselves the
25 product of a considerable body of preparatory work

1 involving the drafting and completion of detailed and
2 lengthy statements and expert reports and the recovery,
3 production and preparation for disclosure of many
4 documents.
5 It is therefore right that I should also record my
6 appreciation not only of the hard work of the Inquiry
7 team, which has been considerable, but also the efforts
8 already committed by core participants and their
9 representatives to the evidence-gathering process, the
10 consideration of disclosed materials, and more recently
11 the exercise of contributing with suggestions to the
12 evidence proposals for individual witnesses.
13 Contributing in this way is of the essence of the
14 privileges and responsibilities of being and acting for
15 core participants in a public inquiry. I have said
16 before but it merits repetition, the Inquiry team and
17 I rely on your positive engagement to help us to fulfil
18 the challenging mission set for us by the Terms of
19 Reference. We all have an interest in the successful
20 pursuit of an investigation underpinned, if I may say
21 so, by a spirit of dignity, courtesy and respect and
22 which meets the justifiable expectations of former
23 patients, members of the medical profession then and
24 now, and the wider public who rely on the provision of
25 safe, reliable, patient-centred and accessible

1 healthcare.
2 If these objectives are to be achieved, and I'm sure
3 they will be, I will necessarily continue to rely on
4 your help and support as well as your encouragement.
5 On a separate but related point I anticipate that
6 during his address Mr Dawson will remind you of
7 an important paragraph in the Inquiry's protocol on its
8 approach to evidence and written statements which
9 concerns the provision of evidence by individuals and
10 organisations to the Inquiry. In particular I expect he
11 will take the opportunity to issue a further call for
12 evidence as we move towards more detailed systemic
13 investigations which will follow the hearing of the
14 evidence in Section 1 and evidence of the patient group
15 in Section 2.
16 Can I simply ask anyone watching these proceedings
17 or reading about them to pay close heed to that call.
18 I strongly encourage anyone to get in touch with the
19 Inquiry team if they feel that they have information,
20 views or recollections to share with us. You may be
21 assured that any such approaches will be greatly
22 appreciated and valued.
23 In a statement I issued to coincide with the
24 commencement of these hearings I expressed the hope that
25 those with an interest in our work would find their

1 content interesting and informative in providing
2 evidential context for what will follow in later
3 sections of the Inquiry plan. In saying that, I also
4 recognise the risk that some aspects of the evidence may
5 be difficult, even traumatic for some to listen to.
6 I make no assumptions as to what that evidence might
7 be, but wish to stress that the risk is well appreciated
8 and that steps have been put in place in an effort to
9 address it as best we can, consistent with the
10 trauma-informed approach which we have sought to adopt
11 in our work.
12 I therefore wish to assure you that support and
13 assistance is available through the Inquiry secretariat
14 and through the professional services of the Spark
15 charity, representatives of whom will be available at
16 the hearing suite each day or remotely for those
17 watching online. They are all on hand to offer help and
18 support if you need it.
19 With those introductory remarks I now intend to
20 invite Mr Dawson, senior counsel to the Inquiry to
21 address the hearing with his update and overview of the
22 stage we have reached in our investigations with a view
23 to commencing the evidence of the first witness in the
24 Inquiry, Liz Smith CBE, immediately after we break for
25 lunch today.

1 Mr Dawson.
2 Opening statement by MR DAWSON
3 MR DAWSON: Thank you, sir. I am Jamie Dawson KC, senior
4 counsel to the Inquiry. I appear at these evidential
5 hearings alongside my learned junior Mr Ross Crawford.
6 I'm also accompanied by other members of the Inquiry
7 legal team as well as members of the Inquiry secretariat
8 team who have played and continue to play a dedicated
9 role in the delivery of these Inquiry Section 1
10 hearings.
11 Sir, the Inquiry has reached a significant milestone
12 today in that this is the first day on which oral
13 evidence will be heard by this Inquiry. For many,
14 indeed many who join us today, this day has been a long
15 time coming. The subject matter of this Inquiry is
16 relatively historic, focused as it is on the systems
17 surrounding the practice of Mr Sam Eljamel, a consultant
18 neurosurgeon who worked in the Tayside area, in
19 particular at Dundee Royal Infirmary and at Ninewells
20 Hospital, a prominent teaching hospital in that city, as
21 a consultant neurosurgeon from 1995 until his suspension
22 on 10 September 2013, resignation from his post at
23 Ninewells on 31 May 2014 and the subsequent voluntary
24 erasure of his name from the General Medical Council's
25 medical register.

1 Many who have been harmed as a result of treatment
2 received over that period or as a result of the way that
3 the state has responded to their treatment in the
4 subsequent years have fought for a long time to reach
5 today. It is right that we recognise their efforts and
6 their sacrifice as well as those of their loved ones in
7 reaching this point.
8 The evidential hearings of any public inquiry like
9 this one represent a significant milestone in their
10 progress. Sir, this is a public inquiry. Inquiries
11 like this are inevitably fought for by members of the
12 public. They concern matters of public interest, in our
13 case the most revered of our public services, our
14 National Health Service, the fundamental principle and
15 purpose of which is to promote and protect public health
16 and safety. They are commissioned by public servants
17 for the benefit of the public. Often, as here, they are
18 commissioned because of a reasonable apprehension that
19 previous efforts to address or deal with an issue of
20 public importance have been inadequately focused on the
21 interests of those members of the public whom some
22 service or agency was designed to protect and serve.
23 Far too often in my experience of them to do these
24 processes look like lawyers speaking to lawyers. We are
25 lawyers and I am afraid we cannot help that fact. We

1 are used to speaking to one another in language that we
2 understand and are used to or even at times in Latin but
3 that does not mean that an important public process like
4 this which is designed for the benefit of the public,
5 and which has been committed by you, sir, to being
6 patient-centred, that we cannot do better.
7 Thus, this address is unashamedly aimed at the
8 public whose interest we serve and the patients for whom
9 you have deliberately placed at the centre of what we
10 do.
11 I take a keen, deliberate and direct interest, sir,
12 in correspondence received by this Inquiry from members
13 of the public be they former patients of Mr Eljamel or
14 others with a direct involvement in or interest in our
15 work. This correspondence often expresses
16 disappointment and apprehension about the past which
17 manifests itself as an apprehension about the Inquiry
18 process and what it will be able to achieve. In
19 particular in light of external forces which place
20 impediments in our path.
21 However, this correspondence also shows hope. It
22 shows faith in you and in the Inquiry team, albeit at
23 times not in others which must never be assumed or taken
24 for granted that this Inquiry can work and fulfil its
25 not immodest aims. That correspondence often shows

1 selflessness, a keen interest in the wider public good,
2 and expresses itself in particular and clearly well
3 thought through terms. It shows the courtesy and
4 respect for your process which you have offered and
5 expected from others. It embodies, sir, a commitment
6 from those who take the time to get in touch, that this
7 Inquiry can be a force for good and that it can be
8 an Inquiry which takes place properly in public with the
9 participation of the public and ultimately for the
10 benefit of the public.
11 I taken encouragement from that and from the
12 possibilities that such a collaborative attitude has the
13 potential to bring.
14 Sir, it would not be uncommon in statutory public
15 inquiries or this one for the opening days of
16 an evidential hearings like these to be focused on
17 hearing opening statements from, or on behalf of, the
18 Inquiry's core participants. Instead, as those who have
19 been following the progress of this Inquiry are well
20 aware, the procedure which we have adopted took
21 a different course. You, sir, heard opening statements
22 from the Inquiry's core participants at a hearing
23 specifically designed for that purpose in November 2025.
24 That course was taken both so that proposals and
25 aspirations of our core participants could be ventilated

1 at an early stage allowing the Inquiry to take account
2 of what was said at that time in its planning. But also
3 so that at this hearing the focus could be on oral
4 evidence from the outset.
5 As a result, we will hear from our first oral
6 witness this afternoon. In light of your desire, sir,
7 to get to the oral evidence at these hearings as soon as
8 possible, and in light of the opportunity afforded to
9 them to make extensive submissions and written and oral
10 statements at the Inquiry's three previous hearings,
11 core participants have not been called upon to produce
12 written submissions in advance of the hearings today,
13 nor have they received a written Counsel to the Inquiry
14 note as they did at previous hearings. They will,
15 however, have an important part to play over the next
16 four weeks and indeed have been part of our preparations
17 for these hearings before today to which I will return
18 in due course.
19 Though the focus today and the weeks to follow is
20 and must be on oral evidence, it is incumbent upon me to
21 provide some important context to the proceedings which
22 are about to commence for those who have an interest in
23 our work. It is important for those who have been with
24 us since the start that they be provided both with
25 an update on what has been happening since we last held

1 a public hearing in May this year and also that they
2 receive a clear indication as to the structure and
3 intentions for these hearings as well as an explanation
4 as to where they sit and what will happen after these
5 four weeks are finished.
6 In addition, it is likely that there are others who
7 have had or who have acquired an interest in our work
8 who are taking a keener interest as we have now reached
9 the evidential stage, including representatives of the
10 media who are welcome and an important part of our
11 public function. They too deserve an explanation of
12 what is passed, what we plan for these hearings and
13 where we intend to go next. Therefore, sir, we have set
14 aside some time this morning to enable me to make this
15 opening submission in the hope that it will fulfil those
16 important purposes. I intend to address the following
17 matters this morning which are designed to help explain
18 the intentions for these Section 1 hearings as well as
19 to provide an update on progress in the Inquiry and our
20 planning more generally.
21 Therefore my submission will be split into the
22 following parts.
23 One, representation. Who is here today and their
24 role in the proceedings. Two, the delay in the holding
25 of these hearings and developments in connection with

1 our hearings venue here at Waverley Gate in Edinburgh.
2 Three, the scope of the Section 1 and the Inquiry's
3 evidential plan and the witnesses who are due to give
4 evidence at these hearings. Four, the procedural plan
5 for these hearings. Five, Section 2 progress and the
6 plans for the next set of evidential hearings
7 in December 2026. Six, planning beyond December 2026.
8 Seven, other important developments in the Inquiry's
9 progress. And eight, conclusions and next steps.
10 To turn then, sir, to representation. Who is here
11 today and their role in the proceedings.
12 It is very important to observe, sir, that these
13 proceedings are being transmitted to those who cannot or
14 do not wish to be here today via a feed available
15 YouTube. A video of the proceedings will be available
16 after the hearing for those who wish to watch it back.
17 A transcript of the proceedings for each day will be
18 uploaded to the Inquiry's website as soon as the end of
19 each day's proceedings finish and it can be reasonably
20 achieved in the light for the need for it to be
21 accurate. The availability of this feed and the regular
22 publication of transcripts of the proceedings are
23 derived from your statutory responsibility, sir, to take
24 such steps as you consider reasonable to allow public
25 access to our proceedings but are also important parts

1 of your additional commitment, sir, to making our work
2 including but not limited to what goes on at our public
3 hearings available to as wide an audience as possible in
4 the knowledge that there are individuals who take
5 an interest in our work and who cannot be here due to
6 physical disability, geographical distance or due to the
7 fact that attending would be too difficult for them for
8 some other reason. Such individuals include but are not
9 limited to members of the patient core participant body
10 upon whose active engagement in our work we do and will
11 continue to rely.
12 This hearing, as I said, sir, is taking place at
13 a hearing room in our hearing suite at Waverley Gate
14 premises in central Edinburgh. When not available to
15 us, the space is used for the hearings of the Scottish
16 Covid-19 Inquiry, another public inquiry set up by the
17 Scottish Ministers. Within the hearing room today my
18 colleagues within the secretariat have, as at previous
19 hearings, managed to configure the seating arrangements
20 as they are currently so that every patient who applied,
21 along with at least one supporter if they wanted one, as
22 well as all representatives of our core participants who
23 wished to be here, have been offered a seat. This has
24 been done to accommodate everyone who applied, in
25 particular the former patients of Mr Eljamel and their

1 supporters, who are all most welcome here today.
2 Their presence either in person or online is
3 of fundamental importance to the work of this Inquiry and
4 consistent with the public commitments you have made,
5 sir, to putting them at the centre of our work.
6 By way of reminder, those wishing to take a formal
7 role in the Inquiry were invited to become core
8 participants within the meaning of Rule 4 of the
9 Inquiries (Scotland) Rules 2007. Those applications for
10 core participant status were considered by you, sir, as
11 chair of the Inquiry in accordance with Rule 4 of the
12 2007 Rules.
13 All of our core participants are legally represented
14 at these hearings and they are the following.
15 139 former patients of Mr Eljamel and
16 21 representatives of former patients represented by
17 Levy & McRae solicitors a total 160 patient core
18 participants as individuals.
19 These patient core participants are represented by
20 my learned friends Ms Joanna Cherry KC and
21 Mr Euan Scott.
22 NHS Tayside are represented by a solicitor from the
23 NHS Central Legal Office and by my learned friends
24 Ms Una Doherty and Cat MacQueen. Healthcare Improvement
25 Scotland and Public Services Delivery Scotland are

1 represented at these hearings by another solicitor from
2 the Central Legal Office and my learned friend
3 Mr Shane Dundas.
4 The latter body is the successor of the
5 previously designated core participant NHS Education for
6 Scotland which has, this year, become part of a new body
7 Public Services Delivery Scotland, as a result of
8 an administrative rearrangement of the NHS which has
9 resulted in the dissolution of the previous body and the
10 redesignation of the new one as an organisational core
11 participant in this Inquiry.
12 It is also worth clarifying, sir, that these two
13 bodies are separately represented from NHS Tayside.
14 The Scottish Ministers are represented at these
15 hearings by solicitors from Messrs Harper Macleod and my
16 learned friends Laura Thomson KC and David Blair. As at
17 previous hearings of the Inquiry they represent the
18 Scottish Ministers in their capacity as core
19 participants in and material providers to the Inquiry
20 only as opposed to the sponsors of the Inquiry in which
21 capacity they were represented at the last hearings we
22 held in May but in which capacity they are not
23 represented today.
24 The University of Dundee is represented at these
25 hearings by solicitors from CMS and my learned friend

1 Emma Toner KC. The Royal College of Surgeons of
2 Edinburgh are legally represented at these hearings by
3 Brodies solicitors from which firm Mr Marshall appears
4 as their representative at these hearings.
5 For clarity, sir, some may recall that at previous
6 hearings of the Inquiry you invited Professor Stephen
7 Wigmore, chair of the Independent Clinical Review or
8 ICR, to be a represented and extended to him the same
9 rights of reply and participation in those procedural
10 hearings as others for the objective of seeking to allow
11 them to contribute to the efficient work of those
12 hearings and ultimately of the Inquiry.
13 As the Inquiry moves into its evidential phase, it
14 has not been considered appropriate for the ICR to
15 continue to be represented as they have no role in the
16 leading of the evidence which we will hear, unlike our
17 core participants. Though I do have something to say in
18 due course by way of update about the ICR and its work
19 as part of this submission.
20 Indeed as we move to our evidential phase the
21 participation of the ICR and its representatives may
22 become in the capacity of witnesses providing evidence
23 as opposed to contributors to our structural plans.
24 Sir, we will also be joined at these hearings on
25 occasion at least by legal representatives of witnesses

1 who are not from core participant groups or not
2 themselves core participants in this Inquiry. As
3 presently advised, Mr James of Circle Healthcare, the
4 witnesses who will give evidence from the GMC,
5 Dr Gillies of NHS Lothian and Professor Smith of the
6 Royal College of Surgeons of England are legally
7 represented or have some form of legal support being
8 provided to them in connection with their evidence.
9 Those representatives will usually sit at the front row
10 of the hearing suite while their witnesses are giving
11 evidence.
12 I will say more, sir, in due course about the
13 practical features of the important role which our core
14 participants and their legal representatives can play at
15 this hearing. I would say, sir, that the opportunities
16 for participation in the hearings, unlike in some other
17 public inquiries, are neither small nor illusory. They
18 are considerable and of considerable value to our work
19 both at these oral hearings and beyond.
20 All of our core participants have committed to
21 cooperation with the Inquiry in the fulfilment of its
22 stated aims. In their written opening statement to this
23 Inquiry, NHS Tayside said that it very much views this
24 Inquiry as an opportunity for an independent assessment
25 of what went wrong and why. It welcomes recommendations

1 from this Inquiry as to further changes which should be
2 made, the Inquiry's conclusions will be of great
3 importance to NHS Tayside as the safety, well-being and
4 trust of patients is at the heart of its work. As
5 a learning organisation it wants to hear from patients
6 and families, those best placed to advise and share
7 their experiences as to how it can consistently improve
8 and build confidence in the services it delivers.
9
10 NHS Tayside went on to say it is fully committed to
11 assisting the Inquiry and will work collaboratively with
12 the Inquiry team. It welcomes the Inquiry's
13 trauma-informed approach, to which I will return, and is
14 keen to ensure that this is adhered to. NHS Tayside
15 recognises that its systems and processes are
16 a significant focus of the Inquiry's investigations and
17 it will closely review relevant materials and will
18 listen carefully to the evidence to understand the
19 perspectives of those directly affected, all with
20 an openness and willingness to get things right for
21 patients.
22 In their opening written statement to the Inquiry
23 the Scottish Ministers said that they welcome the
24 opportunity to participate in this Inquiry and to assist
25 the Inquiry in its work. They said that the Scottish

1 Ministers recognise that legitimate questions and
2 concerns exist regarding their responsibilities to
3 secure the effective provision of national health
4 services in Scotland and in particular oversight of
5 NHS Tayside and the handling of complaints about
6 Mr Eljamel.
7 They welcome, they said, both the scrutiny and the
8 opportunity for learning that this Inquiry will bring.
9 They say that the Scottish Ministers wish to ensure that
10 the Inquiry of their commitment to learning lessons and
11 to taking positive steps to improve the experience of
12 all who receive treatment and care within the NHS. They
13 said that patient safety is their priority.
14 They also added that the Scottish Ministers are
15 grateful for the opportunity to contribute to the
16 Inquiry's work in particular by making the opening
17 statement which they were invited to make in November.
18 They reiterated their willingness to work
19 collaboratively with the Inquiry and to assist the
20 Inquiry in fulfilling its Terms of Reference.
21 In their written opening statement to the Inquiry,
22 Healthcare Improvement Scotland said that HIS looks
23 forward to working with and assisting the Inquiry in
24 fulfilling its Terms of Reference. They said that that
25 organisation will share any knowledge and experience

1 that it has in relation to the Inquiry's areas of
2 investigation and they renewed their commitment to
3 supporting the Inquiry with its work in any way that
4 they could.
5 In their written opening statement to the Inquiry,
6 NHS Education for Scotland, now as I've said part of
7 Public Services Delivery Scotland, said that NES looks
8 forward to working with and assisting the Inquiry in
9 fulfilling its Terms of Reference, that it will share
10 any relevant knowledge and experience that it has in
11 relation to the Inquiry's areas of investigation and NES
12 also renewed its commitment to supporting the Inquiry
13 with its work in any way that it can.
14 In their written opening statement to the Inquiry, the Royal
15 College of Surgeons of Edinburgh said that the Royal
16 College will seek to assist the Inquiry in any other way
17 the Inquiry considers appropriate.
18 And in their written opening statement to the
19 Inquiry, the University of Dundee stated that the
20 university would wish to make clear that it welcomes
21 this Inquiry and recognises immediately its importance
22 and undertakes to co-operate fully with the Inquiry in
23 its investigation of the issues noted and more
24 generally. They added that finally, if the Inquiry
25 should find in due course that there may be any lessons

1 to be learned on the part of the university in relation
2 to any of the Inquiry's Terms of Reference both the
3 Inquiry and the public should be in no doubt that
4 comprehensive steps will be taken by the university to
5 address those matters which have been identified.
6 And in their written opening statement to the
7 Inquiry the patient core participant group said that
8 this Inquiry has been a long time coming and hard-fought
9 for, a matter which I've already recognised. They said
10 that the group are fully intent on supporting the
11 Inquiry so that it may fulfil its remit.
12 The Inquiry, sir, very much welcomes these
13 commitments made by these various different bodies or
14 groups and values the contribution which the Inquiry can
15 expect as a result of them having been made and made so
16 publicly.
17 In that regard may I say a few words about our
18 organisational core participants. It is too often the
19 case in public inquiries in my view, sir, that
20 organisational core participants see themselves as
21 occupying a defensive role. With respect, may I suggest
22 that that is not an appropriate way in which to view the
23 designation of organisational core participants even if
24 their designation has been based, in part at least, on
25 the possibility that they may face criticism in the

1 Inquiry's work. When you selected our core participants
2 for this Inquiry, sir, you exercised your wide
3 discretion bearing in mind a number of features. You
4 considered the applications you received in light of
5 your obligation to run the Inquiry as thoroughly and as
6 effectively as possible, bearing in mind the Inquiry's
7 wide-ranging Terms of Reference and the need for Inquiry
8 processes to be rigorous and fair. As is set out in the
9 Inquiry's core participant protocol, you assessed
10 carefully whether applicants could assist the Inquiry in
11 its work and whether their designation would actively
12 contribute to the efficient and thorough operation of
13 the Inquiry. That is the touchstone by which you
14 determined their applications and the benchmark for our
15 expectation that they will participate actively in what
16 we do.
17 As we committed to doing, core participants in this
18 Inquiry have been accorded rights, roles and
19 responsibilities which exceed the rights they derive
20 automatically from the law to ensure that they have
21 every opportunity to participate actively in our work.
22 Bodies which have received such status have the
23 responsibility of and experience of important features
24 of our remit: patient care and safety; the organisation,
25 funding and operation of hospital-based surgical care;

1 the performance of surgery and the setting of the
2 surgical standards; medical and surgical education and
3 training; and the betterment of those important
4 services.
5 In line with the Inquiry's commitment to cooperation
6 and the commitments which have quite properly been made
7 by these organisations, I would remind them of the
8 background to their involvement, the importance of their
9 active participation, the commitments they have made and
10 the opportunity which this Inquiry affords for the
11 betterment of the care of those who receive surgical
12 treatment or care in Scotland.
13 I look forward to continuing to work with them in
14 the achievement our mutual aims and aspirations for this
15 process.
16 Sir, to move on then to a matter which you have
17 mentioned in your opening address, namely the delays in
18 the holding of these hearings and developments in
19 connection with the hearings venue in which we find
20 ourselves in Waverley Gate in Edinburgh.
21 Sir, before I turn to the objective of and plans for
22 these hearings as well as the plans beyond them which
23 I will in due course, I must, I feel, take some time to
24 seek to explain developments with regard to the safety
25 of this building, an issue which necessitated the

1 postponement of our Section 1 evidential hearings which
2 were originally due to take place in April and May of
3 this year and which was the main focus of the procedural
4 hearing you held on 14 May.
5 I require to do so for the reasons you held the
6 hearing at that time in the interests of transparency
7 and openness with all those in attendance and who take
8 interest in our work.
9 It is an important feature of the Inquiry's approach
10 to its hearings and indeed its work more generally that
11 people should feel safe when they engage with our work.
12 That is why, sir, when safety issues beyond your control
13 came to light earlier this year they were not taken
14 lightly, they were interrogated and investigated, action
15 was taken as a result.
16 As many of those who are in attendance today will
17 recall you held a procedural hearing on 14 May this
18 year, part the purpose of which was to seek further
19 clarification from the Scottish Government as to what
20 steps were being taken by it, in its capacity as the
21 tenant of this building which has accorded the Inquiry
22 permission to use it, to address fire safety concerns
23 which had arisen. At that time I set out a detailed
24 history of what had happened to that point, when the
25 issue had arisen and what the Inquiry knew about it, as

1 well as what steps had been taken by that point by us
2 and to our knowledge to seek to resolve the issue.
3 That history as a matter of public record was fairly
4 not disputed by the Scottish Government at the hearing
5 and need not be rehearsed here. Needless to say, the
6 Inquiry's position at that time was characterised by
7 a dissatisfaction with the fact that the issue had
8 arisen in the first place as well as with the limited
9 and poorly explained efforts to resolve them on the part
10 of the Scottish Government and the amount of time and
11 effort which had to be spent by the Inquiry team in
12 seeking to see that it was resolved. Counsel who
13 appeared on behalf of the Scottish Government at the
14 hearing in May made clear that fire safety issues had
15 arisen which would necessitate certain works being
16 undertaken on what was called a shaft wall which forms
17 part of these premises. Relatively few details could be
18 provided at that time as to what those works would
19 entail but it was intimated that plans were being
20 progressed to have the works undertaken so as to
21 facilitate the Inquiry in progressing with its planned
22 public hearings which, by that stage, you had committed,
23 sir, would be hearings at which public attendance would
24 be possible, in light of the public nature of this
25 process and the importance of physical attendance which

1 had been conveyed by you in particular on behalf of
2 patient core participants by various means.
3 The Inquiry received a further letter from the
4 Scottish Government on 27 May of this year which set out
5 more detail of the shaft wall works which were proposed.
6 It was stated that a meeting had taken place the day
7 before the procedural hearing on 13 May between the
8 government and the property's landlord and that the
9 outcome was as follows.
10 At that meeting the landlord confirmed that in order
11 to ensure compliance with the required fire safety
12 standards, a shaft wall was required along the whole of
13 the corridor serving both Inquiry spaces which serves as
14 fire escape route. The City of Edinburgh Council has
15 indicated that a full corridor shaft wall remedy would
16 be acceptable and meet the standards required to secure
17 the necessary building warrant sign-off. The landlord
18 has indicated that they are willing to undertake the
19 required works on behalf of the Scottish Government
20 subject to agreement from the Scottish Ministers on the
21 funding arrangements. The landlord is currently engaged
22 with contractors to explore the practical delivery of
23 a solution.
24 It was also pointed out that at a subsequent meeting
25 which took place on 26 May to ensure the landlord and

1 contractors remained committed to the urgency of the
2 completion of the works and that, to quote, "Other
3 options are also being looked at by the landlord on
4 which we will update you as early as we can".
5 In that correspondence it was concluded that while
6 progress is being made, it is not yet possible to
7 confirm a resolution date due to the ongoing design and
8 options work outlined above.
9 On 11 June the Inquiry was provided with a copy of
10 a note intimated by the Scottish Government which
11 explained that another solution to the ongoing fire
12 safety issue may have arisen despite the previous
13 apparent requirement for and commitment to the building
14 works which the Scottish Government had intimated would
15 take place. The proposed solution involved a new lease
16 being entered into between the Scottish Government and
17 the landlord which would include the corridor within the
18 area leased to the Scottish Ministers and combine the
19 two current leases held by the Scottish Government over
20 this hearing suite and the neighbouring office used by
21 the Inquiry into one overall lease to the Scottish
22 Ministers.
23 This, the Inquiry was told, would align the
24 arrangements for the occupation of this floor of the
25 building with the leased areas on the upper floors of

1 the building. It was suggested without further
2 explanation that this conveyancing solution would allow
3 the construction which had taken place to configure this
4 floor as it is to comply with the technical safety
5 standards required without the need for further works to
6 be undertaken at all.
7 It was intimated that agreement in principle on this
8 proposed solution had been secured between the council
9 and the landlord supported by their technical advisors.
10 On 17 June the Inquiry responded to this proposal
11 with a number of further queries about the proposed new
12 arrangement. In any event, work proceeded with the
13 implementation of a new lease which was considered by
14 the Scottish Government to be necessary based on the
15 assurance provided to them by the landlord which
16 included the assurance that the council will be content
17 with this new arrangement. A project plan was issued to
18 the Inquiry with steps setting out when the new solution
19 could be delivered against various milestones.
20 By 16 July an update was received by the Inquiry
21 that the initial steps undertaken in terms of the
22 project plan involving intimation of a new draft lease
23 arrangement and a commitment from the sponsoring
24 Minister of the Inquiry to enter into such a lease meant
25 that a retrospective building warrant had been granted

1 by the council in connection with the previous building
2 works which had been undertaken to configure the
3 property as it is. Further intimations were received by
4 the Inquiry when key aspects of the project plan were
5 met including the signature of the new lease.
6 On 5 August the Scottish Government confirmed that
7 use of the hearing suite could resume as a building
8 warrant had been received from Edinburgh City Council
9 and missives had been exchanged relating to the new
10 lease over the premises. On 17 August after further
11 reassurances about progress received by the
12 Inquiry from the government including in relation to the
13 issuing of a completion certificate by the council
14 relating to the building works and progress towards the
15 finalisation of a new lease. As a result the Inquiry
16 was able to publish the following on its website that
17 day. The Scottish Government as tenants of the premises
18 has informed the Inquiry that:
19 "It has now been confirmed that the lease
20 arrangement has beenfinalised and the required
21 retrospective building warrant is now in effect. The
22 hearing suite therefore fully complies with the
23 appropriate building regulations which set the necessary
24 safety standards."
25 Based on this update, the Inquiry intends to hold

1 full in-person hearings as-planned in September at the
2 hearing suite in Waverley Gate.
3 Sir, an important part of the Inquiry's commitments
4 to safety, as part of its trauma-informed strategy and
5 more widely, involves clarity about why it is that those
6 who are here today with us should feel that they are now
7 safe. That is particularly difficult to set out when
8 the Scottish Government has not taken any action, as
9 they explained in May that they were required to do, to
10 undertake or instruct any works on this property at all.
11 That may seem unusual, and reasonably so, in the face of
12 detailed explanations provided to you, sir, on behalf of
13 the Scottish Government in May about the nature of the
14 remedial works which would be necessary for the property
15 to be made safe at that time.
16 Those who are in attendance should feel safe and
17 should feel that the Inquiry has done everything it can
18 to make sure that they do. The secretary to the Inquiry
19 has spent a considerable amount of time over many,
20 many months trying to resolve the safety issue as, to
21 a lesser extent, have all members of the Inquiry senior
22 team.
23 The Inquiry is now as satisfied as it can be that
24 the fire safety issue has been resolved. The Inquiry
25 secretariat staff are on hand to address any concerns or

1 queries which those who are here with us today have in
2 that regard or indeed any other. Many of those with
3 a keen interest in our work have told us that in the
4 past they have not felt safe and moreover that when they
5 had expressed that that is how they feel they have not
6 been listened to or their sensation of insecurity has
7 not been treated with dignity and respect. Our
8 commitment to safety is not just to assert that people
9 are safe but to do what we can to make them feel that
10 way. Their safety is not a matter to be taken lightly
11 or for granted, it is a matter to be secured by us for
12 them and for us to show them that we have secured it.
13 Throughout this process the need to keep people
14 informed of details which could be shared has been at
15 the forefront of the Inquiry's approach. Aspects of the
16 detailed negotiations to do with the property could not
17 be shared because of their commercial sensitivity.
18 However, the need for openness and transparency has been
19 appreciated and actioned by the Inquiry as best it could
20 at all times. Moreover, the needs of those who
21 participate in our process to remain adequately informed
22 about what is going on has been impressed upon the
23 Scottish Government by the Inquiry team at all stages of
24 the process and it continues to be.
25 These principles need not only to be adhered to by

1 our staff, which they are, but by those such as the
2 Scottish Government on whose support and services the
3 Inquiry continues to require to rely. It is our hope,
4 sir, that shortcomings in that regard on the Scottish
5 Government's part will not be repeated and that the need
6 not only for speed and efficiency in their support of
7 the Inquiry but also for the ability to share details of
8 what is going on with our core participants and the
9 wider public will be appropriately factored into our
10 dealings with them in future. That is what those core
11 participants reasonably expect and it is what you and
12 your team are committed to delivering.
13 Sir, can I now move to the scope of Section 1 of the
14 Inquiry's evidential plan and the witnesses who are due
15 to give evidence at these hearings.
16 Before turning to the ambit of the evidence which we
17 intend to cover at these hearings, sir, may I take some
18 time to remind those listening about our approach to the
19 gathering of evidence at this Inquiry as well as the
20 purpose of evidential hearings such as these.
21 It is the process which has been adopted by this
22 Inquiry and authorised by you, sir, that evidence does
23 not require to be spoken to at oral hearings to be
24 amongst the evidence which you can consider in the
25 determination of your findings in your ultimate report

1 or reports. That final report or those final reports
2 are the ultimate aim of your process, the written record
3 of what you have found, what you have found went wrong,
4 who was responsible and what you think can reasonably be
5 recommended for such adverse outcomes as you have found
6 to have taken place at a broad level to be avoided in
7 the future.
8 Evidence contained in documents, including for
9 example in ICR applicant statements and other witness
10 statements provided to the Inquiry, will be deemed by
11 the Inquiry to be evidence in the Inquiry which you as
12 the Chair can consider in making findings and
13 recommendations in the fulfilment of your Terms of
14 Reference.
15 Such evidence will be able to be relied upon without
16 the need for it to be spoken to in oral evidence in
17 hearings or otherwise adduced formally. You have
18 determined that such formality would be inconsistent
19 with the inquisitorial nature of this process and likely
20 to involve unnecessary cost.
21 Thus, evidential hearings are not an end in
22 themselves but a part, though an important part, of the
23 journey to the report or reports which are the ultimate
24 aim of everything we do. Paragraph 5 of the Inquiry's
25 Public Hearings Protocol provides as follows.

1 The public hearings of the Inquiry serve a number of
2 important purposes including (a) in accordance with the
3 Inquiry's obligations under Section 18 of the 2005 Act
4 to permit attendance by core participants, members of
5 the public including reporters, at the Inquiry and to
6 see and hear a simultaneous transmission of the
7 Inquiry's proceedings subject to any restriction notice
8 or order made under Section 19.
9 At evidential hearings to enable evidence already
10 gathered by the Inquiry in the form of written
11 statements or other documentary evidence to be
12 ventilated in public, explored, examined and their
13 contents clarified or supplemented by the oral evidence
14 heard as hearings, to challenge witnesses on the
15 evidence already given by them to the Inquiry in the
16 form of written statements, or based on material
17 contained in documentary evidence recovered by the
18 Inquiry, ultimately to assist the Inquiry in making
19 findings in its report or reports, including where
20 appropriate the identification of things which occurred
21 falling within the ambit of the Inquiry's Terms of
22 Reference and/or which fell below a reasonable standard
23 which they did as well as who or what organisations were
24 responsible. And finally to enable core participants
25 via their legal representatives to submit questions for

1 consideration by Counsel to the Inquiry and to make
2 applications, if necessary, under Rule 9 of the
3 Inquiries (Scotland) Rules 2007 as set out in
4 paragraphs 31 below.
5 Thus evidential hearings such as these ones have
6 been designed to serve the purpose of the public
7 ventilation of issues covered by the Inquiry's Terms of
8 Reference, challenge of evidence received by the
9 Inquiry, and the opportunity for our core participants
10 to submit questions for consideration by the Inquiry as
11 part of our investigative process. I will return to the
12 precise processes which have been and will be adopted in
13 particular to allow core participants to contribute
14 proposed questions for witnesses but it is important to
15 understand that the ability of core participants to
16 contribute to these hearings is a very important feature
17 of the hearings process.
18 In essence, sir, the Inquiry has the ability to ask
19 questions and even to compel them to be answered at any
20 time by issuing Rule 8 requests for witness statements
21 and/or documents to be produced or Section 21 notices
22 for those purposes where required. Though the questions
23 which have been asked by us are, in this Inquiry,
24 apparent to core participants and the wider public as we
25 have asked respondents to repeat them in their ultimate

1 written statements, core participants do not contribute
2 to the formation of Rule 8 requests or Section 21
3 notices other than in a general sense as a result of the
4 broad suggestions as to the lines to follow which have
5 been made by them, for example in their opening
6 statements to the Inquiry.
7 Thus, the opportunity for core participants to
8 propose questions which our systems are designed to
9 promote and also take seriously represents
10 a particularly important feature of these evidential
11 hearings and subsequent ones in which matters will be
12 examined with witnesses in more detail as we progress
13 beyond our introductory evidential phase.
14 In too many public inquiries in my view the role of
15 core participants is too passive. Not here, as far as
16 we are concerned.
17 Sir, as was announced as early as the preliminary
18 hearing last September and is set out in the Inquiry's
19 Public Hearings Protocol which was published as long ago
20 as 10 June 2025, Section 1 of our evidential plan and
21 hence these hearings which are associated with it is
22 unashamedly introductory in nature. It is inevitable
23 that amongst our audience there will be those with
24 a deep interest in the subject matter of this Inquiry,
25 to whom some or possibly even much of the information we

1 will examine in this section is already apparent.
2 However, this Inquiry is conducted in the public
3 interest and it must not be assumed that everyone with
4 a legitimate interest in our work has the same degree of
5 understanding or insight into what we are investigating.
6 Some who may have made certain assumptions about what
7 has occurred may even be enlightened by the evidence
8 which actually emerges. In any event, it is important
9 that we start at the beginning in particular for those
10 who may know less. Those who know less at this stage
11 have no less of a right to understand what we have
12 discovered and what we will discover. On one view they
13 rely on the Inquiry even more to provide them with
14 information about what has happened which is within our
15 remit. The public ventilation of the evidence we have
16 uncovered is an important part of our public function
17 after all.
18 Even amongst our core participants groups it is
19 already apparent, sir, that there is a varied level
20 of understanding of what the professional practice of
21 Mr Eljamel in the Tayside area entailed, what it caused
22 and what issues it created. There is certainly a varied
23 understanding of what was done or could have been done
24 about those issues possibly even to have prevented them.
25 As all of these groups and the individuals within

1 them are equally important, we must treat all within
2 them equally. To assume the knowledge of those who
3 already know the most on the part of others who may, for
4 whatever reason, know less would be to exclude those who
5 have an equal right to be here and to be provided with
6 a reasonable opportunity to learn from and participate
7 in our process.
8 It is important that for our investigations to be
9 focused and appropriately orientated we spend time at
10 the beginning understanding the context in which the
11 detailed investigations to come must be undertaken.
12 That is not to say, sir, that there may not be
13 matters into which these hearings will enable to us
14 delve more fully than others. It may be by the end of
15 these hearings, or even by the end of evidential
16 Section 1, that you, sir, will form the view that the
17 evidence that we have heard means that certain matters
18 which are important to your investigations could be
19 deemed to have been proven to your satisfaction. That
20 is not to say that you or we will close our minds to the
21 possibility that the evidence may reveal new information
22 which requires such matters to be looked at with fresh
23 eyes. However, it is a feature of going where the
24 evidence takes you that we anticipate that there will be
25 matters which become clear or at last clearer within

1 this evidential section whereas there will inevitably be
2 others where a much fuller investigation will be required.
3 That is particularly the case, sir, in this Inquiry
4 where there is considerable uncertainty as to what
5 questions can be answered by reference to
6 contemporaneous documents. Indeed, it is part of the
7 purpose of this section to try to understand what
8 documents exist, what they contain and hence what level
9 of controversy in relation to the issues you have
10 undertaken to resolve remains. It is only by gaining
11 an understanding of that context that it will be
12 possible to formulate a plan as to where we go next and
13 how deeply we need to look into certain areas for
14 answers.
15 The result of this approach we hope will be to
16 provide a proper and useful context in which our more
17 detailed investigations can be undertaken in due course.
18 The matters related to which we will hear evidence
19 have been published for some time in the Section 1 scope
20 which is available on our website.
21 It is an important aim of this section of our
22 evidential plan to try to ascertain an impression as to
23 what documents are held within organisations as I have
24 said which played or could have played a part in key
25 events falling within our remit. This is an important

1 part of scene-setting for a two reasons. One is that
2 Term of Reference 14 requires us to examine document
3 management systems within NHS Tayside including the
4 extent to which absence of documents undermine the
5 effectiveness of previous investigations into the
6 professional practice of Mr Eljamel and systems
7 surrounding it, such as those listed in Term of
8 Reference 12.
9 In addition an analysis of available documents is of
10 evidential significance. Where documents exist they may
11 tell us the answers we need. They may not have been
12 previously available and provide illumination for those
13 who have not had access to them before. They may
14 confirm suspicions or answer burning questions.
15 Equally, they may not tell the whole story. They may be
16 partially useful or even not exist at all in connection
17 with certain matters of significance to our mission.
18 Whatever the picture which emerges, this is a useful
19 part of our preliminary foray into the evidence. Where
20 questions are answered by existing recovered documents
21 we are on the way to fulfilling our mission which is to
22 resolve our list of issues. Where we remain in the dark
23 we will find ways to seek evidence from other sources
24 directly from other witnesses in our quest for the
25 truth. Either way, we hope that we will able to form

1 a clear impression of what evidence there is and what we
2 need to find by the end of the section. I will return
3 to the contribution we anticipate core participants
4 making to that process in due course.
5 Sir, in this section we will also hear independent
6 expert evidence, instructed by the Inquiry itself, from
7 three expert groups. I will discuss the remits of these
8 groups and their proposed role in more detail in due
9 course but in broad terms they will provide important
10 independent expert context on surgical procedures, rules
11 and systems, considerations of best practice and
12 developments in their areas of expertise, all of which
13 relate to key areas covered by the Inquiry's Terms of
14 Reference.
15 It is inevitable I think, sir, that those with
16 a keen interest in the subject matter of this Inquiry
17 will be keen that we delve deeply into certain subjects
18 of interest to them. That is an entirely natural
19 instinct especially amongst those who have waited so
20 long for answers to their ever more pressing and urgent
21 questions.
22 Sir, I will return in a moment to the processes
23 which will be followed to achieve participation from
24 core participants in this section and the importance of
25 that in these hearings. However, for present purposes

1 may I emphasise that systems have been put in place so
2 questions from core participants which are deemed to go
3 too far, too deeply into the details to be merited being
4 addressed within the context of our present introductory
5 ambitions will be retained for future use. It should
6 not be thought that these hearings will be the last
7 opportunity for witnesses to be examined, or issues
8 which merit more detailed investigations to be
9 undertaken.
10 An introductory section means just that. By the end
11 of our Section 1 investigations, which I should say will
12 stretch beyond these hearings, we will merely be at the
13 end of the beginning. We will use what we have
14 discovered here as a basis for what comes next.
15 Sir, I'd like to say something about patients. From
16 the time of your public consultation on the Terms of
17 Reference you committed, sir, to putting patients at the
18 centre of our process. That is why you have taken steps
19 to designate that 160 patients or patient
20 representatives are core participants, why they have
21 a full-time funding award for lawyers to assist their
22 participation to support and advise them in their work
23 and why you have sought their input on key aspects of
24 this Inquiry, from the Terms of Reference to the list of
25 issues, to letters of instruction for experts and our

1 procedural planning via the three procedural hearings
2 including in their valuable written and oral opening
3 statement.
4 It is a fact of these hearings that evidence will
5 not be heard in this section from patients directly.
6 This, in my submission, should not be taken into be any
7 departure from or even dilution of your firm commitment
8 this that is a patient-centred Inquiry. It most
9 certainly is not. In fact the entirety of the oral
10 hearings led in December which will now come from
11 patients or their representatives, a matter to which
12 I will return in due course. The importance that the
13 patient voice be heard will in part, we anticipate, be
14 satisfied by the oral evidence we will hear from
15 Liz Smith CBE, a former MSP and long time campaigner on
16 behalf of a considerable number of Eljamel patients.
17 Written statements have also been obtained and disclosed
18 to core participants from other political
19 representatives who are able to relay an element of the
20 communal patient experience as well as a result of their
21 involvement in the campaign for this Inquiry, namely
22 Willie Rennie MSP and Michael Marra MSP from different
23 parts of the political spectrum and with different
24 experiences of the patient voice and patients'
25 experiences.

1 It is anticipated that Ms Smith's evidence will
2 cover her long-standing acquaintance with the experience
3 of Eljamel patients including but not limited to her
4 experience of campaigning for this public inquiry as
5 well as her more recent involvement in the Scottish
6 parliament's public administration committee's
7 investigation into the cost-effectiveness of public
8 inquiries in Scotland which forms an interesting context
9 to our own investigations under Term of Reference 12 of
10 the Scottish Government's approach to the announcement
11 of this public inquiry.
12 The Inquiry's forward-looking function and the
13 importance of patient care in that aspect of our work
14 means that patients are also represented to an extent in
15 the evidence of the Patient Safety Commissioner,
16 Karen Titchener, who it is anticipated will cover the
17 remit and ambitions for that relatively new role, her
18 experiences so far of issues in the achievement of good
19 quality patient care in Scotland, some of which we
20 anticipate will chime with the experience of the
21 patients at the centre of this Inquiry, thus enabling it
22 to become a focused environment in which wider patient
23 safety and patient care considerations can be examined
24 and possibly addressed.
25 It is hoped that that evidence will provide a useful

1 context in which the Inquiry's ambitions to making
2 patient-centred recommendations can be fulfilled
3 ultimately in Section 6 of our evidential plan which
4 will be devoted to evidence relating to recommendations
5 which may future in your final report.
6 Though patients will not give evidence at this
7 hearing session, their voice will be heard through these
8 witnesses and through the participation of the large patient
9 core participant group in the proceedings in the next
10 four weeks. These patient-focused witnesses will be
11 heard near the start of these sessions, this afternoon
12 and on Thursday morning, to ensure that the evidence
13 which you hear, sir, will rightly be heard in
14 a patient-orientated and centred context. I say
15 "rightly" because patient care is legally required to be
16 at the centre of the National Health Service in
17 Scotland. So patients should be at the centre of
18 an Inquiry whose remit concerns that institution.
19 Sir, could I say something about our approach to
20 core participant organisational witnesses. You will
21 hear evidence, sir, from witnesses who speak on behalf
22 of a number of organisations with remits which are
23 related to the subject matter of this Inquiry. In
24 particular, you will hear from the following.
25 Mr Mark Egan of the Royal College of Surgeons of

1 Edinburgh, Mr Robbie Pearson of Healthcare Improvement
2 Scotland, Ms Emma Watson of Public Services Delivery
3 Scotland of which NHS Education for Scotland now forms
4 a part. The evidence of these individuals relate to
5 their role and remit and any connection they may have to
6 Mr Eljamel or involvement they may have had in aspects
7 of his professional practice to which this Inquiry
8 directly relates.
9 As far as other organisations are concerned, sir,
10 you will also hear evidence from representatives
11 of other organisations which had, or could have had,
12 roles to play in the matters with which this Inquiry is
13 primarily concerned. These representatives are expected
14 to be able to provide evidence to the Inquiry on the
15 general functions/operation remits of their organisation
16 but have also, as part of the Section 1 remit, been
17 asked to provide evidence of more specific aspects of
18 the Inquiry's remit in which their organisation did have
19 a role. Such witnesses including Professor Frank Smith
20 of the Royal College of Surgeons of England. As well as
21 outlining that organisation's general role evidence is
22 also anticipated on the RCS investigation into
23 Mr Eljamel practice which took place in 2013 as referred
24 to in Terms of Reference 12. Dr Tracy Gillies of NHS
25 Lothian who will outline that organisation's general

1 role, but evidence is also anticipated from her on the
2 investigation undertaken by her in 2018/19 also referred
3 to in Terms of Reference 12. Mr Charles Massey and
4 Mr Anthony Omo of the GMC. They have requested that
5 evidence be given by both of these individuals though
6 the GMC statement was provided by and is signed by
7 Mr Massey alone. Mr Omo, we understand, has experience
8 of the GMC's current fitness to practice rules and
9 systems. As well as outlining the organisation's
10 general role, evidence is anticipated on the broad
11 nature of any involvement of the GMC in matters relating
12 to the professional practice of Mr Eljamel which arises
13 under Term of Reference 7 and Term of Reference 13, as
14 well as information which they have about the voluntary
15 removal of Mr Eljamel's name from the GMC's medical
16 register, in particular focusing on the role of
17 NHS Tayside in that process which is covered by Term of
18 Reference 11.
19 Professor Rory McCrimmon and Professor John Connell
20 of the University of Dundee, two witnesses are being
21 called from that organisation. As was the right of any
22 organisational recipients of a Rule 8 request, the
23 university elected to complete two statements as, in its
24 view, this would be the best way of responding to the
25 Inquiry's relate request Rule 8 request. One was

1 completed by each of the witnesses who were giving
2 evidence during the course of these hearings. As well
3 as outlining that organisation's general role, evidence
4 is also anticipated to be heard on the roles which
5 Mr Eljamel held within the university, his
6 responsibilities in them, how he was appointed to them,
7 the extent to which his teaching and other commitments
8 with the university occupied his time and attention
9 possibly with an effect on his clinical commitments
10 covered by Term of Reference 2(d), any oversight
11 function carried out by the university of Mr Eljamel's
12 work possibly relevant to Term of Reference 6 as well as
13 his research and his commitment to research activities
14 covered by Term of Reference 2(e).
15 Mr Peter James of Circle Healthcare, the body
16 ultimately responsible for the operation of Fernbrae
17 Hospital in Dundee where Mr Eljamel undertook his
18 private work, will also give evidence. I have already
19 explained at previous hearings that the Inquiry
20 interprets its Terms of Reference as not permitting
21 a detailed systemic analysis of the systems which
22 related to the neurosurgical service provided at
23 Fernbrae which was in part delivered by Mr Eljamel.
24 This is an Inquiry with a focus on the NHS. However, as
25 well as outlining that organisation's general role,

1 evidence is also anticipated from Mr James on the nature
2 and extent of Mr Eljamel's private work, the time
3 commitments he had to it, as well as the practising
4 privileges which he enjoined at Fernbrae, all of which
5 are relevant to Term of Reference 2(a). In addition
6 there will be an investigation of the issues, if any,
7 which arose in the practice of Mr Eljamel at Fernbrae as
8 well as the systems which were in place for any issues
9 to be communicated to the NHS which is covered by Term
10 of Reference 3(c).
11 Miss Caroline Lamb will give evidence on behalf of
12 the Scottish Ministers. As well as outlining the
13 Scottish Government's general responsibilities for the
14 delivery of healthcare and in particular neurosurgical
15 services in Scotland, it is anticipated that matters
16 which will be covered by her will include the nature and
17 extent of the Scottish Government's knowledge of and
18 involvement in issues relating to the professional
19 practice of Mr Eljamel, including but not limited to the
20 investigations into him and the systems surrounding him
21 conducted by others under Term of Reference 12. There
22 will also be an opportunity to understand the remit,
23 operation and main conclusions of the Scottish
24 Government review of unresolved and outstanding concerns
25 concerning Mr Eljamel in 2022 as well as the Scottish

1 Government's involvement in or knowledge of other
2 reviews conducted by other bodies including those listed
3 in Term of Reference 12.
4 It will also be intended to cover the broad picture
5 with regard to the Scottish Government's approach to
6 handling calls for a public inquiry into the Eljamel
7 affair which Ms Cherry told us in her opening
8 statement started in 2014, the Government's position
9 on and in response to that, including the thought
10 process of alternatives to a public inquiry being
11 offered and the thinking behind the announcement of
12 a public inquiry in September 2023.
13 It was submitted indeed in the patient group's
14 written opening statement that this Inquiry is also
15 about the way the patients and their loved ones have
16 been treated simply for seeking answers and redress.
17 The potential that the state response to traumatic medical
18 treatment may be as serious as the treatment itself and
19 its potential to compound the harm already suffered by
20 patients is not lost on this Inquiry. It will be
21 examined by the Inquiry in its examination of the
22 Scottish Government at these hearings and in Section 5
23 of its evidential plan.
24 Sir, as far as NHS Tayside is concerned, as will no
25 doubt have been expected by those who take an interest

1 in our work, a significant number of witnesses who will
2 be called at these hearings will be employees or former
3 employees of NHS Tayside. This is the result of two
4 related matters.
5 First the bulk of the Inquiry's Terms of Reference
6 relate in some way to the systems and actions or
7 inaction of NHS Tayside. Their Rule 8 request was
8 therefore by far the most comprehensive. Even though these
9 hearings are introductory in nature, there are lots of
10 matters relating to NHS Tayside which require to be
11 introduced. Further, as a consequence of the wide range
12 of subjects covered in the statement, NHS Tayside, as
13 was their right, took the view that having a number of
14 different individuals respond to the Inquiry's questions
15 would be the best way for the organisation's evidence to
16 be presented. Therefore different topics have been
17 covered by a number of different individuals all of whom
18 have important aspects of the NHS Tayside position to
19 cover.
20 These witnesses will not be called in the order or
21 at the time when the Inquiry would have liked not,
22 I should say, as a result of any issues with the
23 witness' availability, they have in fact been most
24 accommodating in that regard, but due to the need to
25 accommodate availability or other issues and due to how

1 numerous the NHS Tayside witnesses are. We will do what
2 we can to make sure the evidence is presented in a way
3 which maximises comprehension despite these unavoidable
4 consequences of availability considerations.
5 Sir, as far as NHS Tayside is concerned the Inquiry
6 will hear evidence from the chief executive,
7 Nicky Connor. Her evidence will include an examination
8 of the destruction of theatre logbooks which would have
9 been relevant to the Inquiry's investigations, how that
10 was allowed to occur, and the steps which have been
11 taken in the aftermath of their destruction. It was
12 made clear, sir, in the opening statement and associated
13 submissions by Ms Cherry on behalf of the patient group
14 that this was a matter of some considerable and some
15 might say understandable concern on part of the patient
16 group. As such, this matter will be addressed with
17 Ms Connor in the first week of these hearings.
18 In addition, sir, it is an important part of
19 providing evidential context to our work to do what
20 lawyers might describe as narrowing the ambit of the
21 dispute. What that means, sir, is trying to understand
22 what it is from the outset that NHS Tayside,
23 an organisation with which this Inquiry is principally
24 concerned, accepts and does not accept. Again, it is
25 intended to try to address those matters with

1 Nicky Connor and other witnesses.
2 In the second week of the hearings the Inquiry will
3 hear from the Executive Nurse Director of NHS Tayside,
4 Mr Simon Dunn. It is anticipated that his evidence will
5 focus on the NHS Tayside complaints and feedback systems
6 as well as the nature and extent of the complaints and
7 feedback received from NHS Tayside relating to
8 Mr Eljamel, investigations broadly undertaken as
9 a result, the remaining documentation which was held
10 relating to those and the steps taken by NHS Tayside as
11 a result of these investigations, all of which are
12 covered by the Inquiry's Terms of Reference 4 and 5. He
13 also covers NHS Tayside's significant event management
14 policy and adverse event management policy as well as any
15 incidents relating to Mr Eljamel falling within those
16 systems.
17 In week three the Inquiry will hear evidence from
18 NHS Tayside's Director of People and Culture,
19 Ms Elaine Watson. It is anticipated that her evidence
20 will focus on the appointments of Mr Eljamel and
21 information relating to how he was successful in gaining
22 key positions he held including his appointment as
23 a consultant in 1995, all of which are covered by Term
24 of Reference 1. It will also cover the trajectory of
25 his career in NHS Tayside, the main roles and

1 responsibilities he had and the terms on which he held
2 them, including the rules relating to matters covered by
3 Term of Reference 2 such as private work, workload,
4 teaching and research commitments and the
5 responsibilities of consultants towards junior staff,
6 including the allocation of surgical responsibilities to
7 them.
8 Her contribution also covers the rules within
9 NHS Tayside relating to supervision, suspension,
10 dismissal and removal of a medical professional's name
11 from the GMC medical register as well as Mr Eljamel's
12 clinical supervision, Term of Reference 8, his
13 suspension, Term of Reference 9, his resignation from
14 NHS Tayside, Term of Reference 10, and the removal of
15 Mr Eljamel's name from the GMC medical register in
16 particular NHS Tayside's role in that process under Term
17 of Reference 11.
18 Also in week three the Inquiry will hear the
19 evidence of the board's secretary of NHS Tayside,
20 Ms Margaret Dunning. It's anticipated that her evidence
21 will focus on the broad roles and responsibilities of
22 NHS Tayside and other bodies which exercise control over
23 the operation of neurosurgical services in the past as
24 well as the roles and identities of key individuals
25 within the board and those other bodies. Her

1 contribution also covers the roles of certain committees
2 within NHS Tayside as well administrative records
3 management within the board and data protection.
4 In the final week of the hearings, the Inquiry will
5 hear from Dr James Cotton, NHS Tayside's Executive
6 Medical Director. Dr Cotton is the signatory of the
7 NHS Tayside written statement and has answered by far
8 the largest number of questions in it. It is
9 anticipated that his evidence will cover the
10 investigations undertaken under Term of Reference 12
11 insofar as they involve NHS Tayside including the
12 ambitions, remit, methodology and broad conclusions of
13 each, as well as steps taken or not taken in the
14 aftermath of them. His contribution also covers
15 a number of other important aspects of the NHS Tayside
16 evidence including the remits of various departments and
17 committees, relative responsibilities of the board and
18 other bodies with key roles in the provision of
19 healthcare in Scotland, mortality and morbidity
20 structures, professional governance structures, internal
21 and external information sharing systems, including with
22 patients, professional regulators, the Scottish
23 Government and the police, the NHS Tayside neurosurgical
24 service, the use of products and devices in
25 neurosurgery, aspects of Mr Eljamel's career with

1 NHS Tayside including his teaching and training
2 responsibilities and NHS Tayside's responsibility for
3 investigating complaints against surgeons. Which is
4 hopefully enough to cover in a day.
5 The Inquiry will hear from NHS Tayside's Chief
6 Officer for Acute Services, Ms Lynn Smith. It is
7 anticipated that her evidence will focus on the work of
8 the neurosurgical services offered by the NHS in Tayside
9 as well as its main operational methodologies including
10 working practices between the neurosurgical unit at
11 Ninewells and other clinical departments of the
12 hospital, as well as document management within the
13 neurosurgical unit and information about the spread of
14 work covered by Mr Eljamel himself.
15 Also in week three the Inquiry will hear the
16 evidence of NHS Tayside's Director of Communications and
17 Engagement, Ms Jane Duncan whose evidence will focus on
18 apologies which have been made by NHS Tayside in
19 connection with the professional practice of Mr Eljamel
20 including when and why they have been made.
21 Finally the Inquiry will hear the evidence of
22 NHS Tayside's former Deputy Chief Executive,
23 Ms Sandra MacLeod. Her evidence will include
24 information about NHS Tayside's document management
25 systems with a focus on the management of patient

1 medical records and subject access requests. Such
2 evidence is important. As I have said, Term of
3 Reference 14 requires the Inquiry to look at the
4 effectiveness of such systems. It is also important,
5 sir, for us to understand what documents exist and why
6 they exist in order to inform our future investigations.
7 Sir, as I have set out at previous hearings and as
8 I have mentioned already today, the Inquiry will also
9 hear evidence from its three expert groups who have been
10 instructed by the Inquiry to assist you by providing
11 technical, factual and opinion evidence to inform and
12 help guide your understanding as well as your
13 investigation and assessment of the factual evidence.
14 In terms of understanding and orientation, it is hoped
15 that the evidence of these groups will be of value to
16 core participants, their recognised legal
17 representatives and others who take an interest in the
18 work of the Inquiry in maximising their participation
19 and engagement in our work. The areas of expertise
20 which have been covered are neurosurgery, medical ethics
21 and healthcare administration. Evidence from these
22 groups will also be heard at these hearings to assist
23 with these important purposes.
24 Sir, the Inquiry's approach to the instruction of
25 experts is set out in its Expert Evidence Protocol, the

1 principles of which are made clear to experts not least
2 in their letter of instruction which forms the basis of
3 their engagement with and provision of evidence to the
4 Inquiry, to the terms of which core participants were
5 invited to contribute suggestions as happened with the
6 standard form letter of instruction sent to the ICR's
7 neurosurgical experts. Along with expertise in the area
8 in which they are instructed independence forms
9 an important part of the experts' instruction.
10 Paragraph 10 of the Expert Evidence Protocol provides
11 that individuals who are appointed as experts are
12 commissioned by the Inquiry to give it their independent
13 professional opinions. The Inquiry looks to receive the
14 best available input each is able to give and to be
15 informed by the best available independent expert
16 opinion. No expert will be expected to act as
17 a spokesperson for or representative of any individual
18 or organisation interested in the Inquiry nor will they
19 be instructed for that purpose.
20 All three of these groups have provided detailed
21 written reports in response to their detailed letters of
22 instruction to which, as I have said, core participants
23 had the opportunity to contribute. It is important to
24 understand that consistent with the methodology and
25 ambition which underpins these evidential sections these

1 experts have not been asked at this stage to consider or
2 address any evidence relating to Mr Eljamel's
3 professional practice. That is because the Inquiry will
4 continue to go about the process of gathering that
5 factual evidence in its subsequent sections.
6 However, it should be understood that the
7 instructions issued to these groups have not been
8 compiled completely in the abstract. They have been
9 specifically designed to seek expert opinion and
10 technical information relating to areas, activities or
11 matters which are a part of the Inquiry's remit already
12 such as the training involved in becoming
13 a neurosurgeon, the purpose and main complications of
14 common neurosurgical procedures, or the duties of
15 candour of neurosurgeons which feature under Term of
16 Reference 7 or which the Inquiry reasonably anticipates
17 will arise as its factual investigations progress, such
18 as the ethics of taking a patient's informed consent or
19 the pitfalls involved in operating a successful
20 complaint system. It remains the Inquiry's intention to
21 seek to re-involve these expert groups at later stages
22 of the Inquiry's work in particular when more evidence
23 of the factual matters involved in Mr Eljamel's practice
24 come to light. To the extent that you require it to be
25 of assistance in your assessment and analysis as well as

1 becoming involved when we turn, sir, to the
2 consideration of recommendations in Section 6.
3 It is important to reiterate, sir, that as in court
4 actions experts do not determine the matters which are
5 for you to decide. That applies equally to the expert
6 groups whom we have instructed as it does to the experts
7 who have been instructed in the neurosurgical field by
8 Professor Wigmore of the ICR. You are the ultimate
9 arbiter of what happened, what went wrong and who is
10 responsible as well as why. These experts therefore
11 have an important part to play in providing opinion and
12 technical support but their role should not be
13 misunderstood or overstated. Equally, the evidence
14 which they provide including their opinions are not
15 conclusive on any matter. The conclusions are for you
16 to draw.
17 Sir, the Inquiry has instructed a neurosurgical
18 group from which we will hear evidence in the second
19 week of our plan, which comprises
20 Professor Peter Whitfield, honorary professor and
21 consultant neurosurgeon who is the group lead,
22 Mr Robert Redfern, a retired consultant neurosurgeon,
23 and Mr Crispin Wigfield, a consultant neurological and
24 spinal surgeon. This group has extensive knowledge and
25 experience of clinical practice in neurosurgery. It is

1 an independent group, none of the experts has worked
2 within neurosurgery in Tayside. The group was selected
3 based on the experience of its members and their
4 slightly different backgrounds, one being focused
5 currently on spinal surgery, one on intracranial surgery
6 and one with experience of being a consultant
7 neurosurgeon from a period around our relevant period in
8 which we are interested as a general neurosurgeon in
9 an environment not dissimilar to the service offered to
10 NHS patients in the Tayside region in which Mr Eljamel
11 played a part.
12 Sir, we have also instructed and received a detailed
13 report along with a number of documents from our medical
14 ethics group which comprises Professor Richard Huxtable
15 who has kindly taken the role as the group lead,
16 Dr Catriona McMillan and Professor Angus McNair. They
17 are respectively the professor of medical ethics and law
18 at the University of Bristol, a reader in medical ethics
19 and law at the University of Edinburgh and deputy
20 director of the Mason Institute for Medicine, Life
21 Sciences and the Law, and a professor of colorectal
22 surgery at the University of Bristol and honorary
23 consultant colorectal surgeon in the North Bristol NHS
24 Trust.
25 As with the neurosurgical group their report has

1 been disclosed to core participants for their
2 consideration in advance of these hearings. The group
3 which has been put together deliberately comprises three
4 slightly different perspectives on the important ethical
5 issues which have been covered by them. One is a lawyer
6 by training and academic with a strong interest in
7 a number of matters of direct relevance to the Inquiry's
8 remit. One is an academic lawyer based in Scotland and
9 hence with a particular Scottish perspective on matters.
10 And the other is a consultant colorectal surgeon with
11 an academic interest in medical ethics, in particular
12 the importance of the application of ethical principles
13 in surgical practice.
14 The evidence which will be presented will in fact
15 come only from two members of the group as Dr McMillan
16 is, for very good reasons of which the Inquiry has been
17 aware for some time, unavailable to attend to provide
18 oral evidence as these hearings. We will take care in
19 presenting the evidence from other two members of the
20 group one of whom is the group's lead to make clear if
21 there are any matters of detail which will be more
22 appropriately addressed to Dr McMillan and
23 an opportunity can be afforded for those to be addressed
24 to her at a later date. Professors Huxtable and McNair
25 are both based in Bristol and in light of their

1 considerable clinical and academic commitments you, sir,
2 have agreed that they will give their evidence remotely
3 from there, a matter to which I will return.
4 The Inquiry team has also obtained an expert report
5 from its healthcare administration group which covers
6 matters which have been set out in previous
7 documentation including in our expert protocol. The
8 members of the group are Professor Anne-Maree Farrell,
9 the professor of medical jurisprudence and director of
10 the Mason Institute at the University of Edinburgh who
11 has kindly taken on the role as that group's lead.
12 Professor Kieran Walshe, professor of health policy and
13 management at the University of Manchester, and
14 Dr Fay Gilder a former NHS trust medical director and
15 consultant anaesthetist. As with other groups this
16 group was put together with particular regard to the
17 various experience and perspectives of its members.
18 Professor Farrell is an academic lawyer based in
19 Scotland who, as well as having published and researched
20 widely in the field of healthcare administration, also
21 has considerable experience in the field of medical
22 ethics. Professor Walshe is a very experienced academic
23 with a particular focus on a wide range of matters
24 relating to healthcare administration who also, as it
25 happens, has a particular interest in healthcare-related

1 public inquiries. Dr Gilder is a consultant
2 anaesthetist who not only has considerable surgical
3 experience as a result of holding that position but has
4 also held the position of medical director of an English
5 health trust and so has considerable practical
6 experience of clinical governance issues which arise in
7 connection with that role and which form
8 a very important part of our remit, sir.
9 May I say that the Inquiry is grateful to the
10 members of these expert groups for their contributions
11 to date and the contributions which I hope they will
12 make in future. The evidence of these groups will be
13 heard in weeks two, three and four of the Inquiry
14 respectively. It is right also to acknowledge the
15 Inquiry's appreciation to the experts who are giving up
16 their time to give evidence which they will provide. In
17 particular as all have multiple other professional
18 clinical or academic commitments which make their time
19 extremely precious and hence all the more valuable to
20 us.
21 Sir, may I make one observation about the Inquiry's
22 evidential expectations of the witnesses. I will
23 explain in due course what steps have been taken to
24 ensure witnesses are well placed to provide useful and
25 accurate evidence to the Inquiry at these hearings.

1 These have been thorough and systemic and deliberately
2 so as per the Inquiry's Public Hearings Protocol. The
3 Inquiry has received witness statements from
4 organisations in Section 1 who were selected to speak
5 for these organisations. In the case of NHS Tayside, as
6 I have said, multiple contributors to the statement were
7 selected and so there will be multiple witnesses from
8 that organisation to speak to the various aspects of
9 NHS Tayside's evidence.
10 Few, if any, of the witnesses were involved in
11 the events of the time though some who have been
12 selected by the organisations have deliberately been
13 selected because of the fact that they were, at least to
14 some extent. Witnesses who are called to evidence under
15 oath will be expected to be able to speak to the
16 passages that they have contributed to statements and to
17 documents which they have produced in a reasonably
18 discursive and explanatory way. There will be little
19 point in simply expecting to attend to read out the
20 statement or to point to a document for the answer. All
21 organisations involved have committed, or are at least
22 certainly expected to contribute, to the important
23 public work of this Inquiry constructively. At this
24 stage this means witnesses from those organisations
25 attending with the aim of answering reasonable questions

1 about what has been produced for the illumination of the
2 Inquiry and its wider audience within the clearly
3 expressed aims of this section of the Inquiry's work.
4 Equally, from the other perspective, those who seek
5 to have questions asked amongst our core participants
6 should remember that the time divide between where we
7 are now and the events we are seeking to examine as well
8 as the approach of the Inquiry to seeking largely
9 organisational evidence in section 1 will inevitably
10 place some limitations on what witnesses can speak to at
11 this stage. In particular, those who advise their core
12 participant clients will be expected, as a feature of
13 their professional advisory obligations, to advise when
14 questions their clients seek to pose go beyond what
15 could reasonably be asked of witnesses in this forum at
16 this time. That does not mean that we are not here to
17 probe. We are. To be effective, however, such probing
18 must be undertaken in light of our evidential aims in
19 this section and the reasonable expectations which can
20 be placed on the witnesses in light of them.
21 Sir, I have a little more to say about some of the
22 materials which have been collected as part of the
23 section 1 workflow before moving on to other sections
24 but as I tend to speak very quickly, I suspect the
25 stenographer may require a break. So perhaps I

1 could suggest that we have a break at this stage maybe
2 for around 20 minutes.
3 THE CHAIR: 20 minutes. If that is a convenient moment,
4 yes, of course we'll do that. Ladies and gentlemen,
5 you've heard Mr Dawson signal an appropriate moment
6 where it might be expedient for all concerned to have
7 a break. We'll do that and we'll resume again in
8 20 minutes' time. Thank you.
9 (11.30 am)
10 (A short break)
11 (11.52 am)
12 THE CHAIR: Yes, Mr Dawson.
13 MR DAWSON: Sir, I was in the process of explaining the
14 preparations which have been undertaken for this hearing
15 and our intentions for it and I had just got to the part
16 where I was going to set out some information about
17 materials which have been sought and to some extent
18 obtained by the Inquiry as part of its Section 1
19 workflow which are perhaps unlikely to feature during
20 the course of these hearings.
21 There is a good deal, sir, of evidential material
22 which has been gathered under the Section 1 workflow of
23 general contextual importance to the remit of the
24 Inquiry and to our investigations to come which is
25 unlikely to be ventilated at these hearings.

1 I will turn in a moment to suggesting what can be
2 done with that material by core participants which would
3 be of use to the Inquiry. However, for present purposes
4 I would not like to seek to suggest that it is not of
5 importance to our work when that material certainly is.
6 It is just that other material was thought to be more
7 worthy of public ventilation at this stage and in
8 connection with the witnesses whose identities I have
9 outlined. As previously announced written statements
10 and associated documents for which the Inquiry is
11 grateful with have been obtained from campaigning members of
12 the Scottish Parliament, Mr Marra and Mr Rennie and from
13 a number of other organisations, including Police
14 Scotland, the BBC, the Health and Safety Executive and
15 the British Medical Association.
16 In addition further evidence requests have been
17 issued by the Inquiry as its investigations in this
18 section have progressed. It became apparent that
19 documents of relevance to the Inquiry's Terms of
20 Reference which were held by organisations which no
21 longer exist and possibly other documents passed to them
22 from other bodies may be held by the National Records of
23 Scotland. Therefore a written witness statement and
24 document request has been sent to that body seeking
25 further documents which may be of use and which may be

1 of value to you, sir, and the core participants in the
2 Inquiry as we go forward.
3 The Society of British Neurological Surgeons is
4 a national body which supports the study advancements of
5 the neurology. Equally, it became apparent that it was
6 a body that either did or could have had involvement in
7 matters relating to the professional practice of
8 Mr Eljamel and so a Rule 8 request has been sent to that
9 body to find out more about that.
10 Further, it also became apparent during the course
11 of our investigations that there was a body called the
12 Managed Network for Neurosurgery which played
13 a significant part in the way in which neurosurgical
14 services have been delivered in Scotland. In particular
15 by supporting the delivery and audit of neurosurgical
16 units in Scotland including in Dundee and reporting to
17 the Chief Medical Officer for Scotland as well as
18 issuing evidence-based national standards for
19 neurosurgery in Scotland, the first of which appears to
20 have been issued in September 2010. A Rule 8 request
21 has thus been sent to that organisation to understand
22 the role it plays, played, or could have played in
23 connection with matters relating to Mr Eljamel's
24 professional practice.
25 Further, it emerged during the course of our

1 investigations that Mr Eljamel appears to have carried
2 out a relatively large amount of functional
3 neurosurgery. Functional neurosurgery is an area of
4 that field which adopts procedures to target the nervous
5 system for the alleviation of the symptoms of other
6 conditions. Examples would include deep brain
7 stimulation for conditions such as Parkinson's Disease,
8 dystonia, tremor or pain. This is an area in which, as
9 you will discover, the experts on our neurosurgical
10 group have relatively less experience than in other
11 areas of neurosurgery though they have been able to
12 provide some helpful general assistance in understanding
13 its goals and ambit.
14 We have therefore issued a Rule 8 request to the
15 British Society for Stereotactic and Functional
16 Neurosurgery to find out more about their role,
17 functional neurosurgery in general and what we
18 understand to have been Mr Eljamel's connection to that
19 organisation in light of the organisation's apparent
20 involvement in that potentially significant area of
21 practice.
22 Assertions were recently made by the patient group
23 to the Inquiry about matters concerning the role of
24 nurses involved in their care. Connected to that was
25 a suggestion that a Rule 8 request similar to that sent

1 to the General Medical Council could be sent to the
2 Nursing and Midwifery Council. It has not unfortunately
3 been specified what the particular issues are which have
4 been experienced nor what evidence should be sought from
5 the NMC or what Terms of Reference such investigations
6 would be connected to or why. However, in light of this
7 helpful suggestion a Rule 8 request has been drafted and
8 issued to the NMC. For clarity it is not currently
9 accepted by the Inquiry team that it would be
10 appropriate for such a Rule 8 request to be of a similar
11 nature to the one issued to the GMC given the fact this
12 is an Inquiry which focuses on the systems involving the
13 practice of a neurosurgeon as opposed to nurses and the
14 clear, direct involvement of the GMC in parts of the
15 Inquiry's Terms of Reference. Nevertheless, it was
16 considered in light of this representation to be of
17 relevance for aspects of the role and responsibilities
18 of the NMC and of the nursing profession to be examined
19 to a certain extent and it is expected that a draft of
20 the Rule 8 response from that organisation will be
21 received in early course which will be analysed and
22 processed in the normal way.
23 These written statements and any exhibits as well as
24 any other documents produced by these organisations in
25 response to calls made of them by the Inquiry have been

1 or will be disclosed to core participants in due course.
2 It should of course be borne in mind that the Inquiry
3 will, in Section 4 of its evidential plan, assess the
4 responsibilities of bodies that did play or could have
5 played a role in the professional practice of Mr Eljamel
6 to the extent that has not already been made reasonably
7 clear by that point. I will return to the thinking
8 behind their disclosure when I address the plans for
9 what will happen after these hearings in due course.
10 Sir, I turn now to the procedural plans for these
11 hearings.
12 Against that background, I would like to say more,
13 sir, about how these hearings will work. It is
14 important to understand that these hearings are part of
15 a process of investigation. They are an important part,
16 as I have said for reasons I will return to in a moment,
17 but they are not the only part of what we do in this
18 section. They are part of a process of investigation,
19 analysis and planning which has been ongoing and which
20 will continue when all of the oral evidence in these
21 four weeks has been heard even within the
22 introductory confines of Section 1. Beyond that they
23 are part of a process which is designed ultimately to
24 lead you to expressing conclusions about matters within
25 your remit in a report or reports at a stage in the

1 proceedings when you feel you have heard enough to be
2 able to reach those important conclusions. They are not
3 the end of anything, not even a Section 1 of our
4 evidential plan.
5 The importance of hearings in general terms
6 including these hearings is set out, as it has been for
7 some time and as I've already said, in the Inquiry's
8 Public Hearings Protocol. What is contained there from
9 a procedural perspective merits clarification and
10 explanation at this time.
11 In order to achieve its investigatory aims the
12 Inquiry has followed certain processes and will continue
13 to follow others at these hearings. I will set out now
14 what has happened in advance of these hearings and what
15 will happen at them so that everyone with an interest
16 knows how things will work and why.
17 As with all material received by the Inquiry, draft
18 statements and documents either exhibits to statements
19 or otherwise required by the Inquiry in terms of our
20 requests were analysed by the Inquiry team. Comments
21 were provided on the draft statements by the Inquiry and
22 proposed sets of documents produced with a view to
23 seeking to improve the overall quality and
24 comprehensiveness of the evidence being provided by
25 an individual or organisational material provider.

1 Amendments were made by the providers to draft
2 statements accordingly and further sets of documents
3 provided, as the material provider or witness saw fit in
4 accordance with the comments and suggestions provided by
5 the Inquiry team before the statements and documents
6 became evidence in the Inquiry, at which time they were
7 catalogued using the Inquiry's referencing system by
8 which unique reference and page numbers are attached to
9 all evidential documents.
10 The information and documents received as a result
11 of the Rule 8 requests for written statements and
12 documents produced went through a lengthy process of
13 legally required assessment for relevance and then
14 redacted in line with the Inquiry's general restriction
15 order so as to remove sensitive material such as
16 personal data amongst other generally applied
17 restrictions and the two restriction-related protocols
18 which have been prepared and published.
19 The Inquiry has taken a view that, given the general
20 introductory nature of the evidence being looked at in
21 this section, it is unlikely that individual patient
22 cases or experiences will be examined in any detail and
23 so it is unnecessary for the names of patients referred
24 to in documents to be disclosed or published. Thus the
25 names of all patients have been redacted from the

1 materials other than two prominent campaigners whose
2 names do appear in the documents and may need to be
3 referred to and who have agreed to that course, as well
4 as having been given the opportunity to make
5 representations about any sensitive passages within
6 documents relating to them in connection with which they
7 have been offered the opportunity to make
8 representations about possible restriction. In due
9 course, when patients' cases become a greater part of our
10 investigations as they become more focused on patient
11 and their important experiences, patients will be
12 offered the opportunity to apply for anonymity. Thus,
13 for now the Inquiry has applied temporary redactions to
14 patients' identifying information for the sake of
15 efficiency and respectful to the undoubted wish of some
16 of them to remain anonymous.
17 For those who do it will be the default that
18 anonymity orders will be granted to patients who wish
19 them. In such cases the redactions protecting the
20 identity of these individuals will remain in the
21 documents which have been which have had temporary
22 redactions applied for present purposes.
23 There are other redactions which have been applied
24 to documents for reasons of the proper administration of
25 the work of the Inquiry in accordance with the Chair's

1 statutory power to do so. Some of these may be able to
2 be removed when certain further steps are taken, in
3 which case documents will be redisclosed and if necessary
4 republished. Given these decisions about the
5 application of potentially temporary redactions, the
6 Inquiry's General Restriction Order and relevant
7 protocols have been slightly altered to cover this
8 course for the sake of clarity. Updated versions are
9 available on the Inquiry's website.
10 For the sake of completeness, those who follow these
11 matters keenly will have observed the Scottish Ministers
12 made an application to have the names of junior
13 officials mentioned in their documents redacted. That
14 application was refused by you, sir. Your reasoning is
15 available on the Inquiry's website. With the result
16 that these names of these junior officials remain to be
17 seen in these documents, as will the names of other
18 public officials unless there is a reason why, sir, you
19 have thought it fit to redact them whether permanently
20 or temporarily for a good reason in accordance with the
21 balancing exercise you're obliged to carry out of openness
22 and transparency on one hand and other competing rights
23 on the other.
24 Documents including written statements have been
25 gradually disclosed to core participants in the lead up

1 to these hearings in tranches as the processes I have
2 described have been completed and the redactions have
3 been applied to the documents. It is neither necessary
4 nor proportionate for the Inquiry to disclose every
5 document it receives. That is not required and would
6 hinder the Inquiry in the performance of its functions.
7 It would also be a derogation from the Inquiry's
8 functions were it to pass to the core participants all
9 the material that it receives.
10 However, in this section at least a liberal approach
11 to disclosure has been taken to maximise the information
12 available to core participants and to provide them with
13 a broad context in which to participate in these
14 hearings but also to assist the Inquiry with the steps
15 we intend to take next to which I will return.
16 A draft list of witnesses was sent to core
17 participants to contribute to in the week of 6 July 2026
18 as had been planned after initial contact had been made
19 prior to that with proposed witnesses themselves to seek
20 to understand where they had any availability issues
21 which the Inquiry sought to respect as far as possible.
22 Alterations and additions to the witness list were made
23 according to the reasonable requests and suggestions of
24 the core participants, a final witness list was then
25 published after accommodation had been incorporated to

1 deal with reasonable witness requests based on
2 availability. Further, some witnesses have been allowed
3 to give evidence remotely, to which I will return.
4 In accordance with our published processes,
5 documents called Evidence Proposals have been drafted
6 and circulated for every witness. These are contributed
7 to by core participants and the witnesses themselves and
8 serve two broad purposes. Namely (a) to inform the
9 witness and core participants of the broad topics which
10 may be covered with the witness in the oral evidence
11 session and (b) to list the documents which might be put
12 to the witness in their evidence. That is in the
13 interest of fairness but also to allow the witness to
14 prepare properly for their evidence session.
15 Further, on the basis of the materials they have
16 received in the disclosure, core participants have been
17 provided with the opportunity to contribute proposed
18 questions for witnesses. The input of core participants
19 to the Evidence Proposals and their proposed questions
20 have been and continue to be considered by myself and my
21 learned junior Mr Crawford. We are
22 grateful for them and the contributions made and to be
23 made by core participants to the list of witnesses, the
24 Evidence Proposals and the questions in due course.
25 The way that witnesses will be called to give

1 evidence will be that they will enter the room, for
2 remote witnesses they will appear on screens. They will sit in
3 the witness seat which is opposite me there. They will
4 either swear or affirm that they will tell the truth,
5 the whole truth and nothing but the truth before their
6 evidence commences. The oath or affirmation as the
7 witness prefers will be administered by you, sir. The
8 witness will then be asked questions by me.
9 Previous consultations with our core participants
10 have made it clear that for very good reasons those with
11 an interest in our work who are either here in person or
12 watching via the YouTube link prefer to have regular
13 breaks and be aware in advance what our plans are in
14 this regard. Anyone who has experience of inquiries,
15 courts or other similar tribunals will know there are
16 numerous factors which can scupper the best laid plans
17 for hearings like this but in light of these reasonable
18 requests and the need for careful management of the
19 precious time at the hearings we have put some time into
20 developing a detailed plan, at least as our starting
21 point. We will generally work on the basis that the
22 hearings will commence 10 am and will aim to finish the
23 day by 4.30 pm. As was clearly conveyed in previous
24 consultation there is a need for breaks to be
25 incorporated into our planning as I have said and we

1 have listened to that reasonable request.
2 Though there are many factors that can influence
3 running times, such as unexpected turns in the evidence,
4 technological hitches which we will do our best to avoid
5 and reasonable requests by core participants for
6 important questions to be put to a witness, the
7 following is the basic timing structure which we intend
8 to adopt. The day will be split into a morning and
9 afternoon session. On most days a witness will be
10 called in the morning and in the afternoon but on
11 some days there will be a full-day witness or a group
12 giving evidence. The morning and afternoon sessions
13 will generally be split into two equal sessions of
14 2 hours 45 minutes with a break for lunch from 12.45
15 until 1.45 which will occur every day.
16 There will generally be breaks in the morning
17 session and in the afternoon session totalling
18 30 minutes meaning that evidence will be heard for up to
19 2 hours 15 minutes in each half-day session. It is
20 important to understand that core participants' main
21 opportunity to contribute proposed written questions was
22 7 days before the hearings when these were communicated
23 between counsel. As I have said these have been and
24 will continue to be considered by myself and my learned
25 junior and incorporated into our planning as we see fit.

1 In light of our plans and areas we think are likely to
2 be useful in illuminating you, sir, and the public more
3 widely, some have been retained for later use as I have
4 said as they are too detailed for now. However, there
5 will be a further opportunity on the day of a witness's
6 evidence for questions to be proposed. Guidance on the
7 timings and opportunities which this window affords have
8 been explained between counsel.
9 Therefore for a half-day witness whose evidence will
10 be heard over a total 2 hours and 45 minutes, there will
11 be 2 hours notionally allocated to examination by the
12 Inquiry with a 15-minute break in the middle. That will
13 leave around 15 minutes for a further break during which
14 time proposed further questions from core participants
15 will be considered and 15 minutes will be reserved for
16 those additional questions to be asked.
17 Some witnesses will be shorter than that, given the
18 limited scope of their evidence, but that is the basic
19 structure. For a full-day witness we will follow the
20 same plan as that in the afternoon session with
21 a half-hour break in the morning. Lunch will usually be
22 taken, as I say, for an hour between 12.45 and 1.45.
23 For the expert groups we will endeavour to leave a bit
24 more time for the core participant input given that
25 their evidence is wide-ranging within their specialist

1 areas. Core participants' recognised legal
2 representatives have been informed they will need to
3 develop systems for gathering possible questions from
4 their clients, formulating them and deciding upon
5 proposed questions as we go along. There will not be
6 long breaks, the timetable will simply not permit it.
7 In our view they would be unnecessary.
8 Equally, those recognised legal representatives have
9 been reminded that these are introductory hearings and
10 that matters of detail beyond our stated remit in this
11 evidential section will need to wait until later.
12 Though questions from client core participants are
13 welcomed, recognised legal representatives will be
14 expected to use their professional judgments in making
15 their proposals for further questions in light of our
16 plans and not simply act as a postbox for their clients.
17 They are all experienced and skilled professionals whose
18 role involves judicially picking what questions need to
19 be asked and advising their clients why. In particular,
20 they will be expected to propose questions which are
21 designed to fulfil the basis upon which their clients
22 were recorded CP status in the first place, their
23 ability to assist the Chair of the Inquiry in the
24 investigation and the determination of key matters
25 within our remit.

1 It is against that context that proposed questions
2 will be judged. We have every confidence that those
3 core participants have a huge amount to contribute and
4 that their recognised legal representatives will
5 represent their clients with skill and judgment. Being
6 a core participant does not equate to the role of
7 a spectator, sitting on the sidelines passing judgments
8 or a criticism. Your role is to be part of the play on
9 the pitch suggesting and supporting the Inquiry team
10 and the Chair in progressing towards our common goals.
11 Witnesses whose evidence go over a break will be
12 told that they are not permitted to discuss their
13 evidence with anyone during the break. They will be
14 held to that and are therefore not entitled to discuss
15 their evidence with anyone including their recognised
16 legal representatives over that period. When witnesses
17 return they will remain subject to the oath or
18 affirmation they are given. The Chair may see fit to
19 remind them of that but whether he does or not, that
20 will be the position. I will generally ask witnesses at
21 the end of their evidence if they have anything to add.
22 That can be a pre-prepared statement if they wish, that
23 is a matter for them, but witnesses are asked to bear in
24 mind the purposes and remit of the Inquiry and that
25 ultimately the purpose of their evidence is to assist

1 the Chair. Therefore we do not expect or require
2 witnesses to come along with pre-prepared scripts in the
3 expectation that they will be delivered at the start of
4 their testimony. Our experience is that such statements
5 are often unhelpful to the extent that they tend to be
6 subsumed within the testimony given anyway in response
7 to questions and by the end of his or her testimony the
8 witness can, in light of our plan, reassess what they
9 feel needs to be assessed in light of the general final
10 question which I intend to ask.
11 The Chair will normally give me or another
12 questioning counsel the opportunity to ask follow-up
13 questions arising from that response to that overarching
14 question. Core participants will of course be entitled
15 to propose follow-ups to this or any other part of the
16 witness's evidence as I have set out.
17 Witnesses should remember that their evidence is
18 their responsibility even if they are giving evidence on
19 behalf of an organisation or a group. As with written
20 evidence to which they have attested in written
21 statements that they have said is true, they are giving
22 evidence under oaths or affirmations administered by the
23 Chair under his legal authority to do so under the Act.
24 Some witnesses will give evidence remotely. What
25 that means is they are not physically here and will give

1 evidence via a videolink. The default position the
2 Inquiry expects witnesses to appear before the Inquiry
3 in person. If they have been granted dispensation by
4 the Chair to give evidence remotely it's because the
5 Chair considers it within the public evidence that their
6 evidence be taken in this way in the exercise of his
7 statutory power and responsibility to regulate the
8 procedure of the Inquiry as he sees fit within the
9 strictures of Section 17 of the 2005 Act.
10 Witnesses will be treated as best we can and in all
11 legal respects in precisely the same way if they appear
12 remotely as if they have been here in person. They will
13 be subject to the same oath or affirmation as other
14 witnesses and be subject to the same rules about not
15 discussing their evidence with anyone during breaks or
16 otherwise.
17 As I've said at previous hearings, the video feed by
18 which we are watching the evidence via YouTube will be
19 transmitted with a delay of 3 minutes. This mechanism is
20 part of the systems we have to try to prevent any
21 confidential information being transmitted to the wider
22 public which should not be. In the event that something
23 is said by me or by any another contributor which seems
24 to contain information which ought not to have been
25 referred to, I will cut the feed or told to do so by the

1 other members of the Inquiry team. They will stop the
2 transmission. We will most likely have a short break to
3 work out how to proceed. My apologies to all in advance
4 for any interruption which we need to make to the
5 evidence of any of the witnesses for this purpose. This
6 is why it will be necessary to do so.
7 I would urge witnesses to avoid revealing any
8 matters which are likely to be potentially confidential
9 including patients' names other than of the two
10 prominent campaigners, Ms Jules Rose and Mr Pat Kelly,
11 who have waived the right to be anonymous and whose name
12 does appear in materials which have been disclosed by
13 the Inquiry in this section. Any such information which
14 is inadvertently referred to must not be referred to or
15 otherwise shared outside this room and is subject to the
16 Inquiry's First Order covering those in attendance
17 including members of the media.
18 For the avoidance of doubt you have pronounced
19 a further Order of the Inquiry, sir, shortly in advance
20 of these hearings relating specifically to the
21 information which may be transmitted to those within the
22 hearing room but ultimately not published via the
23 YouTube feed or becoming part of the published video of
24 proceedings or in published documents. If there is any
25 doubt about what can be transmitted or broadcast outside

1 the room the Inquiry legal team can be contacted or
2 spoken to for clarity.
3 Sir, these proceedings are not adversarial and
4 parties do not have the same rights to object as they do
5 in adversarial litigation. The question of policing
6 restricted information is largely a matter for you and
7 the Inquiry team in accordance with the approach which
8 has been adopted or ordered by you in connection with
9 the disclosure and publication of documents which have
10 been produced in connection with these hearings. If
11 a recognised legal representative wishes to assert the
12 materials should be restricted they should ordinarily
13 communicate that to the Inquiry's solicitors by email on
14 their legal email address that they think material ought
15 to be restricted or that they wish to apply for
16 restriction bearing in mind that time to do that is
17 limited in light of the feed delay being only 3 minutes.
18 Sir, the statutory rules relating to the rights of
19 core participants to make opening and closing statements
20 are to be found in Rule 10 of the 2007 Rules. As there
21 will be no opening statements in addition to those
22 delivered in November, for the reasons I have already
23 touched on, the same logic underlies the position that
24 there will also be no closing statements or submissions
25 by core participants at this time. The focus of these

1 hearings is evidential and core participants have had
2 the opportunity to contribute via question proposals as
3 I have set out. We had a separate opening statement
4 hearing so we could listen to what core participants had
5 to say and incorporate their helpful contributions into
6 our plans and investigations as well as allow the focus
7 to be on the evidence at these hearings. There will be
8 an opportunity afforded to core participants to make
9 closing statements and written submissions at the end of
10 our hearings.
11 This may not be the experience of some participants
12 from other public inquiries where core participants have
13 the opportunity to make opening or closing statements in
14 each evidential section. Those that do adopt such
15 an approach tend to be more modular in scope where their
16 subject matter lends itself to sections or modules on
17 different subjects with separate submissions being
18 appropriate on each. Examples might be the UK Covid-19
19 Inquiry or the Scottish Child Abuse Inquiry. Our
20 approach to our remit is different. As our Terms of
21 Reference all relate to the systems surrounding the NHS
22 career of one man and our sectional approach looks to the
23 totality of the evidence relevant to each section and
24 focuses on different categories of witnesses. It has
25 thus been thought to be of more use to the Chair if the

1 core participants' contributions at this stage focus on
2 the evidence and that statements and submissions on the
3 totality of the available evidence will be invited later
4 in order to assist you, sir, in the compilation of your
5 final report or reports.
6 That is not to say that core participants may not be
7 invited to make submissions as we go along in the course
8 of the Inquiry on a particular matter which you, sir,
9 deem to be of any particular assistance at any time.
10 Indeed, I will return to a proposal for such
11 a submission to be made later in this opening address.
12 Finally, sir, in relation to the plans for these
13 hearings I would like to say something about publication
14 of material. The Inquiry's protocols differentiate
15 between disclosure on the one hand and publication on
16 the other. Disclosure relates to the dissemination of
17 material or information to core participants or others
18 such as witnesses or recognised legal representatives
19 who are bound by the Inquiry's First Order and
20 confidentiality undertakings provided to the Chair of
21 the Inquiry by individuals from publishing beyond the
22 groups in which they reside. Publication, on the other
23 hand, involves information or documents being available
24 to the public at large which generally removes the
25 restrictions on core participants and their lawyers from

1 discussing or disseminating the information or documents
2 more widely.
3 Generally certain materials will be published at the
4 end of the day of the evidence or the next day. This
5 may be in addition to the information contained in this
6 speech and the oral testimony of any witness which by
7 that stage will have been published publicly via the
8 YouTube feed. The material which will generally be
9 published will include the statements of witnesses who
10 have given evidence or the statement of an organisation on
11 the last day on which evidence is given about it or
12 extracts from those statements as the Inquiry deems
13 appropriate. In addition the Inquiry will publish
14 documents referred to in the evidence that day or
15 extracts from them as appropriate.
16 Care should be taken by those who are in possession
17 of information or documents which have been disclosed to
18 them to make sure that they are aware of what has been
19 published on the Inquiry's website so that they do not
20 release information or material which has not been more
21 widely disseminated than is permitted.
22 I would like to take the opportunity to reiterate
23 the principles of the First Order and the further Order
24 of a similar nature relating to these hearings which
25 I have mentioned. I should say that I do so for the

1 sake of completeness and not out of any particular
2 concern or by way of censure. In fact our experience
3 has been that our core participants, in particular
4 patients and their recognised legal representatives,
5 have been careful and respectful of the need to observe
6 the Inquiry's confidentiality rules and have taken care
7 to seek advice where necessary and otherwise to respect
8 and observe their terms. Again, if those in attendance
9 who have otherwise received materials or information
10 from the Inquiry have any questions about their
11 publication or the rules in that regard the Inquiry
12 legal team is on hand to deal with any such queries.
13 Sir, moving now beyond the intentions for these
14 hearings I'd like to say something about Section 2
15 progress and the plans for the next set of evidential
16 hearings in December of this year.
17 As those with an interest in this Inquiry will know,
18 Section 2 of the Inquiry's workflow is the part in which
19 we gather and examine the evidence of former patients of
20 Mr Eljamel and in certain cases their personal
21 representatives. There are two components to this work,
22 both of which are well underway, namely the oversight
23 function which the Inquiry holds over the work of the
24 ICR and the direct gathering of evidence by the Inquiry
25 from patients and patient representatives. The ICR, as

1 those who take an interest in our work will certainly be
2 aware, is a review process in which applicants, former
3 patients of Mr Eljamel or their representatives, can
4 seek to have their cases subjected to clinical analysis
5 by one of a term of independent expert neurosurgeons
6 appointed by Professor Stephen Wigmore, the chair of
7 that process.
8 The ICR evidence itself has two main parts, namely
9 the completion of statements of applicants to the ICR
10 and exhibits to those statements and separately the
11 neurosurgical reports themselves as well as any exhibits
12 associated with those. The Inquiry has the ability to
13 nominate patients' cases which it wishes the ICR to
14 prioritise either by way of identifying cases where
15 individuals have applied to the ICR to be amongst this
16 priority group or by referring cases for neurosurgical
17 review. I will return to progress in the ICR and its
18 impact on our procedural plans in a moment.
19 A provisional outline of the scope of Section 2 of
20 the Inquiry's evidential plan has now been published on
21 the Inquiry's website which provide some further detail
22 of the matters which we intend to cover in that section.
23 The broad areas set out there are the areas in which the
24 Inquiry feels patients are most likely to have
25 an important and valued perspective and on which

1 neurosurgical experts in the ICR may have relevant
2 opinions to offer. Around 6 weeks ago, the Inquiry
3 issued Rule 8 requests to 23 former patients of
4 Mr Eljamel and two spouses of former patients of
5 Mr Eljamel, 25 Rule 8 evidential requests in total.
6 These Rule 8s had been issued in accordance with the
7 Inquiry's known duplication principle which seeks to
8 minimise the number of times a patient requires to
9 repeat their story about what happened to them. Amongst
10 the means by which the patient voice will be heard in
11 this Inquiry on matters of systemic significance or the
12 matters foreshadowed is in paragraph 22 of the Inquiry's
13 protocol on its approach to evidence and written
14 statements which form part of what patients have been
15 asked about in this Inquiry Rule 8 requests. In most
16 cases in addition to their perspective on clinical
17 matters which they have already provided to the Inquiry
18 via their ICR applicant statements and associated
19 exhibits.
20 Sir, in terms of the Inquiry's Term of Reference 16
21 the Inquiry will be obliged to take account of the ICR's
22 finding in its work. The intention is that the ICR will
23 set out what went wrong clinically. The Inquiry's role
24 will then be to investigate what systems should have
25 existed to detect and prevent those things going wrong

1 and harm occurring and whether those systems were in any
2 way defective.
3 By way of reminder, patient evidence contained in
4 the Inquiry Rule 8 statements will be taken into account
5 by you, sir, in addition to the ICR applicant statements
6 and any exhibits. For individuals not called upon to
7 provide Inquiry statements their ICR applicant
8 statements and exhibits stand as their evidence in the
9 Inquiry.
10 Sir, I will return in a moment to the progress of
11 the ICR but those with an interest in our work will
12 recall that concerns were expressed by me at the time of
13 the procedural hearing in May as to progress in the
14 ICR's work in light, in particular, of the need to be
15 ready for the important evidence of patients to be heard
16 at the hearings which have been scheduled for December
17 of this year. At that time I reiterated the need for
18 efforts to be redoubled within Levy & McRae, in
19 particular in light of the fact that they would soon
20 become responsible, as they have been over the last
21 six weeks, for assisting with two important streams of
22 work at the same time, namely the ICR applicant
23 statements with which they had been supporting their
24 clients during the course of this year and the Inquiry
25 Rule 8 statements which were issued around six weeks

1 ago.
2 In order to assist with this development, sir, you
3 have funded an additional solicitor to be involved
4 in the work of the Inquiry within the firm of
5 Levy & McRae in order to enable the clear targets for
6 the drafting of the Rule 8 statements to be met. As
7 will be in hearings when draft Rule 8 are due, which is
8 this week as it happens, progress will be able to be
9 monitored and discussions can take place alongside them
10 as representatives of the Inquiry and the patients will
11 be on hand to address any issues which may arise. Given
12 the reasonable demands on the part of Levy & McRae and
13 indeed other parties at previous hearings for clarity
14 and advance notice of what would be expected of them, we
15 have made efforts to be clear about what will be
16 required, when and perhaps most importantly why, as well
17 as you, sir, going the extra mile to ensure that
18 adequate funding for the process was in place.
19 We helpfully received a breakdown from Levy & McRae
20 a couple of weeks ago about the progress which had been
21 made towards the completion of the Rule 8 statements for
22 the recipients of the Rule 8 requests whom they
23 represent. I was also pleased to learn from my learned
24 friend Ms Cherry recently that she has been taking
25 a keen interest in trying to ensure that reasonable

1 progress is being made, for which the Inquiry is
2 grateful. We hope that the process of drafting these
3 written statements by those who have been called upon to
4 do so by the Inquiry has been a profitable experience
5 for them and very much look forward to reading and
6 commenting on the written drafts of them in early
7 course. A team is waiting and ready to do so as soon as
8 they are received. We are appreciative of the work
9 which has gone into the production which we are sure
10 will not have been easy for some. It is integral to the
11 success of this Inquiry that the voices of patients are
12 heard, in particular at our hearings in December and
13 those ongoing efforts play, and will continue to play,
14 a pivotal part in that aspect of our plans and of our
15 evidence.
16 By way of an update on the work of the ICR I can
17 report, sir, that as its work has moved into the sphere
18 of the instruction and production of neurosurgical
19 reports in order to provide additional assistance to the
20 ICR in this expert stage of its work in addition to the
21 oversight which the Inquiry provides by way of
22 commentary on draft neurological reports the Inquiry
23 team has also created a draft template for the surgeons,
24 much like the template for the applicant statements to
25 ensure consistency, both from the point of view of

1 evidence being provided to the Inquiry in both form and
2 substance, but also clarity and consistency amongst the
3 applicants who are the primary recipients of the ICR
4 evidence.
5 It is important to understand that the evidence of
6 the ICR plays a number of important roles in the
7 investigation of the Eljamel affair. It allows for the
8 ambition of the appointing Cabinet Secretary to be met
9 that patients who wish to have one will have
10 an individualised review of their care. It allows
11 a wide variety of patient voices to be heard in the
12 Inquiry on a variety of clinical matters in addition to
13 evidence they provide on systemic matters to the Inquiry
14 directly. It constitutes a body of clinical evidence of
15 what went wrong across the period of Mr Eljamel's
16 working life in Tayside both in the NHS and in private
17 care upon which basis the Inquiry's systemic
18 investigations of the NHS can proceed.
19 A Rule 8 request has been issued to
20 Professor Wigmore as the Chair of the ICR some weeks
21 ago. I'll return to the intention with regard to oral
22 evidence of Professor Wigmore and potentially from the
23 ICR beyond that in due course in connection with our
24 plans. You will however recall, sir, as part of my
25 opening address at the opening statement hearing back

1 in November I had occasion to point out that delays in
2 getting the ICR initially up and running had become, by
3 that point, intolerable.
4 A plan was put in place based on a timetable which
5 had been put in place by Professor Wigmore involving
6 a three-month projection for the completion of
7 an applicant's case which involved the top 50 cases
8 being completed by March 2026. No objection to that
9 plan at that time was raised though an opportunity was
10 afforded to everyone represented at the hearing to do
11 so. As a result of the forced postponement of the
12 Section 1 hearings to this hearing slot now
13 in September, and the subsequent knock-on delay of the
14 planned Section 2 hearings to December, a further
15 opportunity was taken to get a second batch of priority
16 cases underway so as to increase the pool of cases to
17 which the Inquiry might have regard in Section 2 in
18 addition to plans for our own investigations amongst the
19 patient group via the Rule 8 requests which I've already
20 referred to.
21 Thus the priority group was increased to 111 cases,
22 an increase designed to mitigate the effects of the
23 forced procedural delay. That group of 111 cases is
24 comprised of three separate batches of cases. The first
25 is the top 50 priority cases which were selected by the

1 Inquiry for the ICR to handle first based on materials
2 to which the Inquiry had access. A further group of the
3 next priority cases, 51 as it happens, was identified by
4 the Inquiry thereafter using the same materials and
5 criteria. Further, a third group of ten cases was set
6 in motion by the ICR itself thus completing the set of
7 111 priority cases now making their way through the ICR
8 process.
9 At the procedural hearing in May the process was up
10 and running but had continued to be affected by delay
11 predominantly arising from the need to address issues
12 relating to the quality and comprehensiveness of draft
13 applicant statements prior to their consideration by
14 an expert, this resulted in deadlines set down by the
15 ICR process being missed often by considerable margins.
16 As I say so far 111 cases are making their way through
17 the ICR process. Of these 18 are cases which were
18 referred to the ICR by the Inquiry for review. 93 are
19 applicant cases, meaning cases in which an application
20 has been made by a patient or patient representative and
21 an applicant statement has been provided. Of those
22 93 applicant cases I understand that 46 applicant
23 statements have now been completed and are available for
24 evidence to the Inquiry along with their attached
25 exhibits. Those statements will be used by the

1 neurosurgical expert instructed in those cases as part
2 of the evidence to which they will have regard in
3 compiling their final reviews. All applicant statements
4 and neurosurgical reviews which emanate from the ICR
5 will, as I said, ultimately be evidence in the Inquiry
6 in accordance with our processes.
7 I will return to the subject of progress of these
8 neurosurgical reviews in due course, but as a general
9 observation progress in the ICR remains too slow with
10 various consequences which I will outline momentarily.
11 It is worthy of note, sir, that in order to address the
12 issues which were debated at the May hearing the Inquiry
13 redoubled its efforts to perform its support and
14 oversight role in the work of the ICR. This has
15 involved a full-time team of two junior counsel and one
16 assistant solicitor as well as a team of three
17 paralegals doing nothing but the work of the ICR for
18 most of the time since May. In addition the Inquiry
19 will shortly benefit from the services of a new
20 assistant solicitor whose role will, in part, involve
21 that function also. The plan for the longer term had
22 been, and remains, that the two junior counsel and one
23 assistant solicitor will move on to later sections as
24 befits the systemic focus of the Inquiry's work.
25 However, systems we put in place to ensure that cases of

1 novelty or apparent significance continue to be analysed
2 by the Inquiry throughout, all will be evidence in the
3 Inquiry and available to you, sir, in the determination
4 of your ultimate findings.
5 Sir, as far as the December hearings are concerned
6 it had been the intention, as I announced previously,
7 that the Inquiry would hear evidence at that time both
8 from patients, patient representatives and the evidence
9 of Professor Wigmore who was due to provide a Rule 8
10 statement in the form of an interim report on what the
11 neurosurgical experts in the ICR had discovered in their
12 reviews. In order to enable necessary preparations for
13 that evidence to be made, it had been intimated to the
14 ICR that the 50 preliminary priority reviews required to
15 be completed by the end of July and the remaining 61 by
16 the end of August.
17 At this moment I understand that only one
18 neurosurgical review has been finalised and signed.
19 There are a few more which, as I understand it, are in
20 their final stages towards signature. While that
21 situation is likely to change hopefully in early course
22 it is unrealistic in our view to think that reviews will
23 be advanced in sufficient numbers and to a level which
24 would permit consideration at hearings as soon
25 as December, in particular in light of the time it will

1 take for the Inquiry to go through it's own risk disclosure
2 processes relating to the materials associated with the
3 examination of the ICR's neurosurgical evidence. The
4 result of this is a necessary change of plan
5 for December and beyond, the main goals of which are to
6 try to make what progress we can and to seek to maintain
7 the important concept of stability for patients.
8 Accordingly, the intention is that the December
9 hearings will involve patient and possibly patient
10 representative evidence only.
11 In order for this to be able to be achieved once
12 again I must stress to those patients who have received
13 Rule 8 requests and their legal advisers the importance
14 of meeting the Inquiry's deadlines both in terms of time
15 but also in terms of comprehensiveness, of clarity and
16 of formatting as are clearly set out in the Rule 8
17 request in its terms. The position and experiences of
18 the witnesses will, as with all such statements, be
19 expected to be set out as clearly as the witness is
20 able. Exhibits will be expected to be clearly
21 referenced and their significance to the witness clearly
22 laid out in the statement. Those responding to Rule 8s
23 and their recognised legal representatives are reminded
24 of the provisions of the Inquiry's protocol and its
25 approach to evidence in this regard. Paragraph 59 says

1 that not every document in the medical records will be
2 relevant. For instance, many may contain details of
3 other medical issues of no relevance to the Terms of
4 Reference. Only key documents for medical records, if
5 they are available, should be exhibited to any written
6 statements together with any other documents that may be
7 relevant to matters outlined in the Rule 8 request.
8 The Inquiry's clear and consistent formatting
9 requirements will need to be respected in order to avoid
10 delay after a first draft is produced. A failure in
11 this regard will jeopardise the Rule 8 statements being
12 completed and the witness not being eligible to be
13 considered as a witness for the hearings in December.
14 Sir, it is anticipated that their now considerable
15 experience of solicitors at Levy & McRae in providing
16 assistance and advice in connection with the ICR
17 applicant statements since the start of this year will
18 prove to be of considerable assistance in this regard,
19 given that the processes involved there were
20 deliberately designed to be similar to the Inquiry's own
21 process for completing written statements as well as the
22 additional funding to which I referred which you have
23 provided.
24 Your further guidance in that regard features as
25 parts of correspondence you have also sent to the firm

1 in July and should, I anticipate, have proven useful in
2 responding to the Inquiry's evidential request for
3 written statements as well.
4 In addition the Inquiry will continue to have regard
5 in its oral witness selection process to completed ICR
6 applicant statements which of course focus on the
7 clinical experience of the applicants. Of the
8 93 applicant cases going through the ICR presently, as
9 I have said, I understand that 46 applicant statements
10 have been completed. These are being further analysed
11 by the Inquiry team as we speak. However, those which
12 are near completion may also be considered for the oral
13 hearings and so should be attended to as quickly as
14 possible by the applicants for that important purpose.
15 For the sake of clarity the Inquiry team intends to
16 meet and discuss the finalisation of a witness list of
17 patient or patient representatives whom it would like to
18 call to give oral evidence in December. That
19 process is planned to take place in the week after these
20 hearings, the week commencing 5 October, at which time
21 the Inquiry team will take decisions about whom to
22 invite to call in December soon thereafter. Those on
23 the list will be contacted about specific dates
24 thereafter and a final timetable will be issued to core
25 participants and published as soon as possible.

1 Disclosure of documents received in response to
2 Rule 8s will continue to be done in an order which is
3 appropriate to the way in which the Inquiry's sections
4 are structured. Given that the Inquiry will, in
5 Section 2, focus on the evidence of patients and in due
6 course evidence emerging from the ICR it is considered
7 likely that disclosure for the updated December hearings
8 will focus on written statements from patients and
9 exhibits, applicant statements and exhibits, as well as
10 relevant complaint files and extracts from medical
11 records which the Inquiry or the patients may wish to
12 ventilate in their evidence.
13 These materials are the most closely related to the
14 patient experience of and perspective on the subject
15 matter of the Inquiry.
16 Sir, entirely understandable concerns have
17 repeatedly been expressed to the Inquiry about its
18 intentions with regard to the publication of material
19 emanating from the ICR including applicant statements
20 and associated exhibits as well as Inquiry materials
21 which may reveal the identity of individuals who wish to
22 be anonymous. Before publishing an applicant statement
23 and any attached medical records or other exhibits and
24 any Inquiry statement, the patient in question will be
25 given the right to apply to the Inquiry for anonymity

1 before these materials are disclosed or published.
2 As I have said, the default position for patients is
3 that such an order will be granted with the result that
4 identifying information redacted from any materials
5 disclosed or published. Anonymous witnesses will
6 generally give evidence in the room where they can be
7 seen by those in attendance and will be restricted
8 from revealing any information publicly about the individual
9 in question. They will normally be able to be heard on
10 the YouTube feed, but their faces will not be shown.
11 Any other adjustments which any witness wishes to apply
12 for will be listened to and sensitively handled by the
13 Inquiry. The patient's voice must be heard but not in
14 a way which causes undue distress or risks
15 retraumatising patients at all.
16 The same process will apply to the Inquiry Rule 8
17 statements and exhibits as I said where witnesses do not
18 wish to apply for anonymity. Where witnesses do not
19 wish to apply for anonymity sensitive passages of the
20 materials relating to them will be put to them for their
21 views of possible redaction of them as well as their
22 right as material providers or interested parties in the
23 contents of the material.
24 Sir, as far as the preparations going forward are
25 concerned as part of the preparations for the Section 1

1 hearings organisations or some selected individuals
2 which were thought to hold relevant documents were
3 issued with requests for them. Some were issued by way
4 of Section 21 notice given the sensitivity of the
5 material which it was anticipated they would contain.
6 Where it was thought that the documents held by any
7 recipient would be of a relatively small scale those
8 organisations were in fact asked for all the documents
9 they hold relating to the Inquiry's Terms of Reference.
10 Examples of organisations falling into that category
11 were NHS Education for Scotland and Healthcare
12 Improvement Scotland.
13 Where it was thought that these documents would be
14 more numerous or where the types of documents held were
15 not yet well-known by the Inquiry, the Inquiry issued
16 more specific requests for documents of a more specific
17 nature relating to the matters to be covered in
18 Section 1 only. Examples of organisations falling into
19 that category NHS Tayside, Police Scotland and the BBC.
20 After these hearings the Inquiry will issue wider
21 documentary Rule 8s seeking documents more generally
22 relating to the full ambit of the Inquiry as appropriate
23 to an organisation or individual's involvement in the
24 subject matter with which we are concerned. These will
25 be processed and assessed as above, a process which the

1 Inquiry anticipates will take a longer period of time to
2 do due to its likely volume and potentially the
3 sensitivity issues which may be associated with some of
4 the documents.
5 Sir, to move then to our planning beyond
6 December 2026.
7 It remains the position that the section in
8 connection with which we are to hear evidence this month
9 will be an introductory one designed to try and help us
10 and those with an interest in our work to understand the
11 roles, structures and key milestones in the story
12 underpinning our remit. There's always been and remains
13 a section in which we seek to uncover the extent of the
14 disputes which lie within our Terms of Reference and try
15 to understand where the answers might lie beyond these
16 hearings to be looked at in more detail in later
17 sections of our evidential plan be it in documents or,
18 where documents do not exist, in the written and oral
19 testimony of those who live through the events on which
20 or focus is centred. A precise plan for where we go
21 next will depend on where we get to and that cannot be
22 known until the evidence laid over the next four weeks
23 has been heard and an opportunity has been taken to
24 reflect upon it.
25 It will for example be necessary for the Inquiry

1 team to reflect on what documents it has received, what
2 documents it has been told exist beyond the sets which
3 have been recovered to date and to formulate a plan as
4 to whether existing Rule 8 requests can be relied upon
5 with more extensive searches being required under their
6 terms or whether further, more wide-ranging or more
7 specific Rule 8 requests will need to be issued for
8 further documentation to be recovered. It will only be
9 in light of the recovery of those materials that we will
10 be able to plot a clear and detailed way forward. These
11 hearings should help us know where to look and what we
12 expect to find.
13 The progress made as a result of the section 1
14 investigations to date and the changed circumstances
15 resulting from the impediments to progress in Section 2
16 which I have already outlined have, however, led to us
17 slightly altering our Section 2 plans. Further given the
18 change in the planning for the Section 2 hearings which
19 I have already set out there is a need in my submission
20 for core participants to be given an opportunity to
21 contribute to the details of those hearings which will
22 involve evidence of the ICR neurosurgical output being
23 examined by the Inquiry. We have currently planned
24 an evidence session for May 2027 to hear that evidence.
25 Therefore, as a result of these two components of our

1 work on which we feel that contributions would be of
2 benefit, we have sketched out the following working
3 plan.
4 Details of what precisely will be required will be
5 provided in due course but as clarity, transparency and
6 advance notice are always aspired to and I know are
7 appreciated, in particular by my professional colleagues
8 but also by others, it is hoped that the following broad
9 plan will be of value.
10 It is intended that considerable efforts will be
11 required all round to prepare for the Section 2
12 patient-focused hearings which will now take place
13 in December. Though that will involve all participants
14 to an extent it will be a particularly busy time for those
15 who represent witnesses whom we plan to call to give
16 evidence at those hearings,
17 particularly in the firm of Levy & McRae and their
18 instructed counsel and those witnesses themselves. It
19 would not be reasonable to expect that group to be doing
20 more than focusing on that important work for the rest
21 of 2026.
22 The focus then becomes on 2027 and what is planned
23 for then. The broad plan is as follows. The Inquiry
24 plans to hold a procedural hearing in mid-March 2027.
25 Core participants will be called upon to make a written

1 submission to the Inquiry in advance of the hearing.
2 The details of the precise dates and the content of
3 those submissions will be clarified in due course. For
4 planning purposes the dates of Thursday and Friday, 11
5 and 12 March 2027 have been provisionally booked.
6 The purpose of the hearing and the written and oral
7 submissions will be twofold. In the first place core
8 participants will be asked to address the Inquiry in
9 writing and orally about the evidence which has been
10 gathered, led and shared with them in Section 1 for the
11 purpose of identifying what investigations they say
12 should be undertaken by the Inquiry in the more detailed
13 sections which are to follow. Which witnesses should be
14 contacted for Rule 8s. Which further documents should
15 be sought. Which other organisations should be
16 contacted for statements or evidence in light of the
17 framework which Section 1 of the evidential plan will
18 hopefully by then have created.
19 Core participants will not be being asked to provide
20 a final submission containing their analysis of the
21 evidence which will have been gathered to date but
22 proposals based on that evidence as to what should
23 happen next within the broad evidential framework which
24 the Inquiry has already announced. As I say, a more
25 detailed list of matters to be addressed such as the one

1 which was circulated to core participants in the advance
2 of the opening statement hearing last November will be
3 provided at the appropriate moment but this is the
4 general direction of travel.
5 It may be that the opportunity will be taken by core
6 participants in that submission to address written
7 material which has or will be disclosed to them by that
8 time which is not the focus of these evidential
9 hearings. As I have said, some evidence has been
10 gathered from certain bodies which provides context to
11 our work whether in the form of organisational
12 information, such as from the HSE or BMA, or other
13 bodies which have been or are conducting investigations
14 relating to the professional practices of Mr Eljamel,
15 which are not themselves the subject of the Inquiry's
16 investigations which may provide a useful base for
17 forward planning within the Inquiry. As I have said,
18 examples of such bodies are the BBC and Police Scotland.
19 I mention these as I know that some core participant
20 groups questioned why and what we wanted them to do with
21 that material. The answer is to analyse the material to
22 the extent you wish for question in these hearings but
23 also for the purpose of these later submissions.
24 The second purpose of the contemplated March
25 procedural hearing will be to address what core

1 participants propose should be the format of the
2 hearings in May, which as I have said will form the
3 second part of the Section 2 hearings of which the
4 Inquiry will consider, to the extent the Chair
5 ultimately considers appropriate, neurosurgical evidence
6 which will by then have emanated from the ICR. In order
7 to inform the decision-making around the preparation for
8 that hearing, the Inquiry intends to disclose to core
9 participants gradually over January and February
10 materials which will enable submissions to be formulated
11 about which witnesses should be considered to be called
12 to give evidence in that context and why. Those
13 submissions will then be able to be taken into account
14 in deciding the final format of the May hearings.
15 It follows logically from that intended hearing
16 in March that the precise format of the hearings in May
17 must remain up in the air until those submissions are
18 heard. It may be possible that at those hearings
19 evidence is only taken from Professor Wigmore about the
20 interim findings of the ICR process for which a Rule 8
21 request has already been issued or it may be that
22 evidence will need to be taken in the public interest
23 from others in connection with the work of the ICR most
24 notably the neurosurgeons or some of them who have
25 provided opinions to it. It is not currently

1 anticipated further evidence on issues relating to the
2 ICR will be heard from patients at that time not least
3 because they would already have made positions clear in
4 written applicant statements or in some case would be
5 continuing to do so as the ICR progresses or would have
6 been called at the evidence sessions which will be
7 dedicated to patient evidence in December of this year.
8 Given the uncertainties, the Inquiry has reserved
9 the hearing suite for the whole of May and more details
10 will be released after the March hearing about what
11 dates will be used for the ICR evidence sessions in
12 Section 2.
13 By way of reminder, in section 3 the Inquiry will
14 hear evidence from medical professionals. In section 4
15 the focus will be on evidence from other organisations
16 not covered in section 5. Section 5 will focus on
17 NHS Tayside and the Scottish Government and section 6 we
18 will focus on recommendations.
19 Again, beyond the plans I have already announced the
20 timings of the hearings in Section 3 shall be focused on
21 the evidence of medical professionals. It's hard to
22 predict with any precision. It will of course depend on
23 the submissions made by the core participants at the
24 planned procedural hearing in March. The experience of
25 Section 1 has shown even though clear deadlines are set

1 by the Inquiry they can sometimes not be adhered to
2 often due to draft statements or materials not produced
3 with sufficient quality by the deadlines necessitating
4 a more prolonged second drafting period than should have
5 been required and elongating the process. Rule 8s need
6 to be prepared which are fair but probing, precise but
7 not long-winded, if they are to serve their purpose.
8 When documents become evidence to the Inquiry it
9 requires to undergo lengthy but necessary processes of
10 review for disclosure and ultimate publication. These
11 are inherently time-consuming.
12 It is anticipated that evidence will be sought from
13 a wide range of medical professionals in Section 3 such
14 that a significant amount of time will be taken for these
15 processes. These inevitable labours are all part of
16 undertaking an investigation of this scale and dare
17 I say importance. Within the Inquiry structures and
18 processes have been devised to seek to minimise delay
19 but ensure substantive process such as having teams
20 which work ahead for future sections of the plan while
21 an earlier section is going on. The Inquiry constantly
22 reviews and refines its processes and operations to
23 maximise efficiency. Operational plans are regularly
24 updated to adapt to difficult or unforeseen
25 eventualities. The Inquiry remains, however, reliant on

1 those who have evidence to provide adhering to its
2 deadlines and providing what has been requested or
3 demanded to the desired quality. This does not happen
4 at times with significant results as far as planning is
5 concerned. The support provided by the Scottish
6 Government in connection with recruitment and other
7 logistics remains slow, a feature of our requirement to
8 rely on the systems of a large organisation when we
9 strive to be a small and nimble operation.
10 Slower than anticipated progress in the ICR to which
11 I have alluded has resulted in significant need for the
12 Section 2 operation for whom there are other operational
13 plans to remain committed to that section for around
14 six months longer than had been planned. That too has
15 had and will have a significant effect on our planning.
16 Despite these vicissitudes we remain committed not
17 only to striking the best possible balance between speed
18 and reasonable thoroughness, to which you have committed
19 us, sir, but also to our principles, including clarity,
20 honesty and cooperation. Our planning remains
21 orientated towards having Section 3 hearings in late
22 2027; November is currently earmarked for that purpose.
23 We will keep our core participants and the public aware
24 of our progress as ever and the achievability of that
25 aim.

1 Sir, to turn now to some other important
2 developments in our work.
3 As explained at previous procedural hearings the
4 Inquiry has undertaken a consultation exercise as
5 a means of creating an evidence base for its
6 trauma-informed policy which sets out the Inquiry's
7 practical approach to the way in which it intends to
8 honour its commitment to be trauma-informed, one of our
9 fundamental principles. As a result of that
10 consultation exercise the Inquiry has now published on
11 its website a statement of its approach being
12 trauma-informed for the consideration of those who have
13 an interest in contents. Given the importance of that
14 development I have a few things to say about the
15 Inquiry's intended and now published approach.
16 Sir, there is no existing model for making a public
17 inquiry trauma-informed. In fact we have been told and
18 have discovered in our consultation process and have
19 accepted that for a trauma-informed policy to be
20 effective it must be responsive to the particular trauma
21 experienced by the people engaging with a particular
22 process. That is why we have aimed and continue to
23 intend to deliver a bespoke approach for our
24 trauma-informed public inquiry. That is why we
25 undertook the public consultation exercise and those who

1 wished to participate in it who had direct involvement and
2 interest in the subject matter of this Inquiry were
3 consulted, as opposed to relying solely on information
4 arising from other related, though possibly different,
5 contexts.
6 Thus our response is and will be based on the four
7 core lessons which have emerged from the consultation,
8 namely complexity and unfamiliar process can overwhelm
9 participants who have had traumatic experiences. Roles
10 and responsibilities require clear explanation.
11 Trauma-informed principles are interconnected. Safety
12 relies on trust, trust relies on collaboration and
13 choice and all depend on independence and clarity. And
14 finally, participants strongly value being heard.
15 Former patients want the Inquiry to understand their
16 experiences without requiring repeated retelling of
17 traumatic events.
18 Our policy, sir, is built on the definition of
19 "trauma" that it is in response to extreme or intense
20 experience which is frightening or distressing to the
21 person involved particularly if it is overwhelming,
22 difficult to cope with or feels out of their control.
23 It is derived from the evidence base to which we have
24 paid attention that such traumatic experience has the
25 potential significantly to affect the way in which the

1 traumatised individual interacts with the rest of the
2 world. In our sphere such interaction includes
3 interaction with the Inquiry as a core participant, as
4 a witness, as a provider of information or material, or
5 otherwise.
6 Thus the focus of the starting point of our policy
7 is on those who have suffered trauma of this nature. It
8 is people who have had such experiences whom our policy
9 is designed to help, with a view to listening to them
10 and taking steps to maximise the value to them and to us
11 of their interaction with, connection to, experience of
12 and role in the Inquiry. Our policy also makes clear
13 that though others may have suffered trauma of this
14 nature it will be assumed that patients who assert that
15 they have, have indeed been affected by such past
16 trauma. We will not seek to interrogate those
17 individuals or have them vouch for their trauma. They
18 will be believed and they will be treated as set out in
19 the policy.
20 This approach to being trauma-informed does not mean
21 that the Inquiry does not acknowledge that being
22 involved in an Inquiry in any capacity be in itself
23 an unsettling and difficult experience, for many it may
24 be. Those people deserve to be treated with courtesy
25 and respect and have their experience of the Inquiry be

1 no more disturbing or unsettling than need be. They
2 will be.
3 It is not, however, with such individuals that the
4 trauma-informed policy and the putting of it into
5 practice is concerned. To have a trauma-informed policy
6 which did not recognise that trauma is something more,
7 something more impactful and more long lasting would be
8 to have a policy which was not sufficiently tailored to
9 those who need to have such a policy the most.
10 As I have set out before, the principles upon which
11 the policy is based will be safety, trustworthiness,
12 choice, collaboration and empowerment. However, the
13 statement of approach goes further than principles,
14 important though they are to the way we intend to work,
15 it also proposes practical steps which we intend to take
16 to help counteract aspects of the effects of trauma
17 which have been identified to us in our consultation
18 process. Those steps also seek to avoid retraumatising
19 individuals who have suffered trauma and to avoid
20 undermining any efforts they are already taking, to seek
21 to alleviate or address the impacts of trauma on them.
22 These will include information being shared about
23 the work of the Inquiry in a regular written
24 communication to which recipients are free to sign up as
25 they wish, sent directly to those who wish to receive

1 it. This information will update people on the progress
2 of the Inquiry or lack of it for any reason but will
3 also seek to justify what we have done, are doing,
4 or will do, and seeks to respect and promote our
5 trauma-informed principles. Other initiatives the
6 Inquiry already has in place are set out in the
7 statement of approach.
8 These initiatives include ensuring that support
9 mechanisms which the Inquiry has put in place and which
10 I outlined at our procedural hearing in May and details
11 which are available on our website continue to be
12 available and to be effective. Support is available
13 from representatives of Spark, the Scottish-based
14 charity which provides counselling and mental health
15 support for individuals, couples, families, children and
16 young people, which has provided such services for 60 years.
17 Information about the support services which can be
18 obtained can be found on the Inquiry's support hub,
19 a new dedicated section on the Inquiry website. Such
20 support is provided in two forms: emotional support and
21 participant support.
22 Emotional support is available to all those who need
23 it during hearings such as these, including virtual
24 hearings, though in person at in-person hearings.
25 Trained counsellors can be accessed online or in person

1 to deal with the immediate emotional reactions to
2 involvement in the Inquiry's hearings. Participant
3 support is available for a wider range of situations
4 including witness support but also other support for
5 participants. It will involve a number of support
6 sessions being made available at times when they may be
7 needed. It can be accessed via details on the website
8 or via our Inquiry phone line. The Inquiry's witness
9 liaison manager, Tracy Millar, an experienced
10 professional from the charitable sector who is and will be
11 in charge of directing people to the most appropriate
12 support mechanism for them.
13 Our approach to being trauma-informed will be one
14 which listens, adapts and evolves. The next step
15 towards that aim will be a further consultation which
16 will be launched after these hearings into the nature
17 and form of direct contact which those who have suffered
18 trauma would like the Inquiry to have with them beyond
19 efforts which were already made in this regard as are
20 already set out in the statement of approach.
21 It is contemplated that meetings between members of
22 the Inquiry team and those who wish to participate in
23 them to keep individuals informed, answer their
24 questions and interact with them in an appropriate and
25 helpful way will be part of the plan going forward.

1 However, precisely what this interaction should involve
2 is a matter on which we wish those who have suffered
3 trauma to express a view. We wish to listen as we have
4 done to this point and to tailor such meetings to what
5 precisely is needed and what realistically can be
6 delivered.
7 We are fortunate this work continues to be led by
8 the Inquiry's Deputy Secretary, Dan Farthing, who has
9 many years of experience of working with, promoting the
10 interest of and advocating for a wide range of
11 traumatised individuals in the charitable sector. His
12 efforts are supported directly by the Chair and other
13 members of the Inquiry's senior team, not least myself.
14 Sir, under Dan's expert direction in this area we remain
15 committed to making this Inquiry work for traumatised
16 people. That commitment is real. Informed by
17 consultation with our traumatised participants, built on
18 believing them, respecting them and accepting the
19 profound effects of their trauma and their ability to
20 engage with this Inquiry as a result. That commitment
21 will not diminish.
22 Sir, I have set out in previous hearings ongoing
23 issues that we have had with our engagement with
24 Scottish Government other than those relating to the
25 fire safety of this building. Needless to say a number

1 of those issues relating in particular to the
2 recruitment of appropriate staff for the Inquiry, your
3 reasonable requirement, sir, for those interacting with
4 the Inquiry to sign confidentiality undertakings and the
5 still unsigned management agreement between this Inquiry
6 and the Scottish Ministers are still outstanding. It is
7 hoped that those are matters which will be addressed by
8 the Scottish Ministers responsible for sponsoring this
9 Inquiry in early course.
10 Sir, as you have alluded to in your opening speech
11 I already set out the direction of travel as regards our
12 evidence gathering at previous hearings and in addition
13 a call to provide evidence or information about how that
14 could be done is to be found at paragraph 24 of the
15 Inquiry's approach to evidence and written statements.
16 That request and that information has been heeded by
17 some individuals who have got in touch with the Inquiry
18 with information about their involvement. However, as
19 we start to move towards the more detailed investigation
20 which will be involved in Section 3 and beyond I wish to
21 use this opportunity to issue a further, clear and
22 unequivocal public call for evidence as we plan or move
23 beyond the first two sections.
24 As we move beyond the evidence of the patient group
25 on which we will focus on in December and in our

1 continued oversight, input to, and analysis of patient
2 evidence emerging from the ICR which will continue as
3 I have said, I wish to invite any medical professionals,
4 current or former employees of organisations with
5 an interest in our work including NHS Tayside or the
6 Scottish Government, to make contact with the Inquiry
7 directly to explain what evidence they feel they can
8 offer relating to any matter falling within our Terms of
9 Reference or a more detailed List of Issues.
10 Though we will continue to do what we can to
11 identify and approach those whom we think may have
12 evidence to give, we are open to being approached by
13 such individuals. Some such individuals, as I say, have
14 already contacted the Inquiry directly. We wish to make
15 clear to others who may have stories to tell that, as
16 with all those with whom the Inquiry comes into contact,
17 they will be treated with courtesy and respect. Those
18 who may have something to add may have documents to
19 provide or simply recollections or views about matters
20 with which we are concerned. All are welcome and all
21 are encouraged to get in touch via any of the channels
22 available, which are carefully set out on the Inquiry's
23 website, www.eljamelinquiry.scot.
24 Though that is an open-ended invitation, I would
25 like to extend that call for evidence in particular at

1 this stage to those medical professionals who had
2 an involvement in the work of Mr Eljamel and who feel
3 that they may have something to contribute. They may be
4 other neurosurgeons or doctors or surgeons involved in
5 associated medical disciplines linked to Mr Eljamel's
6 work, such as but not limited to radiology, neurology or
7 anaesthesia. They may have been contemporaries or
8 subordinates. They may be nurses or other staff who
9 worked with him or had knowledge of his work either at
10 a hospital or somewhere else, like in the University of
11 Dundee. They may include medical professionals who were
12 involved in investigations into him or who made
13 complaints, raised concerns or provided feedback about
14 him. Any such individual who may wish to contact the
15 Inquiry can be assured that their approach will be
16 treated confidentially and professionally.
17 You are committed, sir, to accept evidence from such
18 individuals anonymously if appropriate to protect the
19 individuals concerned. As I have stated the Inquiry's
20 entirely prepared to deal sensitively and respectfully
21 with individuals who suffered trauma as a result of their
22 experiences or be otherwise apprehensive about
23 interacting with us. We are flexible about the way that
24 evidence can be provided to us or gathered by us, we can
25 help with finding ways of evidence being provided in the

1 way that suits the individual, for example by providing
2 oral evidence remotely and/or anonymously. Our
3 emotional support services are available to these
4 individuals as well. We are committed to our staff
5 upholding all of the principles to which I have referred
6 and upon which the Inquiry is based.
7 Equally the Inquiry is keen to hear from those with
8 an interest in surgery, in particular those who have
9 perspectives on how things may be improved for the
10 betterment of patient care in that field of practice
11 which gives rise to certain issues, considerations,
12 requirements and responsibilities which apply in
13 particular to it. We remain committed to inclusivity,
14 open-mindedness and going where the evidence takes us.
15 You do not need to wait to be contacted by us,
16 proactively contact us through our witness liaison
17 manager or the legal inbox. Witness engagement
18 initiatives are already being put together as part of
19 our investigations but we also welcome contact in this
20 way.
21 It should be stressed that it's not necessary for
22 an individual or organisation to be a core participant
23 in order to provide information or evidence to the
24 Inquiry. Many individuals and organisations beyond the
25 core participants will have relevant information to

1 provide in relation to the matters we are looking at.
2 There are many things that we do not know. We cannot
3 know unless those who were there and have recollections
4 about what happened and views of them shared with
5 us. We have power to investigate and to compel but do
6 not assume that we know everything. We have not
7 prejudged, it would be quite wrong for us to have done
8 so absent evidence. We will go where the evidence takes
9 us but we need evidence to move forward.
10 Like us, many who have evidence to provide will,
11 I am sure, have a commitment to the betterment of health
12 services in this country, in particular in the field of
13 surgery. It is only through wide engagement and careful
14 and meticulous evidence gathering that we will achieve
15 this important aim. If you have evidence to provide
16 please get in touch.
17 Sir, I have a few closing observations to make at
18 this stage.
19 Even though this section of the Inquiry is
20 introductory, there is a significant risk that the
21 evidence which will be heard will be difficult and
22 traumatic for some. For those who may require it in any
23 way, they will find support and assistance from your
24 dedicated team led by Natalie Smith, the Secretary to
25 the Inquiry and Dan Farthing the Deputy Secretary. They

1 and their team will be on hand to offer support and
2 assistance at any time. Equally, as I have explained,
3 emotional support from the Spark team will also be
4 available.
5 In addition, a room has been made available in the
6 hearing suite for the use of the patient core
7 participant group and their recognised legal
8 representatives as they are the biggest group and also
9 a separate room for NHS Tayside and their legal
10 representatives as they have the most witnesses to
11 represent, as I have set out already.
12 Rooms will be available for witnesses each day where
13 they can meet with their legal representatives and with
14 the Inquiry team. Other rooms can be made available to
15 other teams. If they require them they can be booked
16 with the Inquiry secretariat team. The Inquiry legal
17 team, under the stewardship of Lynn Carey will also be
18 on hand to handle questions or queries more
19 appropriately directed to them.
20 Sir, against that background I repeat the Inquiry's
21 expectations that its work, including the proceedings of
22 these hearings, will be conducted in a spirit of
23 dignity, courtesy and respect. As I've set out in some
24 detail, sir, our organisational participants all pledged
25 in their opening statements and in other written and

1 oral submissions made at, or in connection with, the
2 Inquiry's three previous procedural hearings that they
3 would support the Inquiry's work and respect this
4 approach. They will be expected to do so and witnesses
5 who will come and give evidence, some from those
6 organisations, also deserve to be treated with the same
7 courtesy and respect. I have every confidence that all
8 those who participate in our work will adhere to these
9 important considerations.
10 Sir, you do not expect this Inquiry to be a forum
11 for grandstanding or protest, you expect it to be
12 a forum in which the aims of this process to which all
13 participants have pledged their commitment will be
14 achieved. As such you expect this to be a forum in
15 which all voices are heard and all willing participants
16 are given an opportunity to contribute. It is in that
17 spirit and in that expectation that it is a joint
18 endeavour in which we are all engaged that these
19 hearings will proceed.
20 At the first of the Inquiry's public hearings
21 in September 2025 I explained that this Inquiry had
22 a number of key themes. These themes remain at the
23 centre of what we are seeking to achieve and run through
24 all that we do. They bear repeating at this stage as we
25 turn to examining witnesses in public about them.

1 This Inquiry is concerned with patient care. Where
2 that goal has been lost sight of, forgotten or
3 undermined, where it has been neglected or diminished
4 either in medical care or by corporate action or
5 inaction, this Inquiry will seek to find out why.
6 These hearings are the starting point of that
7 journey. Though it will be at the hearings in December
8 that we will turn to hear oral evidence from patients,
9 as I have outlined at these hearings, patient safety
10 will be a focus not least in the evidence to be heard
11 from Liz Smith and the Patient Safety Commissioner but
12 also in expert evidence which will focus on how patient
13 safety can be kept paramount in healthcare systems.
14 This Inquiry is built on an understanding of the
15 importance of trust, trust in any emanation of the state
16 but those parts which are responsible for healthcare in
17 particular. It is about when and how trust has been
18 undermined and lost, how that loss of trust has
19 manifested itself, whether and how it has been addressed
20 and how harm may have been compounded when it has not
21 been. These hearings, sir, have been built around the
22 Inquiry seeking to foster trust amongst those who will
23 participate in them. They will also be an opportunity
24 to examine the importance of trust and will examine
25 instances where, even in recent times, it appears to

1 have been lost.
2 This Inquiry's main area of investigation is in the
3 field of surgery, a theme which was emphasised on behalf
4 of the patient group by Ms Cherry KC in her opening
5 statement. In the field of surgery it might be said the
6 requirements of patient care and trust are at a premium.
7 Situations where surgical intervention is contemplated
8 or undertaken are, by their nature, situations of
9 extreme complexity, severity and vulnerability.
10 Considerations of respect, dignity and humanity are thus
11 paramount both from those involved in the surgery and
12 those involved when things go wrong. These themes will
13 be part of the evidence led from our neurosurgery and
14 medical ethics expert groups from whom we will hear at
15 these hearings.
16 This Inquiry is concerned, sir, with the importance
17 of communication. Communication is at the heart of good
18 patient care and in particular in the surgical field
19 before, during and after the surgery and where things
20 appear to have gone wrong. Communication is about truth
21 and the effective communication of it, both of which
22 patients deserve. The Inquiry requires to look at the
23 adequacy and candour of communication often with
24 vulnerable, distressed and harmed patients both in the
25 operative sphere and from and with the corporate

1 structures around it. It is about the maintenance of
2 ability to communicate the truth, by the maintenance of
3 records to be able to do so. It is also, sir, about the
4 way in which these structures and organisations whose
5 ultimate aim it is to promote good patient care
6 communicate internally and with each other. Again, at
7 these hearings communication will be a prevalent theme
8 not least in the evidence of the medical ethics group.
9 Sir, this Inquiry is about the need for people and
10 organisations to take responsibility. Our National
11 Health Service owes a legal and moral duty to patients
12 in its care beyond the more immediate duties or by
13 treating medical professionals. When patients go to
14 hospital they reasonably expect they will be protected
15 by a system beyond the individuals normally in charge of
16 their care. That responsibility will extend to
17 other professionals, the health board and other bodies
18 with responsibilities in that regard accorded to them by
19 law.
20 The Inquiry will look at the whole system whereby
21 health and well-being are meant to be promoted and
22 maintained and analyse whether that system was and is
23 fit for purpose. This hearing session has
24 responsibility at its core. Witnesses will include all
25 contributors to the NHS Tayside's Section 1 statement,

1 a senior representative of the Scottish Government and
2 senior representatives of numerous major organisations
3 who played or could have played a part in matters
4 falling within our Terms of Reference.
5 Sir, this Inquiry aims to be a part of achieving
6 improvement. The Inquiry has a forward-thinking
7 function to seek to make meaningful recommendations for
8 change so that aspects of medical, and in particular
9 surgical care, which have not worked well will work
10 better in future in the ultimate service of patient
11 care. At these hearings, though we are at the start of
12 our hearings process, we will have an eye to the future
13 and what might be done to make systems upon which
14 patients rely better and safer.
15 It is on the foundation of these themes, sir, and
16 the advice received from those with whom we consulted
17 that the Inquiry's bespoke principles of being
18 trauma-informed, open-minded, independent, to listening,
19 cooperation, clarity and thoroughness have been
20 constructed. Though, as is perhaps inevitable, hurdles
21 and impediments have been encountered along the way,
22 I said at the procedural hearing in May that we remain
23 committed to these principles and to the endorsement of
24 them provided by and on behalf of the patient body in
25 particular. I am proud to report, sir, that despite the

1 difficulties we have encountered this Inquiry has
2 maintained its focus on the fulfilment of its Terms of
3 Reference and its adherence to the principles which you
4 set out at the start of this process.
5 In addition, the investigation of its remit has been
6 carried out without fear of favour, facts being
7 investigated as fully as the current stage of our
8 progress will permit as well as fairly, as we were told
9 by the patient core participant group that it expected
10 us to do in its opening statement. It is on the basis
11 of these considerations and those principles that these
12 hearings will be conducted.
13 Thank you for your attention, sir, and for the
14 attention of those who are joining us here in person and
15 those who are joining us online. I would suggest that
16 we now break, sir, with a view to the Inquiry calling
17 its first witness in the afternoon session, beginning
18 around 2 pm. As is not uncommon with public inquiries,
19 there will no doubt be many issues which can be
20 canvassed and addressed so that all those in attendance
21 are comfortable and their needs catered for. The
22 Inquiry team stands ready to assist with any such
23 queries and we look forward to hearing the evidence of
24 Ms Liz Smith CBE this afternoon.
25 THE CHAIR: I'm grateful to you, Mr Dawson. Thank you very

1 much indeed. It's gone 1.10. We'll break now for
2 lunch. As you've just heard evidence will commence this
3 afternoon with the first witness in this hearing at
4 2 o'clock and I look forward to seeing you all then.
5 Thank you.
6 (1.14 pm)
7 (The short adjournment)
8 (2.07 pm)
9 THE CHAIR: Good afternoon. Please be seated. Mr Dawson.
10 MR DAWSON: Sir. Yes, the first witness is Liz Smith CBE.
11 THE CHAIR: Thank you, and you'll let me know when we reach
12 a suitable point for a break.
13 MR DAWSON: Of course.
14 MS LIZ SMITH CBE (sworn)
15 Questions by Counsel to the Inquiry: MR DAWSON
16 MR DAWSON: Good afternoon.
17 **A. Good afternoon, sir.**
18 Q. You are Liz Smith. If you could speak into the
19 microphone in front of you and try to keep your voice up
20 so that people can hear you around the room, that would
21 be extremely appreciated. You have received a Rule 8
22 request for evidence from the Inquiry?
23 **A. That's correct.**
24 Q. And the Rule 8 request asked you to provide a written
25 statement to the Inquiry and documents, is that right?

1 **A. That is correct, sir.**
2 Q. And you provided a witness statement to the Inquiry
3 which I think was dated 10 March 2026, is that right?
4 **A. That is also correct.**
5 Q. For the record the reference for that document is
6 G0001-00032. Could we have that statement up, please.
7 Is that your statement?
8 **A. Yes, sir, it is.**
9 Q. Could we go to page 14, please. That's the last page,
10 I think. Is that correct?
11 **A. That's correct.**
12 Q. And although it's blanked out for our purposes, you have
13 signed that, haven't you?
14 **A. I have.**
15 Q. And are the contents of that statement true as far as
16 you are aware?
17 **A. Yes, they are.**
18 Q. You helpfully tell us in your statement that by way of
19 educational background you have I think a joint honours
20 degree in economics and politics from the University of
21 Edinburgh from which you graduated in 1982?
22 **A. That is correct.**
23 Q. And you also hold a diploma in education from Moray
24 House College of Education, Edinburgh, which you
25 received from the following year?

1 **A. That is also correct.**
2 Q. And you have a professional background in teaching?
3 **A. Yes, correct.**
4 Q. And you tell us in your statement that after graduating
5 you taught economics and modern studies at a school in
6 Edinburgh between 1983 and 2001?
7 **A. That is also correct.**
8 Q. And within that employment you were assistant head of
9 department between 1989 and 2001?
10 **A. Those are the correct dates, yes.**
11 Q. I understand that you worked for a period as a policy
12 adviser to Sir Malcolm Rifkind, is that right?
13 **A. That's also correct, yes.**
14 Q. What period did that cover?
15 **A. Largely the period between me finishing my teaching**
16 **career and at the time when the Scottish Conservatives**
17 **had, let's say, not done terribly well in the election**
18 **and so Malcolm had lost his seat, I was an advisor**
19 **through my work in conservative central office.**
20 Q. And so what role did Sir Malcolm occupy at that time?
21 **A. Really having to look at the reasons in politics why the**
22 **Scottish Conservative Party had not done particularly**
23 **well in the election and he was asked by the then**
24 **chairman of the party to look at all aspects of policy**
25 **delivery and why perhaps that was not resonating with**

1 **the general public and I was asked to be the secretariat**
2 **to that policy review.**
3 Q. Understood, thank you. And we understand from your
4 statement that in May 2007 you yourself were elected as
5 a Member of the Scottish Parliament?
6 **A. That's 2007, yes.**
7 Q. In 2007. And you served in that position for 19 years?
8 **A. I did. I was stood down from the parliament at the most**
9 **recent election.**
10 Q. Indeed. And you are a Conservative MSP?
11 **A. Yes.**
12 Q. And I think that you were a regional member for
13 Mid-Scotland and Fife; is that correct?
14 **A. That is also correct, yes.**
15 Q. Could you tell us how you came to be a representative of
16 that geographical area in particular?
17 **A. I had a long-time interest, particularly in the**
18 **Perthshire angle of that, both from sort of sporting and**
19 **general interest in that part of the world and I'd been**
20 **born and brought up in Edinburgh, been at school in**
21 **Edinburgh, been at the University of Edinburgh as well**
22 **and I wanted to broaden my horizons because I felt there**
23 **were a lot of political issues in Mid-Scotland and Fife**
24 **that resonated a lot with my own interests and I was**
25 **lucky enough to be selected in a seat there.**

1 Q. Okay. And could you help us a little bit, one of the
2 things that sort of interest us is the geographical area
3 that's covered in terms of catchment of NHS Tayside and
4 the evidence that we have from other sources
5 suggests that NHS Tayside serves the population of the
6 Tayside region which encompasses the local authority
7 areas of Angus, Dundee City in Perth and Kinross, but
8 also that acute healthcare services are also delivered
9 by NHS Tayside or have been by other bodies in the past
10 relating to north east Fife. If you can, because
11 I'm sure these things are sometimes quite difficult to
12 do, tell us, to the extent to which the area that you
13 represented coincides with NHS Tayside's sphere of
14 operation, if you could?
15 **A. Largely it coincided but not entirely. As you've just**
16 **mentioned, it covered different local authorities and**
17 **part of the Angus constituency was not part of**
18 **Mid-Scotland and Fife, that was part of the north east**
19 **regional alliance in Holyrood. So largely speaking, the**
20 **constituents from Mid-Scotland and Fife who were coming**
21 **to me broadly speaking were ones who had an interest in**
22 **NHS Tayside and the services provided by it.**
23 Q. Right. And was that particularly the case in relation
24 to that aspect that I described which is to do with the
25 acute services, that it also provided it to the part of

1 Fife?
2 **A. Yes.**
3 Q. Yes and I think as we'll come on to find out, that was
4 an area -- a geographical area in which you had
5 a particular interest in relation to the Eljamel matter?
6 **A. That's correct.**
7 Q. Just reverting again to your CV. You told us you stood
8 down as an MSP at the election. I understand that
9 you're now working as a freelance education advisor, is
10 that correct?
11 **A. Yes, I am.**
12 Q. And that you've been appointed to the Court of the
13 University of St Andrews?
14 **A. Correct.**
15 Q. And that you're a patron of the Cricket Development
16 Trust (Scotland)?
17 **A. Correct.**
18 Q. I understand you played cricket for Scotland; is that
19 correct?
20 **A. I did. Don't ask me the scores.**
21 Q. And that you were awarded a CBE in 2024?
22 **A. Yes.**
23 Q. And was that in connection with your services to sport?
24 **A. It was, sir. It was largely I'd convened the**
25 **cross-party group on sport at Holyrood for a very long**

1 **period of time following the death of the late**
2 **Margo MacDonald and during that period of time I had**
3 **a lot of involvement in trying to widen access in the**
4 **sporting world and particularly for people with**
5 **disabilities and those who perhaps were not able to**
6 **access sporting facilities so I did a lot of work --**
7 **kind of the cross-party group at Holyrood was**
8 **a representative body for lots of different sporting**
9 **interests and what I tried to do was to involve some of**
10 **the more minority sports and I think I was quite**
11 **successful in doing that, and it was a great privilege**
12 **and a great pleasure to be the convenor of that group**
13 **and I was taken aback but nonetheless very delighted to**
14 **receive a CBE two years ago.**
15 Q. Thank you. Obviously we're keen on asking you questions
16 today about your long-standing representation of
17 patients who were former patients of Mr Eljamel, and in
18 doing so could I just point out a couple of aspects of
19 our approach to you.
20 As I highlighted in my opening address this morning
21 for various reasons we have taken the approach to these
22 hearings that where individual patient's names may
23 become involved we've decided to redact from the evidence,
24 not at all because we're not interested but because
25 we'll revert to a more specific analysis of their case at

1 a later date. There are, however, two individuals with
2 whom I think you have had some contact who I think it
3 will be almost impossible to conduct a hearing of this
4 nature without mentioning. They are Ms Jules Rose and
5 Mr Pat Kelly.
6 If I can ask your indulgence to try to avoid, in our
7 discussions, mentioning any other patients but feel free
8 to mention them as we have already had conversations
9 with them about them being happy that that should be the
10 case. The other thing I wanted to say to you is we're
11 very interested in trying to understand from you your
12 experiences as they have been relayed to you by patients
13 over the years to try to provide an important context
14 for our hearings, but you shouldn't take any of the
15 questions that I am asking you as in any way seeking to
16 replace or be deemed more important than the evidence of
17 patients themselves. It's useful to speak to someone
18 who has spoken to so many patients to try to give us
19 a flavour of their experiences, but to reiterate, we
20 will return to ask them directly in due course. So
21 again, don't be worried too much about the details which
22 we will get from the patients directly but your
23 testimony in that context is very useful to us.
24 Could we have a look, please, at paragraph 2.1 of
25 the statement, if we could have that up on the screen.

1 Thank you very much. You tell us there that:
2 "In my role as a Member of the Scottish Parliament
3 for Mid Scotland and Fife, my primary responsibility in
4 terms of Eljamel case work has been to represent
5 Mrs Jules Rose (resident in Kinross) but l have also
6 provided a great deal of advice to other former patients
7 and their families and, in several of these cases,
8 particularly those relating to Mr Pat Kelly, I have
9 worked with other MSPs, principally Mr Michael Marra MSP
10 and Mr Willie Rennie MSP."
11 THE CHAIR: Sorry, Mr Dawson, just before you pose
12 a question can I just check that everyone in the public
13 gallery and elsewhere can make out the text of what
14 we're reading? I think we may need to enhance
15 paragraph 2.1 please.
16 MR DAWSON: Yes. So the text that I've just read out is the
17 text that I'm going to ask you some questions about but
18 that's very helpful, sir. You mention there doing case
19 work for Ms Rose. What does "case work" mean generally
20 and in connection with what you did for Ms Rose?
21 **A. It's a parliamentary term that is used when**
22 **a constituent comes to you with a specific issue that**
23 **they would like you to investigate, and you have**
24 **an obligation, a responsibility as a member of**
25 **Parliament to ensure that you listen to all the points**

1 **and information that that constituent is putting in**
2 **front of you and if there is a concern or a complaint,**
3 **or in several cases concerns and complaints in plural,**
4 **then it is your job to go and find out exactly what**
5 **happened and that was my role in representing**
6 **Mrs Jules Rose but also representing some other**
7 **patients.**
8 Q. So you had a role then in trying to engage with them to
9 understand their experiences, their --
10 **A. I did.**
11 Q. -- views on things and what they wanted you to try and
12 achieve for them?
13 **A. Yes.**
14 Q. I understand Ms Rose is herself a former patient of
15 Mr Eljamel?
16 **A. Yes.**
17 Q. And she's also been a prominent campaigner on behalf of
18 a large number, I think, of other patients; is that
19 correct?
20 **A. That's absolutely correct and a very good campaigner.**
21 Q. Did your involvement generally or through Ms Rose lead
22 to you becoming involved with other patients?
23 **A. Yes, it did. I first heard about the Eljamel situation**
24 **way back in 2015 when my former colleague, the late**
25 **Alex Johnstone, had issued some comments in Parliament**

1 **on behalf of Mr Kelly at a time where he was doing**
2 **similar case work and he wanted some information. So**
3 **I was aware of the Eljamel situation but nothing like**
4 **the depth of information that I received from Mrs Rose**
5 **as a constituent. And the information that I then**
6 **received having gone into lots of different directions**
7 **thanks to Mrs Rose pointing me in the right direction,**
8 **I then picked up an awful lot of information about the case.**
9 Q. And you provide us with a list which is heavily redacted
10 in your statement of individuals I think on whose behalf
11 you campaigned you did this case work but also
12 a secondary list if you like of people who have been in
13 contact with you to thank you for your work or to
14 acknowledge it. Does that list represent an accurate
15 reflection of cases that you would say you know about or
16 is there a wider pool? And could you put a number on
17 the sort of number of patients whose experience to some
18 extent you have visibility of?
19 **A. In terms of the detail, both from a medical perspective**
20 **and also the interactions that they had with NHS Tayside and**
21 **with the Scottish Government and in some circumstances with**
22 **Police Scotland and other agencies, I would suggest to**
23 **you, sir, that there are probably five individuals from**
24 **whom I received a very considerable amount of detail**
25 **that allowed me to pursue quite a lot of aspects of this**

1 **case in very considerable detail. But I was picking up,**
2 **right throughout my time as a member for Mid-Scotland**
3 **and Fife from 2015 onwards, an awful lot of information**
4 **partly through what the media was presenting but also**
5 **from what I was hearing from other angles and people**
6 **would phone me up about and it I would get a sort of**
7 **reference to some of that as well.**
8 Q. There's an interesting aspect of what you just said that
9 interests us in the Inquiry because it's not just
10 about learning with the individual's clinical experience
11 and engagement with individual doctors or nurses but
12 their engagement with the wider systems of healthcare.
13 I think you mentioned NHS Tayside there. Was it a facet
14 of the patient experience with which you became familiar
15 that there were concerns being raised about their
16 clinical experiences, their experiences with healthcare
17 services more widely, or both?
18 **A. It's a bit of both, sir. I was reading some**
19 **extraordinary pieces of information that upset me**
20 **greatly about what was being alleged from a medical**
21 **angle. They upset me greatly and I found it difficult**
22 **to accept that that kind of situation could happen but**
23 **I was absolutely determined as a Member of the Scottish**
24 **Parliament that it was my job to help these patients who**
25 **had gone through incredible trauma both physically and**

1 **psychologically, and their families had too, that**
2 **I became exceptionally interested in this case because**
3 **it alarmed me, it appalled me. I was very upset to read**
4 **some of the documentation and I saw it as my moral**
5 **responsibility to ensure that I was going to represent**
6 **these patients because they were not getting the answers**
7 **that I felt and I'm sure they felt should have been**
8 **forthcoming from NHS Tayside and from the Scottish**
9 **Government and so I made it my business to put this case**
10 **work really at the top of my agenda.**
11 Q. Just so I understand the means by which you sought to
12 advance those issues and get those answers. You were
13 a Member of the Scottish Government and therefore able
14 to address questions to the Scottish Government?
15 **A. Yes.**
16 Q. And in your role as an MSP you had a responsibility to
17 scrutinise them, is that right?
18 **A. That's correct.**
19 Q. And the Scottish Government is ultimately responsible
20 for the delivery of NHS healthcare in Scotland?
21 **A. Yes.**
22 Q. Including NHS Tayside?
23 **A. Including NHS Tayside, yes.**
24 Q. So you felt, and no doubt those who contacted you felt,
25 that this would be a legitimate means by which to try to

1 get to their answers which I think you said they had
2 struggled to get through other means?
3 **A. Yes, that's correct. I'm not a medic and I was very**
4 **conscious that I was reading a lot of, firstly,**
5 **confidential private material that constituents had**
6 **chosen to allow me to see but I was also very conscious**
7 **that I was coming up against terminology and**
8 **descriptions of medical procedures that I had no**
9 **knowledge of and I had to go and find out a lot of**
10 **material to help in my understanding of exactly what had**
11 **gone on, but I thought, more importantly than that, was**
12 **to look at the procedures that had manifest themselves**
13 **within patients asking questions about why a lot of**
14 **malpractice had happened and why some aspects of the**
15 **surgery, in most cases, had been so appallingly**
16 **delivered and why the oversight of that and the**
17 **management procedures had, in my impression, completely**
18 **failed.**
19 Q. So just to unpack that a little bit. Your experience of
20 patients was that in the first instance they were
21 interested in finding out why their surgeries appeared
22 to have gone wrong?
23 **A. Mm-hmm.**
24 Q. But beyond that they were interested in trying to find
25 out whether there were other bodies who could have

1 played a role in trying to prevent that happening?
2 **A. Yes, that's correct, sir. There are two aspects to my**
3 **mind and this has been the case right throughout. There**
4 **is the case of the alleged medical malpractice of**
5 **Eljamel and obviously the clinical reviews are**
6 **overseeing a lot of the aspects of that. But there are**
7 **the systems management, or lack of management in many**
8 **cases, of why Eljamel had been allowed to continue**
9 **practising when quite clearly there had been very**
10 **deep-seated concerns raised at earlier stages and why**
11 **this had been allowed to happen and I was interested not**
12 **only in that but in the accountability. Somebody**
13 **somewhere must have known why this was allowed to happen**
14 **and I was interested in trying to help the patients to**
15 **find out the answers to that.**
16 Q. I think in your statement -- I'll get into this in
17 a moment -- you talk about learning about a particular
18 case in 2016 but you've mentioned in your evidence today
19 that what sparked your interest was in 2015. You've
20 explained what that is. Was it always a feature of the
21 patient's position in trying to get the answers that you
22 say that they sought that they were interested both in
23 getting answers to questions about their own clinical
24 experiences but also about that wider context of
25 oversight that you've talked about?

1 **A. Yes, I think I could safely say that in the case of all**
2 **the patients and constituents that I saw that there was**
3 **the medical malpractice. There was a horrendous pain**
4 **and suffering that they had had to endure and they want**
5 **answers it that, quite rightly. But the bigger picture**
6 **in this is not least because there are so many -- we now**
7 **know there are so many patients who are seeking these**
8 **answers -- there is the much wider question and I think**
9 **very substantial question about why on earth was this**
10 **allowed to happen?**
11 Q. Okay. Could I just ask about your preparation for
12 giving evidence today. Have you discussed your evidence
13 with some of the patients or their representatives whom
14 you act on behalf of?
15 **A. Well, I think throughout my whole time of looking**
16 **after this case, I had a very large amount of case work**
17 **and in the documentation that I submitted to the Inquiry**
18 **back on December 4th, a lot of the discussion had**
19 **already happened. In preparing for this session, I have**
20 **re-read many, many pages of that case work and gone back**
21 **over it. Have I spoken to a lot of the patients again?**
22 **I have spoken to some just to check things rather than**
23 **just to go back over and try to revise things because**
24 **the patients have been outstanding in giving me the**
25 **facts about the situations that they have had to face.**

1 **So I think -- I hope that I was quite well informed**
2 **about their situations right throughout, and my job as**
3 **a representative in Parliament was to ask the questions**
4 **of the agencies or NHS Tayside or the Scottish**
5 **Government to answer the questions that I thought were**
6 **standing out almost in all the evidence that I saw.**
7 Q. To be clear, Ms Smith, in case there's any doubt those
8 conversations either before your involvement in this
9 Inquiry or in connection with it were all done in your
10 capacity as their representative?
11 **A. Correct.**
12 Q. Understood, and I think you said that any conversations
13 that have taken place more recently have been on points
14 of detail?
15 **A. Yes.**
16 Q. Which I assume is to try and assist the Inquiry as best
17 you can?
18 **A. Absolutely and obviously the Inquiry has sought**
19 **confirmation of certain bits of paperwork since**
20 **early August and so I took time -- especially when the**
21 **documentation came through again, I took time to re-read**
22 **all the bits of case work that I've had and that was**
23 **very helpful actually in preparing for today.**
24 Q. Thank you. Could I ask a little bit -- you mentioned in
25 the passage that we looked at there that you formed

1 an association in your capacity as an MSP with, in
2 particular I think, two others, Michael Marra and
3 Willie Rennie. Now they are individuals who have
4 an association with the broad geographical area in
5 different capacities as I understand it but they are
6 also individuals who come from a different political
7 persuasion to you. Could you tell me how it was that
8 you joined forces, if I could put it that way, to try to
9 represent the constituents on whose behalf you were
10 speaking?
11 **A. Well, they were both representing constituents, as you**
12 **say, within the wider geographical context but party**
13 **politics didn't come into this at all. I have the**
14 **greatest respect for both Michael Marra and**
15 **Willie Rennie and I saw them as colleagues in the**
16 **Scottish Parliament who I knew were wanting to get to**
17 **exactly the same answers as I was and the more the**
18 **parliamentary debate went on the more I could see them**
19 **in action, asking many of the same questions that I was**
20 **and I felt that partly -- maybe because we were from**
21 **different political parties, I felt it was very powerful**
22 **several MSPs were coming forward with the same questions**
23 **of the Scottish Government and as time went on when**
24 **I felt -- I think we all felt we weren't getting the**
25 **necessary answers, it was actually very helpful that**

1 **there were three of us from different political parties**
2 **and I hope that had some credibility from the First**
3 **Minister and some of his ministers because of that but**
4 **you know that was our job. As I say party politics**
5 **didn't come into it at all.**
6 Q. Is that a common phenomenon in the Scottish Parliament?
7 **A. In some things but in others not at all.**
8 Q. I'm interested in that aspect of things, Ms Smith,
9 because if it is the case that is a rare-ish phenomenon
10 that that might be said to be an initiative from which
11 the Chair may be able to draw some conclusions. Now,
12 first of all as I think you've identified, my
13 understanding is that the other two represent sort of
14 different constituency, if I can use that word broadly.
15 Was it the case though that the questions that emanated
16 from their groups and the issues, was there a commonality in
17 that between what they had been told and what you had
18 been told?
19 **A. Yes, it was almost identical I have to say and we met**
20 **very regularly, particularly in the last three years.**
21 **Particularly when the public inquiry was first announced**
22 **we met very regularly and it was very evident I think to**
23 **all three of us that people we were representing were**
24 **asking exactly the same questions.**
25 THE CHAIR: Just to be clear, both the surgical aspect of it

1 and how it was led to happen aspect?
2 **A. That's correct, sir, yes.**
3 MR DAWSON: I mentioned a moment ago, Ms Smith, you tell us
4 in your statement that -- you told us that you became
5 aware of Eljamel related issues in 2015 but there was
6 a particular case that was brought to your attention in
7 2016, I think August of 2016. What was the context in
8 which that individual's case came to your attention?
9 **A. That member wrote to me from the Perthshire area and it**
10 **was a heart-rending letter that I received about**
11 **a family member's maltreatment and it was a very long**
12 **letter. And I had a couple of phone calls thereafter and**
13 **one of my assistants in parliament likewise dealt with**
14 **some of the aspects of that case, finding out more**
15 **information and it was really quite appalling what I was**
16 **led to believe had happened in the family member's**
17 **treatment and I dealt with that as best I could. It set**
18 **me off on trying to find out other things about the**
19 **Eljamel situation and it wasn't terribly long after that**
20 **where I realised that this was not an event on its own,**
21 **that there were other patients who were involved in**
22 **this -- what became a dreadful scandal.**
23 Q. And you've helpfully provided us with -- well, you've
24 provided us with a lot of documentation but in relation
25 to that particular case you managed to find the

1 documentation. Do you recall broadly what the clinical
2 circumstance of that case had been or we can go to the
3 document if you like, but it's as you say quite --
4 **A. Yes, I recall it vividly and it was obviously a case of**
5 **misdiagnosis alleged by the constituent who got in touch**
6 **with me about her father and the details about what**
7 **she was telling me were horrific and it was very**
8 **traumatic actually. I had a very difficult**
9 **conversation. Naturally she was very upset and I think**
10 **what came across to me was not just the appalling**
11 **treatment by Eljamel, but the fact that her whole family**
12 **had been turned upside down because of the failings and**
13 **the malpractice of Eljamel and it had a big effect on**
14 **that family and as I say it was a very traumatic**
15 **experience.**
16 Q. I think as you say, this was a case in which it was put
17 to you that Mr Eljamel had failed to diagnose a serious
18 condition in the individual concerned, is that right?
19 **A. Yes, that is correct.**
20 Q. And that certainly the letter that was written to you
21 suggested that on what might be described as relatively
22 cursory examination of the symptoms and the
23 presentation, the family member effectively was able to
24 recognise them almost immediately and so had been very
25 shocked that the diagnosis had been missed?

1 **A. That's absolutely true. I think she had looked into**
2 **various internet aspects of the symptoms that her father**
3 **was suffering and she came up with the accurate**
4 **diagnosis and it was quite clear that Eljamel had pushed**
5 **the whole thing aside and misdiagnosed and I think the**
6 **letter I received spells out all the dreadful material**
7 **thereafter.**
8 Q. I think just to get the sort of timescale though that
9 correspondence came to you in August 2016 that it was in
10 2012 that the alleged misdiagnosis or the missed
11 diagnosis had occurred, I think that's right?
12 **A. Yes. Yes.**
13 Q. And this letter goes on to tell us in some detail about
14 the fact that the patient, if you like, had been left
15 with permanent brain damage, is that right?
16 **A. Yes.**
17 Q. And that the assertion that was made by the relative who
18 spoke to you was that if this had been picked up, that
19 permanent brain damage could have been prevented?
20 **A. That's absolutely correct, yes.**
21 Q. I'm interested in looking at some particular aspects of
22 this letter which go beyond the clinical case into the
23 kind of area that you were telling us about. Could we
24 go to G0001-00002, please. I'm looking at page 5 of the
25 document, second paragraph of that. So we have there

1 a narrative. There's a narrative that comes before that
2 about the individual case and this passage starts to go
3 into some other areas and it says there in the second
4 paragraph that:
5 "We now have a copy of Dad's notes from NHS
6 Ninewells. Surprisingly it took 3 months for them to
7 'find' the notes as they '...had been misplaced'.
8 Alarmingly, there are 3 years missing AND there are no
9 notes of his detailing excruciating headaches (and I was
10 with him on occasion when he detailed this), nor upper
11 neck pain. Something is not right here and we are
12 seeking legal advice."
13 So I wanted to focus on that passage in particular,
14 Ms Smith, because there seems to be a suggestion
15 that in this very sad case that not only had there been
16 an alleged -- in fact the letter calls it
17 "non/misdiagnosis" because it's hard to describe exactly
18 what it is, but that there had been issues accessing the
19 medical records?
20 **A. Yes, and I think that paragraph that you've just read**
21 **out tells a dreadful story that it took three months for**
22 **them to find the notes or they might have been misplaced**
23 **and alarmingly, there are three years missing and there**
24 **are no notes of dealing with excruciating headaches.**
25 **I'm sorry this --**

1 Q. This was in 2016 at the latest?
2 **A. Yes.**
3 Q. And the treatment that we were talking about had only
4 been in 2012, so it's not as if you might have -- either
5 particularly historic or anything like that?
6 **A. No, there's just alarm bells ringing for me about the**
7 **overall lack of oversight of what was going on and**
8 **I'm sorry to say that this is an example of some of the**
9 **other --**
10 Q. This is precisely what I wanted to ask you next,
11 Ms Smith. This passage tells us, as well as the
12 circumstances of the individual case, about problems
13 with the accuracy of notes and the time taken to locate
14 notes, in particular in this case a significant period
15 of time of being apparently missing. I was very
16 interested to know whether this was a pattern or
17 a complaint both relating to the accuracy of medical
18 records and the time taken for people to be able to
19 access medical records that came up in other patient's
20 experiences that you learned about later?
21 **A. Yes, it did and it's particularly true I have to say for**
22 **the case of Mrs Rose and Mr Kelly for whom there is**
23 **a huge amount of documentation about things not being**
24 **properly documented and the delay in trying to access**
25 **some of the relevant notes. I'm sure we'll hear more**

1 **a little bit later on about just how difficult that was.**
2 **So, yes, I'm afraid this is a pattern and it was**
3 **a pattern with some of the other constituents with whom**
4 **I was dealing.**
5 Q. I'm interested in just expanding on that a little bit
6 further because one of the themes that seems to come
7 through from your statement is the extent to which the
8 harm suffered by patients in the clinical experience can
9 be compounded or worsened by the response of the state,
10 if I can put it as broadly as that, because that could
11 be Tayside or the government thereafter. Is that
12 a phenomenon you recognise in the Eljamel patients whose
13 cases you have experience of?
14 **A. Absolutely and I think it is probably one of the aspects**
15 **that frustrated and annoyed me the most, that I was**
16 **finding it incredibly difficult to get answers about**
17 **what I thought should be relatively simple questions and**
18 **patients were finding it very difficult to get to the**
19 **relevant notes and the accurate notes that I would have**
20 **thought should be there as a matter of course that in**
21 **particular when it's very difficult operations that are**
22 **being undertaken in difficult -- whether it's brain**
23 **surgery or spinal surgery, these notes should have been**
24 **immediately available and you know the documentation**
25 **that Mrs Rose gave to me -- and I had oversight of**

1 **Mr Kelly -- it's obviously appalling about some of the**
2 **things that were happening and the lack of the accurate**
3 **medical notes that they had a right to be able to see.**
4 **So I'm afraid, yes, it is a pattern.**
5 Q. So just to be clear, that passage was talking about
6 patient records and you mentioned that. You've also
7 emphasised the interest of patients to try to look
8 beyond that into the systems of oversight. Had patients
9 attempted, as far as you understood, to access documents
10 relating to that aspect of things, as well as their own
11 medical records?
12 **A. Well, yes, they had. In Mr Kelly's case he was seeking**
13 **information about what had happened in theatre and who**
14 **was present in theatre. Mrs Rose was largely doing**
15 **exactly the same thing, quite rightly so. She was**
16 **wanting information about what had happened,**
17 **particularly as she was obviously going to have a second**
18 **operation, and I think there was a pattern as well that**
19 **those patients were wanting that information because by**
20 **that time they knew that serious questions had been**
21 **raised about Eljamel continuing with his surgery and**
22 **medical practice and alarmingly, very alarmingly, those**
23 **who should have been having proper oversight of what was**
24 **going on during operations and the aftercare, it's quite**
25 **clear that that was not happening.**

1 Q. It's almost as if you know where I want to go Ms Smith
2 but this is exactly what I want to ask you next because
3 if one read on in this interesting letter from 2016, in
4 paragraph 3, what your correspondence says is that:
5 "My worry is that, it transpires, Eljamel had
6 accusations made against him from 2008. Why, on earth,
7 was this gentleman allowed to continue until 2013?
8 Ninewells have stated that my father did not receive the
9 care he should have done. My formal complaint was
10 admitted 6 weeks before the stories started to hit the
11 papers. We thought Dad was the only one to have been
12 permanently damaged. It is so upsetting to hear he
13 wasn't and there could be upwards of 140 people -and
14 those are the people who have a voice. How many people
15 died at his hands?
16 Eljamel has now handed his Licence to Practice back
17 to the GMC and can no longer carry out spinal surgery
18 nor neurosurgery. However, it has now come to light
19 that he has been attributing his education and
20 experience to institutes which are now refuting that he
21 completed training with them and are publicly distancing
22 themselves from him."
23 And it goes on to call for a public inquiry. Now,
24 I'm particularly interested, Ms Smith, in what
25 information you, either at this time, had or had

1 acquired in your extensive representation of these
2 patients later about what, as it's put here, accusations
3 had been made against Mr Eljamel from 2008 or indeed any
4 other time period?
5 **A. Yes, I think one of the most important things was the**
6 **review that was undertaken by the Royal College of**
7 **Surgeons where it was very clear indeed that some of the**
8 **independent analysis had grave reservations about some**
9 **of the medical actions of Eljamel. But there were also**
10 **other concerns that we were being pointed to by patients**
11 **whereby when they were quite clear about some specific**
12 **bits of information in medical notes that had been**
13 **given, they were quite sure that these were not correct**
14 **and their questions to NHS Tayside were not providing**
15 **them with the answers that would help them to understand**
16 **what had happened. So this was an ongoing process for**
17 **a very long period of time, I'm sad to say, whereby we**
18 **were not getting to the real information about what had**
19 **happened and why it had been allowed to happen when the**
20 **concerns had been raised that there was something wrong**
21 **within Eljamel and the department that he ran. That's**
22 **the big concern and yet he was allowed to continue in**
23 **his medical practice.**
24 Q. Understood. So part of the purpose of this section of
25 our Inquiry is to try to orientate ourselves and the

1 different timescales and that may provide an opportunity
2 for me to do so. The Royal College of Surgeons report
3 to which you're referring is one -- we'll come on to
4 examine that in more detail, I'm not going to ask you
5 about that today -- but it is one that was commissioned
6 and reported in 2013 and looked at aspects of
7 Mr Eljamel's practice. What I'm interested in is trying
8 to understand what evidence base there was of there
9 being more historic problems because this correspondence,
10 in the very difficult circumstances of her father's
11 case, has had not only that to deal with but has also
12 had exposure to information which appears to suggest
13 that this had been going on for a number of years. The
14 treatment here is in 2012 and the suggestion is that
15 this had been going on since 2008. What was it that you
16 learned or campaigners told you was the basis for their
17 understanding that something had been going on which was
18 harmful to patients or potentially harmful to patients
19 before the case that we are talking about here?
20 **A. I think it was a combination of some of the medical**
21 **notes that I saw and the fact that some of the**
22 **information did not tie up with what we had been told**
23 **had been documented officially. Plus I think the**
24 **questions I was asking of NHS Tayside at the time and**
25 **also of the Scottish Government but on a slightly**

1 **different line, when I asked for specific information**
2 **that this information should be released to the**
3 **patient -- because it was my understanding that the law**
4 **should allow that, and it wasn't forthcoming -- and**
5 **I think there are various aspects within my evidence**
6 **that I have provided where I think we can safely say**
7 **that on at least four or five occasions we had to ask**
8 **several times over for answers to the questions.**
9 **I think there's one piece of evidence, if my memory is**
10 **correct, whereby I think -- Jules Rose I think we had to**
11 **ask five times for evidence to be provided back to the**
12 **patient and if I may be allowed to say so, sir,**
13 **I thought it was very interesting two weeks ago when the**
14 **Information Commissioner David Hamilton produced his**
15 **criticism of NHS Tayside that they were not responding**
16 **to FOI material, I think that was part and parcel of**
17 **a lot of the difficulties that my patients -- sorry, my**
18 **constituents, they were at the same receiving end of**
19 **this as well.**
20 Q. But had been for a considerable period into the past?
21 **A. Exactly.**
22 Q. I understand. We'll get to that in a moment, Ms Smith,
23 but I wanted to ask you about -- if we can go back to
24 the statement now. Please take that one down and go
25 back to the statement, we're at paragraph 5.3 and 5.4.

1 So it says there, you tell us there in your statement:
2 "Several of the former patients also expressed very
3 considerable concern and anger about the alleged
4 cover-ups within NHS Tayside. These sometimes related
5 to the perceived silencing of whistleblowers when they
6 wanted to raise issues about the medical malpractice
7 they believed they had witnessed, often in the operating
8 theatre, the alleged bullying by Mr Eljamel of medical
9 staff who worked with him, and the alleged refusal of
10 senior managers to address the situation even after Mr
11 Eljamel had left the employment of NHS Tayside.
12 Some patients alleged that the Scottish Government
13 had not taken the relevant action required given its
14 statutory responsibility towards NHS boards. A number of
15 patients allege that, at times, the Scottish Government
16 and NHS Tayside have been guilty of collusion in order
17 to cover up the true facts. These concerns remain
18 current for some patients."
19 So packed into those two paragraphs a lot of
20 interesting lines of investigation. But first of all,
21 again trying to understand the reasons why patients told
22 you about these things and asked for your help, what
23 were the reasons or what was the evidence that led you
24 to understand that patients considered that there had
25 been a cover-up within NHS Tayside?

1 **A. Well, I think it started with the fact that many of the**
2 **patients found it very difficult to get access to their**
3 **information that would have helped them understand the**
4 **medical procedures that they'd had to undergo and more**
5 **importantly about the management procedures and the**
6 **oversight of Eljamel and those who were in his**
7 **department and we had Mr Kelly with his notes suggesting**
8 **that perhaps Eljamel was not actually in the operating**
9 **theatre at the time.**
10 **We had other allegations that perhaps some of the**
11 **people who had been allegedly assisting Eljamel were not**
12 **actually there throughout as they should have been. We**
13 **had some allegations that patients felt that NHS Tayside**
14 **had not responded to some complaints within the -- and**
15 **this comes out in the Royal College report -- had not**
16 **responded to some of the concerns that Mr Eljamel had**
17 **not been particularly caring about his staff or caring**
18 **about the patients and had taken himself off, some**
19 **allegations that he was preferring to go off and do some**
20 **private work and he was referring patients to do the**
21 **same, to get themselves on to a private register so he**
22 **didn't have to deal with them in NHS Tayside.**
23 **We had all that kind of allegation going on. But**
24 **these were allegations and I had to go and find out if**
25 **there was truth behind that. But I think those**

1 **whistleblowers who were quite clear in their mind that**
2 **there was something wrong in the Eljamel department. As**
3 **it transpired there were and I think the Royal College**
4 **of Surgeons report is pretty damning in its evidence in**
5 **that.**
6 Q. Okay. And the passages here that I have just read out
7 go further than that because they then start to talk
8 about -- so you've detailed all the various
9 NHS Tayside -- or a number of the NHS Tayside-related
10 issues but you've then gone to say there were
11 allegations made against the Scottish Government and
12 allegations made of collusion between NHS Tayside and
13 the government. What was the basis of the concern or
14 where did that come from?
15 **A. That we couldn't get to the answers. There were**
16 **allegations, and I stress that again, but we felt that**
17 **when it came to basic information that should have been**
18 **available in NHS Tayside, sometimes -- this happened to**
19 **me several times, as my documentation evidences. I was**
20 **pushed along to the Scottish Government. Scottish**
21 **Government will be able to answer that. Scottish**
22 **Government comes back: no, it's a matter for**
23 **NHS Tayside. And it was just this back and forth and we**
24 **could not get to the relevant answers and sometimes**
25 **patients had to use FOI information to try to address**

1 **that.**
2 **But there was this obfuscation the whole time and**
3 **sometimes this was taking months and you know it was**
4 **frustrating for me as a parliamentarian but it was even**
5 **more frustrating for the patients who were obviously**
6 **suffering very considerable trauma. Some of this was**
7 **going on for such a long period of time and it was**
8 **infuriating to keep asking the same questions and we**
9 **could not get to answers which I was very sure should**
10 **have been available. And I think David Hamilton's**
11 **comments a couple of weeks ago suggest that this was**
12 **quite a problem.**
13 Q. Okay, and you say you kept on asking the same questions
14 so I'll unpack that a little bit. Do you mean you were
15 asking the same questions on behalf of multiple patients
16 and/or were you asking the same questions on behalf of
17 a single patient because you weren't getting the
18 answers?
19 **A. In both cases, yes. And you know the documents I think**
20 **show that sometimes we had to go back and forth to ask**
21 **the same person: why have you not responded to this, why**
22 **have I been referred somewhere else? Somebody must have**
23 **the answer to this and it was just this back and forth**
24 **and it was actually very time-consuming but I wasn't**
25 **going to give up on my search for the relevant**

1 **information and neither were the patients, quite rightly**
2 **so.**
3 **We absolutely had to get to the right information**
4 **and there were sometimes I was beginning to ask myself:**
5 **am I asking the right question here? Because it's**
6 **possible that I wasn't, but I think I was and I was**
7 **encouraged by not just the patients but other**
8 **parliamentary colleagues who agreed with me the**
9 **information we were seeking was not forthcoming and**
10 **we had a duty to ask: why was that.**
11 Q. Perhaps summarise where we've got to so far. Very
12 interesting evidence. What you have here is a situation
13 where across the various patients whose cases you knew
14 about as well as those represented by others, Mr Marra,
15 Mr Rennie and others whom you've mentioned, there was
16 a multiplicity of patients all of whom had been former
17 patients of Mr Eljamel or their representatives of
18 course, like the lady whose letter we looked at and they
19 were all relaying broadly similar sorts of problems, is
20 that right?
21 **A. Yes, that is correct.**
22 Q. And then a number of those patients started to try to
23 find out the answers to the questions and the issues
24 that they had and that there was a broad picture of them
25 being met with what you've called obfuscation on the

1 part of NHS Tayside, is that right?
2 **A. Yes, that is correct.**
3 Q. Is it then the case that as they considered their
4 requests to be entirely legitimate and reasonable, that
5 the fact that there had been this obfuscation gave rise
6 on their part to concerns as to whether there might be
7 something going on that they didn't know about or that
8 NHS Tayside didn't want them to know about?
9 **A. I think it gave rise to suspicion as to why we weren't**
10 **being given the answers that we were seeking and that**
11 **suspicion -- especially as some of the delays that were**
12 **over quite a long period of time, that suspicion grew,**
13 **particularly amongst the patients who were having to**
14 **wait an awful long time for letters coming back, emails**
15 **coming back or parliamentary questions to be answered or**
16 **whatever it was. And that was a very frustrating time**
17 **because I don't think -- the investigative process which**
18 **should, in my opinion, have been much quicker, was just**
19 **causing more and more concern and I think it was feeding**
20 **the suspicion that nobody was wanting to be held**
21 **accountable for what actually happened.**
22 Q. So the suspicion was fed by the questions not being
23 answered, the amount of time that it took to get
24 a response and the accuracy of the information that was
25 provided at the end of the day if there was anything?

1 **A. That's correct, sir.**
2 Q. Thank you. And this, as I understand it -- please
3 correct me if I'm wrong -- is a process involving a lot
4 of people with similar issues and similar frustrations
5 at their attempt to sort out those issues that led to
6 what you've described in your statement as a -- you
7 described today as a suspicion?
8 **A. Yes.**
9 Q. But you've said in your statement a suspicion of
10 a cover-up by NHS Tayside, is that right?
11 **A. Yes, this suspicion was very strong and there was**
12 **a suspicion that things were being covered up because --**
13 **and I include myself in this -- I think there was**
14 **a growing belief that NHS Tayside must have known more**
15 **about what had happened in the oversight of Eljamel than**
16 **they were ever letting on and that was fuelled I think**
17 **by the fact that we have this quite long time period and**
18 **it was actually very distressing, very distressing for**
19 **the patients, but I think there was a feeling that**
20 **nobody really wanted to delve too deeply into this**
21 **because they knew that there was a substantial concern**
22 **and by this time there were far more patients who were**
23 **coming forward in the media to explain what they had**
24 **gone through and, you know, we now know the numbers that**
25 **are involved and I think that that suspicion that there**

1 **was some kind of cover-up going on was certainly growing**
2 **amongst the patients.**
3 Q. And then in the subsequent paragraph you extrapolate
4 this out to involve the Scottish Government and suggest
5 that some of the patients thought there was collusion
6 between NHS Tayside and them. Is that because when
7 patients and the likes of representatives like you tried
8 to get answers from NHS Tayside and didn't, as you
9 described earlier in your parliamentary role than of
10 others, efforts were made to turn to another agency
11 Scottish Government for responsibility in this area and
12 that similar problems were encountered?
13 **A. That's absolutely correct. The frustration was very**
14 **real because there were certain periods of occasions, which**
15 **again I have documented in my evidence, where we had**
16 **asked for very specific meetings with the health**
17 **minister of the time -- and there were various health**
18 **ministers involved throughout this case -- to meet with**
19 **the patients and could we get a date for this meeting?**
20 **It was put off and put off and put off and they would**
21 **have to go and inquire with NHS Tayside for some more**
22 **information. NHS Tayside sometimes gave some of the**
23 **information but not all of the information and it just**
24 **seemed to go on with this awful period of waiting and it**
25 **was tough getting time to see the minister, or**

1 **eventually the First Minister, to ask some of the very**
2 **basic questions which in my opinion should have been**
3 **answered long ago.**
4 Q. You mentioned in relation to Mr Kelly's case
5 specifically that he had been looking for information
6 I think particularly focused on whether Mr Eljamel had
7 been in the surgery that he had and also who else had
8 been there or not been there at the time, is that right?
9 **A. Yes, that is correct.**
10 Q. Do you know what a theatre logbook is?
11 **A. I do know what a -- I didn't before this case but I very**
12 **much know about logbooks now.**
13 Q. Is that the kind of document that you might expect to
14 contain the kind of information Mr Kelly was looking
15 for?
16 **A. It should contain it, yes.**
17 Q. Could I just ask you -- I'm very keen that we understand
18 at this stage of the Inquiry -- you've been very helpful
19 in giving us a flavour to the progress of the patients'
20 views and experiences, but one of the things I think
21 I don't want to lose sight of or I'm sure the Chair
22 doesn't want to lose sight of is the outcomes for some
23 patients. Can you give us -- you've already given us
24 some evidence about the potential for a compounding bad
25 clinical outcomes through the sorts of processes and

1 frustrations that you've experienced but as far as the
2 sort of clinical outcomes are concerned could you give
3 me a flavour of the sort of range of physical and mental
4 consequences that you have experienced in patients and
5 these are patients of course who are trying to find
6 answers to things?
7 **A. Yes, I mean there's a whole range of disability,**
8 **physical disability for a start. There are allegations**
9 **that some body parts -- the wrong body parts were**
10 **removed and the physical disabilities that have -- well,**
11 **they're with the patients for the rest of their lives,**
12 **as we know. And some of these disabilities are quite**
13 **horrific. People have lost their mobility, people have**
14 **lost all their means of being able to look after**
15 **themselves, some of them can't look after themselves**
16 **without carers. Some of them have been through the most**
17 **traumatic of physical disability, but there's also the**
18 **psychological problems and the effects on families, the**
19 **effect on their well-being, the effect on the fact that**
20 **they can't do the things that they used to be able to**
21 **do, that they can't go out, they can't drive in some**
22 **cases, they can't walk in some cases. The list is**
23 **endless I would suggest and that's what makes it all so**
24 **terrible.**
25 Q. And so it's important I think -- would you suggest that

1 the Chair of the Inquiry should bear in mind that the
2 frustrations, concerns, issues, questions, responses
3 that you have outlined as being at the core of the
4 experience of representing the patients in trying to get
5 answers, from their perspective also includes all of
6 those physical and psychological problems to start with?
7 **A. Yes, and also the fact that it's gone on for such a long**
8 **period of time when these answers were not forthcoming**
9 **and so the trauma that they have endured, particularly**
10 **from a psychological aspect, it's just never ending.**
11 Q. Okay, thank you. Can I ask you about another document
12 that you helpfully provided to us. This document is
13 G0001-00024. It will come up on the screen. I should
14 say for the sake of clarity, core participants will
15 already know this but you've provided to us, as we asked
16 you to, a very large body of material and a huge amount
17 of correspondence with lots of details of the sorts of
18 experiences patients had and sorts of things you did on
19 their behalf. If we were to try to go through anything
20 like that we'd be here for several weeks with just you,
21 Ms Smith. So I think that, as the Chair has already
22 indicated, is all evidence in the Inquiry but this is
23 a document which was of particular interest to us.
24 This document purports to be a CV of Mr Eljamel.
25 Can you tell us how you got this?

1 **A. Yes, I was provided by -- this document largely through**
2 **the efforts of Mr Pat Kelly and Mrs Jules Rose in**
3 **understanding what the background was to Sam Eljamel and**
4 **there was a bit of investigation on the internet and on**
5 **various medical journals to establish what his**
6 **background had been, and you know when you see a CV like**
7 **this which goes on for several pages, if I remember**
8 **correctly, you think: well, you know there must be**
9 **something very impressive about this medical expert, all**
10 **the books and pamphlets that he produced and the more we**
11 **sort of dug away in the background the more we found out**
12 **quite a lot.**
13 Q. Well, that's the sort of thing I'd like to ask in
14 relation to this document. Could we just very briefly
15 go to page 20 of this document. This comes at the end
16 of the curriculum vitae part of this bundle of documents
17 and we can see it's dated May 2009. Now if we go back
18 to the front page -- thanks Rory -- that's
19 a particularly interesting date --
20 **A. It is.**
21 Q. -- because if certain evidence of which we are aware is
22 ultimately to be accepted by the Chair -- of course it's
23 a matter for him to decide -- that date around about the
24 spring of 2009 might, on one interpretation of that
25 evidence, represent a time when Professor Eljamel or

1 Mr Eljamel's career started going in a different
2 direction to the one that you've described as being
3 represented in this very impressive CV. Based on your
4 experience is that a fair assessment? I know that
5 others may take different views about that, but --
6 **A. Yes, I think it is a fair assessment it certainly begs**
7 **various questions and we know that some aspects of the**
8 **CV that he said that he had various -- undertaken**
9 **various studies and medical practice in America, in**
10 **Connecticut et cetera and it turned out they denied all**
11 **that. So it begs a lot of questions about what is real**
12 **on this CV and what was alleged fabrication.**
13 Q. I mean, without needing to look at the -- I know you've
14 looked at the document before and the document will be
15 published and people can look at it but the document
16 contains a broad variety of high-level appointments on
17 Mr Eljamel's behalf; is that correct?
18 **A. Yes.**
19 Q. And it contains information about -- which goes on for
20 many pages -- about the sort of training and others he's
21 been involved in?
22 **A. Yes.**
23 Q. In various guises and that it contains a number of
24 references to publications he's been responsible for,
25 largely in the neurosurgical field?

1 **A. Mm-hmm.**
2 Q. And it contains information about a number of
3 professional bodies of which he is a part; is that
4 correct?
5 **A. That is correct.**
6 Q. And it contains references as well to committees that he
7 sat on to do with the governance of others, such as
8 clinical governance committees, is that right?
9 **A. Yes, that is correct.**
10 Q. It would seem to suggest as at May 2009 Mr Eljamel
11 could, if one looks at this CV as a guide, be deemed to
12 be quite a daunting figure with a very significant array
13 of broad professional experience, would that be fair?
14 **A. Yes, it's absolutely fair.**
15 Q. And moreover that the kinds of things he had been
16 involved in meant that his reach, if you like, in terms
17 of the number of people and organisations that he
18 influenced was very significantly wider than one man but
19 in fact no doubt influenced all these committees, all
20 these educational establishments, all the students, all
21 the readers of his books and all that kind of thing;
22 is that a fair impression?
23 **A. Yes, if this CV is taken at face, then you could easily**
24 **assume that he had very many connections not just with**
25 **his own professional medical governance but with**

1 **teaching bodies and with students, with trainee doctors**
2 **etc. Yes, you could easily assume that.**
3 Q. So even though this looks like a very impressive
4 professional background, if hypothetically something
5 were to go awry in the professional practice of this
6 individual it would have the potential to have very
7 significant and wide consequences?
8 **A. Absolutely.**
9 Q. And so although it might be tempting to look at a CV
10 like this and say: goodness me, what an impressive
11 individual, another way of looking at it would be to say
12 that this man needs to be monitored as much as systems
13 should permit in order to try to minimise the
14 possibility though those wide-ranging consequences of
15 things going wrong don't materialise?
16 **A. Yes, I think that's fair. I mean, let's be honest that**
17 **when it came to the concerns that were first raised**
18 **within NHS Tayside that something was wrong and he was**
19 **under supervision, the reason for that was not what was**
20 **on his CV. The reason for that was the concern about**
21 **what had actually happened within theatre, or within**
22 **medical care, aftercare, and that he was not carrying**
23 **out, on a professional basis, the medical procedures as**
24 **he ought to have done.**
25 **That's what raised the concerns within NHS Tayside**

1 **and within the wider public and of course with the**
2 **patients. So I think the CV, from my perspective, is**
3 **interesting in that you know he's obviously been**
4 **documenting a huge number of professional links that he**
5 **has and things that he's written, but we then find out**
6 **that some aspects of the CV might not be quite so**
7 **accurate.**
8 Q. We'll be investigating that, don't worry, Ms Smith. If
9 I could just ask you -- or get you to look at a few of
10 the entries on this which may again just help us set
11 some context. On the first page we see that the current
12 roles are set out where it says that Mr Eljamel was Head
13 of Department and Section Surgical Neurology in the
14 University of Dundee from 1996, is that right?
15 **A. Yes.**
16 Q. A little bit further down, about five lines further
17 down, it says he, at that stage, was the Chairman of the
18 Clinical Governance Committee Specialist Services Group
19 from 2006?
20 **A. Yes, it does.**
21 Q. It also says that he had been the Secretary of the
22 British Stereotactic and Functional Neurosurgery Group
23 from 2006?
24 **A. Mm-hmm.**
25 Q. At the bottom of that section it says he was a clinical

1 specialist advisor to the National Institute of Clinical
2 Excellence from 2008?
3 **A. Yes.**
4 Q. And that's a body I think that seeks to try to promote
5 high clinical standards in medicine?
6 **A. It is.**
7 Q. And he also indicates then in a section of his past
8 appointments one of which, the last one of course, on
9 that list is that he was a consultant neurosurgeon and
10 was elected a member of the Medical Advisory Committee
11 BMI Fernbrae Hospital Dundee in the past?
12 **A. Yes.**
13 Q. Also, as far as his qualifications are concerned, it
14 points out his medical qualifications but also indicates
15 that he was a fellow of the Royal College of Surgeons
16 Ireland and had been since 1986, yes?
17 **A. That's correct.**
18 Q. And it also points out he was a fellow of the Royal
19 College of Surgeons of Edinburgh, an accolade he had
20 received in 2003, but it notes that that was without
21 an exam, is that what it says?
22 **A. It does say that, yes.**
23 Q. As far as experience is concerned, he lists a number of
24 his past positions including experience in Britain
25 working in Liverpool and working in Dublin. In relation

1 to the first three entries it talks about graduating
2 with honours in December 1982, him having an internship
3 in surgery and medicine between January and December
4 1983 and a general professional and basic surgical
5 training which he claims took place between '84 and '87.
6 It doesn't give details where those took place, is that
7 right?
8 **A. It doesn't say so.**
9 Q. Over the page there's one entry I think you were keen to
10 make reference to which is the one at the very top which
11 suggests that in 1995 he was a Clinical Fellow in
12 Neurosurgery at the University of Connecticut, in
13 Hartford Hospital in Connecticut. Was that the one you
14 were referring to earlier?
15 **A. Yes, it was.**
16 Q. And I think you referred to there being some
17 investigations into the legitimacy of that entry?
18 **A. Well, I think the implication was when various aspects**
19 **of people that he says that he was either helping and**
20 **assisting or being a student of or helping to teach**
21 **students in, some of these could not clarify that that**
22 **was correct.**
23 Q. You mentioned that one in particular. Were there others
24 that you understood had been --
25 **A. I think there is interest to me in what he was claiming**

1 **to have done with the Walton in England. And I think**
2 **it's very important -- and it was particularly important**
3 **quite late on in the Eljamel Inquiry situation -- that,**
4 **you know, bodies in England were being asked to consider**
5 **whether they should look through their records to see if**
6 **Eljamel had had any -- what activities had he undertaken**
7 **in these English institutions and that was a good**
8 **question to ask.**
9 MR DAWSON: Okay. That would be an appropriate time to take
10 a break, sir, if that would be convenient.
11 THE CHAIR: Can I ask one basic question and I probably
12 missed an answer given some moments ago, but can I be
13 clear what the provenance of this CV is? Is this
14 something that you managed to generate as part of your
15 investigations?
16 **A. Yes, but assisted by the patients who obviously were**
17 **very interested. And patients who suffered at the hands**
18 **of Eljamel quite rightly were trying to find out as much**
19 **as they possibly could about his professional background**
20 **and so I was furnished with this information.**
21 MR DAWSON: Had it been found on the internet as far as --
22 **A. Some of it had been.**
23 Q. Because quite a lot of the information looks to us to be
24 the product of extensive, no doubt, research on the
25 internet?

1 **A. Indeed and also through medical journals. When someone**
2 **like Eljamel will produce medical papers or academic**
3 **studies that's all documented in certain medical**
4 **authorities. So some of that was easy to find.**
5 MR DAWSON: Thank you very much.
6 THE CHAIR: Thank you.
7 (3.14 pm)
8 (A short break)
9 (3.25 pm)
10 MR DAWSON: Thank you, sir. Ms Smith, we've encountered in
11 your evidence so far on a few occasions, to put it
12 mildly, issues which were experienced with patients'
13 access to documents and you've explained the role that
14 that played in the conclusions about what was going on
15 to which they were driven and which they asked you to
16 help with. You've produced to us a lot of documentation
17 I think that is on this subject, including -- although
18 we don't need to go it -- one document in particular,
19 it's a bundle of documents really that relates to issues
20 experienced by Ms Rose in I think 2022.
21 **A. Yes.**
22 Q. In the particular context of an FOI request. So
23 I wonder if you can remember the circumstances that
24 surrounded that but also try to tell us more generally
25 about the sorts of problems that have been experienced

1 particularly in the FOI context?
2 **A. Yes, I can. Mrs Rose was asking very pertinent and very**
3 **sensible questions to provide more information**
4 **particularly about who had oversight of Eljamel and**
5 **Mrs Rose had her operation, in fact she was the last**
6 **patient for Eljamel to operate on. And that was just**
7 **beyond the days where it had been fully exposed about**
8 **Professor Eljamel's malpractice. So she was quite**
9 **rightly asking the very important questions about who**
10 **knew what when, why was this allowed to happen? A whole**
11 **range of questions. I think my document details all of**
12 **the questions and there were a large number of them and**
13 **we were not getting very far in ascertaining what the**
14 **answers will be. So we -- and I advised her in this --**
15 **that we would have to have some process through FOI**
16 **material to get to the necessary information. I think**
17 **it's fair to say, and I'm sure Mrs Rose would agree with**
18 **this, that sometimes when we ask very specific questions,**
19 **a list of questions, we might get one answer or two**
20 **answers but we would never get the whole raft of the**
21 **answers that were required. And some of these were**
22 **extremely important questions and I think point very**
23 **much to some of the -- what I would allege were some of**
24 **the difficulties in oversight with Professor Eljamel.**
25 **So I think it was that frustration and then sometimes it**

1 **was suggested that: well, some of that information might**
2 **have to come from the Scottish Government. Scottish**
3 **Government would tell us: well, some of that information**
4 **is definitely at NHS Tayside and there was just this**
5 **constant ongoing back and forth. And the FOI material,**
6 **which is absolutely the correct thing to ask for, we**
7 **were -- well, we know from the information commissioners**
8 **comments we were only getting some of the story and that**
9 **was a sense of very considerable frustration not just to**
10 **Jules Rose but to me as well.**
11 Q. And obviously just for context what you mean I think
12 when you talk about using FOI is trying to use the
13 Freedom of Information legislation in circumstances
14 where a patient has been unable to access the
15 information via the normal routes. Trying to use other
16 legal mechanisms to try, in many ways, force the
17 organisation to give you the information?
18 **A. Yes, that's correct and I think -- and I'm sure Mr Marra**
19 **and Mr Rennie would agree with this -- that we tried**
20 **every which way that we could to assist the patients in**
21 **directions that we felt were the right places to be**
22 **trying to draw the information from and there was**
23 **a constant feeling that we were not getting there. So**
24 **we had to try some other avenue.**
25 **During my time dealing with this case I was dealing**

1 **with three First Ministers, I was dealing with five**
2 **different Cabinet Secretaries for Health and seven Chief**
3 **Executives of NHS Tayside and that's the extent of some**
4 **of the timescale that this has been going on for and we**
5 **had numerous meetings with various people within**
6 **NHS Tayside and within the Scottish Government and**
7 **I can't fault any of them for having some sympathy for**
8 **the patients but were they actually dealing with the**
9 **real questions that were being asked by these patients?**
10 **We were not getting the answers. So sometimes FOI**
11 **material was the only way we were going to establish**
12 **some of that.**
13 Q. So you've explained already in your earlier evidence
14 about using what I have described as the normal
15 processes to get hold of the information. You might
16 have thought that if you -- as no doubt you advised
17 patients to do -- you escalated, if you like, to the
18 Freedom of Information level and that at that point
19 public authorities would sit up and take notice and give
20 you what you need; is that fair?
21 **A. One would have hoped so, yes.**
22 Q. But I think you've explained that was not the
23 experience?
24 **A. No, it wasn't. That was largely my demand for this**
25 **public inquiry which the patients had been campaigning**

1 **for, for quite some time, but I felt it was my**
2 **responsibility as a parliamentarian to go through every**
3 **possible channel that I could that I thought was**
4 **appropriate to get the answers they were seeking. And**
5 **so it was that sense of frustration that persuaded me**
6 **that a public inquiry was absolutely essential because**
7 **all the other means of trying to get to the truth had**
8 **been exhausted.**
9 Q. That's not an unfamiliar story in public inquiries,
10 unfortunately. Do you think that is -- that you have
11 been involved in looking at public inquiries wearing
12 a different hat I know and do you think that that
13 process of failing to get the answers through these
14 escalating stages is one of the reasons why there are
15 lots of public inquiries in Scotland?
16 **A. Yes, I do. I mean I come to this with a bit of**
17 **experience, having been on the finance committee and my**
18 **colleague Mr Marra was on the finance committee at the**
19 **time and we decided that there was a case to be answered**
20 **about why there was an increase in the demand for public**
21 **inquiries but being the finance committee of course**
22 **we're interested in the cost of public inquiries as**
23 **well. But I think just referring back to your colleague**
24 **John Sturrock KC when he provided evidence to the**
25 **committee I think he was pointing out that there**

1 **were various reasons that he believed were behind the**
2 **increase. Firstly, that the public trust in government**
3 **and agencies has been diminished. Secondly, that there**
4 **were too many occasions where perhaps the government of**
5 **the time felt that: well, if a public inquiry dealt with**
6 **this it takes it away off our desk and let the public**
7 **inquiry investigate something that we've not been able**
8 **to solve ourselves. But my fundamental reason -- and**
9 **I think John Sturrock said this too -- I think the basic**
10 **reason why there is an increase in a demand for public**
11 **inquiries is because government and its agencies are**
12 **not, for one reason or another, being able to answer the**
13 **questions that they should be able to answer and**
14 **therefore we are seeing this increase in the demand for**
15 **public inquiries on specific instances.**
16 Q. Was that your understanding of how this public inquiry
17 came about?
18 **A. Yes, I mean I was responsible for coming to the public**
19 **inquiry -- the patients had been asking me to take this up**
20 **for probably the best part of two years and I said:**
21 **well, let's continue trying to get answers from various**
22 **government ministers and NHS Tayside in particular, and**
23 **I was then persuaded that because we were not getting**
24 **the answers that a public inquiry was the only way, not**
25 **least because I think there is a trust in the public**

1 **inquiry, not least one that is overseen by a judge and**
2 **witnesses are providing evidence under oath, that has**
3 **credibility in the eyes of the public, and I think**
4 **that's very important. But should we have as many**
5 **public inquiries? Probably not if the government and**
6 **its agencies were doing their work effectively.**
7 Q. And by "doing their work effectively" I suppose that
8 could comprise providing good services in the first
9 place to the likes of users of healthcare?
10 **A. Yes, absolutely. You know, there is a demand for**
11 **efficient public service. It suggests to me -- this**
12 **case is a classic example, where there has not been good**
13 **public service, in fact very difficult malpractice and**
14 **public service. So I think that's all part and parcel**
15 **of the same thing and the conclusions of the finance**
16 **committee -- they were unanimous conclusions of the**
17 **finance committee and also parliament agreed to that**
18 **report. It wasn't just us presenting our thoughts, this**
19 **was accepted by the parliament as important, that there**
20 **is a real issue about public inquiries that is for**
21 **future parliaments to investigate how that might be**
22 **addressed.**
23 Q. Okay thank you. Could I just take you to the document
24 that you've been referring to which is ELJ-00553, this
25 goes back to FOIs and this is a publication from the

1 Scottish Information Commissioner dated 11 August 2026
2 which is directly relevant to what we're looking at
3 because it says, if we can zoom in a little Rory on the
4 first paragraph there:
5 "A new decision by the Scottish Information
6 Commissioner has found that NHS Tayside fell short of
7 the requirements of Scotland's freedom of
8 information ... law when responding to requests for
9 information about a report into its investigation of
10 Professor Sam Eljamel, the former head of Neurosurgery
11 at Ninewells Hospital in Dundee whose conduct is
12 currently the subject of a public inquiry."
13 Reading just down to the bottom, it says the
14 Commissioner's ruling finds that NHS Tayside's response
15 to those requests failed to comply with the requirement
16 of FOI law in a number of ways. He found, for example,
17 that NHS Tayside:
18 "Carried out inappropriate or inadequate searches
19 for some of the requested information.
20 "Incorrectly informed the requester that it did not
21 hold some information.
22 "Failed to provide appropriate advice and assistance
23 to the requester.
24 "[And/or] incorrectly withheld some information."
25 Now you have referred I think to a number of these

1 phenomena having been experienced in the past. Does
2 this suggest that there is an ongoing problem with the
3 way in which document management works at least within
4 NHS Tayside?
5 **A. Yes, it does and I have great respect for any**
6 **Information Commissioner but I think -- when I saw this**
7 **two weeks ago I thought it was a pretty damning**
8 **indictment of the way NHS Tayside had not been**
9 **performing its duties as would be expected from not**
10 **least the Information Commissioner but the public at**
11 **large.**
12 Q. One of the statements that's frequently been made to
13 this Inquiry by NHS Tayside is it's a learning
14 organisation. In this important regard, has your
15 experience been that it has learned how to respond to
16 requests, via FOI or otherwise, as you have been
17 involved in it or not?
18 **A. This would partly suggest not, that there are still**
19 **ongoing problems. I mean there are documents in my**
20 **files that -- NHS Tayside persuaded us that new systems**
21 **had been put in place for certain aspects and I think in**
22 **some part that was correct. There were new systems of**
23 **oversight that were put in place to try to involve**
24 **greater transparency and ensure there was a greater**
25 **check on documentation, but then not that long ago we**

1 **find the appalling situation where logbooks went**
2 **missing, were destroyed and that was after do not**
3 **destroy notices had been issued. So I'm afraid that**
4 **undermined some of the trust that the new procedures are**
5 **effective.**
6 Q. Your understanding is that the logbooks were destroyed?
7 **A. Yes.**
8 Q. Not that they were lost?
9 **A. No, I'm sorry I misspoke there.**
10 Q. No, not at all. I'm just clarifying that with you for
11 other purposes. I think in your statement you use the
12 word which I'm quite keen to focus on "obfuscation"
13 because presumably within document management which --
14 it does form a key element of all of this -- there will
15 especially with things that are historic like this be
16 circumstances in which normal document retention
17 procedures will mean that unfortunately the documents
18 that are needed are not available. But your use of that
19 word and some of your other evidence today suggest that
20 we're dealing with a very different situation it that.
21 What's the basis for that analysis?
22 **A. Well, I used the word "obfuscation" where you're not**
23 **getting to the direct transparent information that you**
24 **want you might be getting other aspects of sort of**
25 **semi-relevant information that would surround the sort**

1 **of key theme but you're not getting to the core**
2 **issue that you're wanting to find the information about.**
3 **And I think obfuscation to me suggests that there is**
4 **a bit of sort of delay tactic or there's trying to sort**
5 **of put the onus on somebody else to try to find the**
6 **information, and it's just -- you know, we should be**
7 **clear that when somebody asks for this kind of**
8 **information if we can't find it somebody should know why**
9 **we can't find it and be able to be accountable for that.**
10 **But most of the time we should have been able to find**
11 **the information because it's, you know, been part of**
12 **medical records and a management procedure where I would**
13 **like to think that the National Health Service of any**
14 **part of Scotland would be effective in the management of**
15 **that kind of information. That's what part of good**
16 **healthcare should involve.**
17 Q. You mentioned the phrase there used was "putting the
18 onus on someone else". I think you mentioned earlier
19 there had been difficulties sometimes within you've been
20 involved in FOIs or other attempts from patients to get
21 information that there had been a sort of passing of the
22 buck between NHS Tayside and the Scottish Government.
23 If one looks, just as an example from the paperwork at
24 the sort of information Mrs Rose was looking for, that
25 sort of information as I think you've said, was quite

1 specific --
2 **A. Yes.**
3 Q. -- to do with the circumstances in which she underwent
4 her surgeries in 2013 and could only have been answered
5 by medics or NHS Tayside?
6 **A. Yes.**
7 Q. Was your experience in that that the buck was passed to
8 government to suggest they might know the answers?
9 **A. No, not that they would know the answer but that they**
10 **would be able to ensure NHS Tayside would be able to**
11 **provide the answers.**
12 Q. I see.
13 **A. By this time the Eljamel case was a very big public**
14 **issue and it was essential that both Scottish Government**
15 **and NHS Tayside were working in the same direction to**
16 **ensure that we got answers to these questions and**
17 **I didn't feel at some occasions that we were -- in**
18 **a situation where they were working together, that it**
19 **was being passed over to somebody else, passed back**
20 **again, eventually coming back to me and I would then**
21 **have to go back. As Jules Rose would evidence, some of**
22 **the questions that were being asked might be answered**
23 **but they wouldn't all be answered and within the ones**
24 **that weren't answered there would be some key nuggets of**
25 **information that we needed to establish who was**

1 **responsible for what had happened.**
2 **And so this -- and that's obfuscation to me as well**
3 **because you're not answering directly what somebody has**
4 **asked and it was just that frustration that, you know,**
5 **when I put this to a Cabinet Secretary for Health, as**
6 **I did on four or five different occasions, they implied**
7 **that they agreed with that but we still didn't get the**
8 **answer and then they said that they would go and find**
9 **out from NHS Tayside. We would get a letter from**
10 **NHS Tayside, but some of that was never forthcoming.**
11 **And I think there's an occasion where the NHS Tayside**
12 **had agreed to a meeting with some of the patients and**
13 **I think we asked for that three times and it never**
14 **happened. You know that's obfuscation to me as well.**
15 Q. You've mentioned already the process you went through or
16 advised patients to go through to get to the point of asking
17 for a public inquiry by exhausting other avenues.
18 I think the evidence that you've provided suggests that
19 the public inquiry was being called for by patients
20 since at least 2015. Indeed, Ms Cherry in her opening
21 statement on behalf of the patients suggested it might
22 in fact be 2014, but you've explained this systematic
23 process that you advised them to go through. When was
24 it that your view became: okay, enough is enough, we
25 need to have a public inquiry for the sorts of reasons

1 associated with public inquiries that you set out?
2 **A. About a year before it was in fact announced by the**
3 **Scottish Government that they were going to have**
4 **a public inquiry. And obviously there were lots of**
5 **demonstrations outside parliament about this public**
6 **inquiry but I believed I had responsibilities as**
7 **an MSP to try every possible avenue that I could as**
8 **a parliamentarian to get the answers for these patients**
9 **and I became so frustrated in my efforts that I felt**
10 **that the patients were quite right in making that call**
11 **for a public inquiry and so I was relieved when**
12 **eventually that announcement was made.**
13 THE CHAIR: So that would be the middle of 2022?
14 **A. Correct.**
15 MR DAWSON: I wondered, Ms Smith, whether that might have
16 been coincident in time with the publication of the
17 Scottish Government's review of unresolved and
18 outstanding concerns regarding Professor Eljamel which
19 was the Scottish Government's investigation published
20 in May 2022. Would it have been around about that --
21 **A. Yes, that was around about the same time but I don't**
22 **think that was just the issue that determined my support**
23 **for a public inquiry, I think there were other aspects**
24 **as well. Specifically that as I say my own frustration**
25 **was building and I felt I had the case work to**

1 **demonstrate why I had every right to demand a public**
2 **inquiry and obviously I had a lot of discussions with**
3 **the patients at the time and they were very helpful to**
4 **me in persuading me why they felt that, you know, enough**
5 **was enough as you rightly suggest.**
6 Q. You mentioned a moment ago the fact that you had had to
7 deal with a number of different Health Secretaries over
8 the years and a number of different First Ministers
9 I think and probably also I would imagine with Tayside
10 a number of Chief Executives and others as well?
11 **A. Yes.**
12 Q. I think you've explained that they all were sympathetic
13 towards the position but couldn't provide the answers;
14 is that a fair summary?
15 **A. Yes, that is a fair summary and I don't think I found**
16 **any of them who were unsympathetic to the cause of what**
17 **the patients had suffered but the long and short was**
18 **they weren't providing us with the support at some time**
19 **and the answers that we were trying to establish.**
20 Q. And just to focus in on that time period where you say
21 that your view that a public inquiry was the right thing
22 to do, around about the middle of 2022, the Cabinet
23 Secretary for Health at that stage was Humza Yousaf; is
24 that right?
25 **A. That's correct.**

1 Q. And the Cabinet Secretary for Health who eventually
2 announced that public inquiry on 7 September 2023 was
3 Michael Matheson?
4 **A. Yes.**
5 Q. Could you clarify for us, in that period where you were
6 campaigning for that outcome, who was it that you were
7 dealing with and what was your experience of the
8 interaction in response to your now support for such
9 cause?
10 **A. I had two meetings with Humza Yousaf before when he had**
11 **been Cabinet Secretary for Health and then once when he**
12 **was First Minister and then we had --**
13 THE CHAIR: Sorry, two meetings as Health Minister?
14 **A. Yes, as Health Minister, yes, correct. And then there**
15 **was a situation where jointly we had a meeting with**
16 **Michael Matheson and that was, I think -- I think**
17 **I'm right in saying that six MSPs turned up to that**
18 **meeting so there were other MSPs who by this stage were**
19 **interested in that.**
20 MR DAWSON: Yes.
21 **A. But you know we eventually had meetings further on down**
22 **the process after the public inquiry had been announced.**
23 **We met with the Cabinet Secretary for Health and we also**
24 **met with the First Minister.**
25 Q. I'd be interested to try to understand from your

1 perspective of having been someone amongst others who
2 was involved in that process, what your impression was
3 of the Scottish Government's thinking at around that
4 time and who it was, if you like, who was exceeding
5 perhaps gradually towards the idea of a public inquiry.
6 The reason for that is the explanation given publicly by
7 the Scottish Government when the Inquiry was actually
8 announced focused very much on the outcome -- or the
9 content of the NHS Tayside due diligence review which
10 had come out only a matter of weeks before the
11 announcement was made. I'm interested in sort of trying
12 to probe the idea as to whether that report was perhaps
13 the straw that broke the camel's back in a process that
14 was moving that direction anyway or whether it was
15 that report and its outcome that was the reason that
16 that Inquiry was announced?
17 **A. I think there's a strong indication that that report was**
18 **seminal in making up minds because the due diligence report**
19 **presented the public with identifying so many problems**
20 **and I think that certainly was beginning to get quite**
21 **a lot of coverage in the media apart from anything else.**
22 **And by this time we knew that there were more and more**
23 **patients coming through that the volume of patients**
24 **who -- of patient complaints I should say, was very**
25 **substantial. And I think if I look back at the answers**

1 **I was receiving from either First Minister's questions**
2 **or health questions, of which you have a copy, the tone**
3 **was beginning to change to be almost hinting that there**
4 **might be a change in government approach. And that**
5 **change was undoubtedly around that time of the 2022**
6 **report.**
7 Q. The 2022 government report?
8 **A. Yes.**
9 Q. So effectively as I understand it, that 2022 to 2023
10 period straddles Humza Yousaf being the Cabinet
11 Secretary for Health and then Michael Matheson?
12 **A. It does.**
13 Q. But would it be fair to say that there had been a start
14 of a move towards it in 2022 when Humza Yousaf was still
15 the Cabinet Secretary or was it really more under
16 Michael Matheson's leadership that that became the case?
17 **A. I think it was a bit of both. I think at First**
18 **Minister's questions there was a bit of a move as well**
19 **I felt and that was obviously Humza Yousaf for a short**
20 **period of time and then John Swinney and I think there**
21 **was definitely a softening of the tone that maybe this**
22 **is very much bigger than we thought it was and there was**
23 **tremendous courtesy -- I can't fault them in the way**
24 **that you know they responded to my concerns, nor can**
25 **I fault them on the fact that when we were in a meeting**

1 **if we eventually got it organised they were sympathetic**
2 **and took it seriously, but I think that the scale of**
3 **what was being uncovered not just in obviously the**
4 **malpractice issue but what had not happened in terms of**
5 **due diligence of the oversight, I think that was**
6 **beginning to send shockwaves through the Scottish**
7 **Government.**
8 Q. Okay so one aspect of this which I wonder might relate
9 to the softening we're keen to try and understand is our
10 understanding in April 2023 there was a move towards
11 having something in the nature of the Independent
12 Clinical Reviews -- we're going to investigate exactly
13 whether that is what it ended up being -- but as
14 I say the due diligence report by NHS Tayside came out
15 in around August 2023 and by the 7 September 2023 there
16 had been a move towards having a public inquiry but also
17 retaining the Independent Clinical Reviews. Do you
18 recall your understanding of what the clinical review
19 side was to be when it was first announced earlier in
20 2023?
21 **A. That those people who felt they had a case with Eljamel**
22 **on that one-to-one and very confidential basis would be**
23 **able to have their own clinical situation reviewed and**
24 **I think that's absolutely right and proper actually and**
25 **I know there's a very welcome reception to that amongst**

1 many of the patients. And there are patients there who
2 are extremely private about the difficulties that they
3 encountered and find it difficult perhaps to articulate
4 some of the issues that they suffered and have
5 appreciated the opportunity, especially with
6 Professor Wigmore, to undergo these clinical reviews.
7 But I think the overall concern was growing about the
8 extent that the due diligence of the oversight had not
9 been effective and that was definitely sinking in
10 I think with Scottish Government ministers. It took
11 a long time but I think it was sinking in.
12 Q. Had it been -- I understand the two different elements
13 obviously quite intimately but the clinical side and
14 then the more systemic side. Had it always been part of
15 the patients' campaign that they wanted this two-step or
16 two processes or had it been something which the
17 government had given them, as far as the clinical side
18 was concerned in spring of 2023, but they said: well,
19 what we actually want is a public inquiry?
20 A. I think it was inherent in the circumstances because
21 quite rightly they had suffered tremendous physical and
22 psychological harm. Naturally they wanted to know why
23 this had happened and in many case why this had
24 happened after warnings and they want answers about why
25 it was allowed to continue for such a long period

1 without anybody being held accountable. So I think the
2 two go hand in hand, but I think the scandal for me is
3 not just about Eljamel's horrible medical malpractice
4 and all the dangers that he has put upon his patients,
5 it's about the oversight or lack of oversight especially
6 when concerns were raised. That's the nub I think of
7 the concern among most patients.
8 Q. So logically, I'm taking, it must have been your
9 position earlier -- your and the patient's position
10 earlier in 2023 that, although welcome, the clinical
11 reviews were not sufficient as they would never address
12 that aspect?
13 A. Correct.
14 Q. And do you know why it is that Michael Matheson
15 effectively changed his mind on that and decided that
16 there should be a public inquiry shortly before
17 7 September 2023?
18 A. I got the very strong impression that the government
19 ministers were pretty shocked by the report that came
20 out that you mentioned whereby it was quite clear that
21 there were inadequacies within NHS Tayside. I think
22 that was a big shockwave to the government.
23 Q. As I understand your evidence, had that not been what
24 you and patients had been telling them for some years
25 before that?

1 A. Indeed, sir.
2 Q. And what was your view/the view of the patients on whose
3 behalf you were advocating about the retention of the
4 two processes? The reason I ask that is there's
5 an impression from some evidence there might have been
6 a degree of confusion as to why there needed to be two
7 processes.
8 A. Yes, I can understand that up to a point but I think, as
9 you rightly said a few minutes ago, there are really two
10 issues -- they're very strongly connected to each other
11 but there are two issues here. The first is the medical
12 malpractice but the second is why it was allowed to
13 happen. And so I believe that there is a very strong
14 case for not just the public inquiry but for
15 Professor Wigmore's clinical reviews and I think my
16 reaction, certainly from listening to what patients are
17 saying, many of them are very grateful for that
18 opportunity to talk about their actual individual
19 medical cases, but as you rightly said that was not
20 going to be enough to answer the most important
21 questions about why it was allowed to happen.
22 Q. And as regards the systemic issues with which you were
23 keen there should be a public inquiry for some years,
24 did you have the impression that the Scottish Government
25 had a clear list of what those issues would be?

1 A. In some respects I felt they had but not in the detail
2 that I thought was going to be sufficient to be able to
3 address all the circumstances of what had happened.
4 Governments are busy, they have loads of other things to
5 think about and there was Covid at some aspects of the
6 Eljamel situation and you make a little allowance for
7 some of the delays that happened in 2020, 2021
8 particularly, but I never got the impression until very
9 much later in the day that the Scottish Government
10 really saw this right at the top of the agenda and
11 I think credit to the campaigners but credit to my
12 parliamentary colleagues who assisted me in pushing it
13 right up there because we believed it was a matter of very
14 considerable public interest.
15 Q. To continue on the theme of documents but in a slightly
16 different context you mentioned having had not as many
17 or as quick meetings with the Scottish Government as you
18 might have liked but there have been some as
19 I understand it?
20 A. Yes.
21 Q. And who was the Cabinet Secretary with whom you first
22 managed to get a meeting on behalf of the Eljamel
23 patients?
24 A. I think if we go back through the different Cabinet
25 Secretaries for Health, including the late Jeane Freeman

1 **who I found very helpful in some respects and I think**
2 **perhaps Jeane Freeman was the one who commissioned the**
3 **report -- the investigative report.**
4 Q. The one that reported in 2022?
5 **A. Yes. So from that angle I felt that we were -- I had**
6 **a very brief meeting with Nicola Sturgeon when she was**
7 **Health Secretary -- that's obviously going back a long**
8 **period of time -- when Eljamel came up in the**
9 **conversation about various other things but she wasn't**
10 **responsible for the other meetings that I had because we**
11 **met obviously with Michael Matheson, we met with**
12 **Humza Yousaf when he was Health Secretary with**
13 **Jeane Freeman, with Neil Gray, so there was a long list**
14 **of Cabinet Secretaries for Health. I met with them all**
15 **at some stage, some with patients but some with**
16 **colleagues and some privately myself.**
17 Q. As far as meetings of that nature were concerned, were
18 you aware of whether the Scottish Government
19 officials/civil servants minuted those meetings?
20 **A. There were certainly civil servants in the room and**
21 **I think it's the understanding I have and I think my**
22 **colleagues would agree that there were civil servants**
23 **there who were doing their duty in terms of**
24 **taking minutes and therefore these minutes should be**
25 **available.**

1 Q. Did you get copies of the minutes of those meetings?
2 **A. No, but in the circumstances we wouldn't expect**
3 **necessarily to get all the detailed minutes of these**
4 **meetings but these can be sourced and it's a matter of**
5 **record I think that -- it is our understanding that**
6 **civil servants were present and taking notes.**
7 Q. Could I ask you about -- you asked a question on
8 12 March in Parliament, on 12 March 2026, relating to
9 the postponement of the hearings in this Inquiry and you
10 asked the First Minister at First Minister's questions:
11 is the First Minister as appalled as I am that the
12 former patients of Sam Eljamel who were allowed to
13 attend in person the first and second sessions of the
14 public inquiry to hear what was being said in evidence
15 we were told yesterday that that would no longer be the
16 case for session 3 and they would have to listen to the
17 Inquiry's proceedings online? Does he agree that that
18 decision is completely unacceptable? Is it contrary to
19 the principles of a patient-centred and trauma-informed
20 approach? When were Scottish Government Ministers first
21 made aware of that decision?
22 Obviously there was a significant amount of concern
23 which you expressed to the Inquiry about that decision
24 and that's entirely understood. But what I was keen to
25 know was when asking that question had you assumed that

1 that was a decision taken freely by the Chair of the
2 Inquiry?
3 **A. I wasn't sure, I'll be quite honest. I felt very**
4 **strongly that there should be no circumstance where**
5 **patients -- you know, as you say it's all about**
6 **patient-centred inquiries and Lord Weir has always, in**
7 **all his public utterances, been very careful to assure**
8 **patients that you know they are at the centre of this**
9 **Inquiry and that's absolutely right and proper and**
10 **should be. And I didn't feel if they were going to be**
11 **moved online that that was going to be acceptable,**
12 **particularly as we'd obviously had two information**
13 **sessions of this Inquiry when they were free to attend**
14 **and I think it's important that they can attend but**
15 **I wasn't sure, I got the impression that this decision**
16 **to -- well, there was a problem about the room etc, but**
17 **at the time I thought maybe Lord Weir had had to take**
18 **the decision because he was forced into a circumstance**
19 **where this room was not operational and if there were**
20 **safety concerns I could understand that but that**
21 **concerned me. So I wasn't entirely sure what had**
22 **happened.**
23 Q. I'm not in any way seeking to criticise you in this
24 regard because I'm aware I think quite precisely of the
25 amount of information that would have been available to

1 you about it at the point where you asked that question.
2 What I'm quite interested to know, however, is what it
3 is that the Scottish Government told you as a result of
4 that question or otherwise about what the problem
5 actually was? Because of course it's entirely
6 understandable that patients whom you represented wanted
7 to know more and we totally understand that, however,
8 the government could have given you more information at
9 that point I might suggest and I'm wondering whether
10 they gave it to you?
11 **A. I thought they could have given me a lot more**
12 **information because it then transpired that there had**
13 **been some problem with the council and about the**
14 **availability of this facility and I think many people in**
15 **the media were a bit taken aback by this decision as**
16 **well because I think there was a bit of incredulity if**
17 **there's a really big public inquiry, why is there a room**
18 **problem? You know, that just didn't quite sink in and**
19 **didn't seem to be entirely accurate. But it was quite**
20 **clear that there was a problem but the conversation**
21 **I had with Neil Gray at the time, he intimated to me**
22 **that there was an issue about the local council and how**
23 **this building would be leased and I didn't feel we got**
24 **the full facts about that.**
25 Q. Okay. If I could just read out what the First Minister

1 told you in response, he said:
2 "I understand the significance of the point that
3 Liz Smith raises but as I understand it the decision
4 that's been taken by Lord Weir who is the Chair of the
5 Inquiry. Liz Smith will know the obligations that I am
6 under in terms of the Inquiries Act 2005. The Chair of
7 the Inquiry must be free to take the decisions they
8 decide to be appropriate for the running of the Inquiry.
9 They should certainly not be subjected to interference
10 by Ministers and they certainly will not be subjected to
11 interference by me, whatever my personal sympathies are
12 on the issue. As Liz Smith knows, just last week I met
13 those who were affected by Eljamel and had
14 a constructive discussion with them. I have to respect
15 the independence of Lord Weir's Inquiry. It would be
16 thoroughly inappropriate for me to intervene on any
17 matter of that nature." (As read; not shown on screen).
18 Would it be fair to say in his response, Ms Smith,
19 that the First Minister rather gave the impression that
20 the decision-making in this regard had been that of the
21 Chair and the Chair alone?
22 **A. Yes, what you have just read out, in terms of the 2005**
23 **Act that is correct, that you know it is a matter that**
24 **the government can interfere in issues that will be**
25 **decided by the appointed Chair of the Inquiry. That is**

1 **correct, that's a correct summary. But I think given**
2 **that there were specific issues about why this building**
3 **could not be used, and obviously there were problems**
4 **about the lease, about the local authority, I think**
5 **perhaps they could have given us a little more information**
6 **about what exactly had happened.**
7 Q. I'm sure you know, Ms Smith, because you follow these
8 matters in detail that I have, in minute detail, set out
9 now two hearings exactly what's happened in this regard.
10 **A. Indeed.**
11 Q. In light of what you now know about the underlying
12 reasons for the proposal and the Scottish Government's
13 responsibilities as tenants of this building, do you
14 think that the response of the First Minister was
15 entirely candid?
16 **A. No, I don't actually. I think what he said was correct**
17 **up to the point of the interpretation of the 2005 Act**
18 **but that was a general tone. But obviously there were**
19 **very specific issues which, as you have pointed out, you**
20 **made clear. I think we could have had more information**
21 **at the time.**
22 Q. Connected to that general area -- I have asked you a few
23 questions already I don't want to dwell on it too much,
24 but the subject of the Finance and Public Administration
25 Committee report into the cost-effectiveness of public

1 inquiries is one that we're interested in hearing from
2 you on as well and of course both yourself and Mr Marra
3 sat on that, and you've already given some evidence
4 about what you heard from Mr Sturrock KC and his views
5 which I think you accepted about why there are so many
6 public inquiries and difficulties in that regard.
7 One of the things that is of interest because this
8 Inquiry is almost introspectively looking at why it
9 itself was created which is why I have been asking you
10 these questions to try to illuminate that a little bit
11 further, but in many ways it's interesting to understand
12 what the understandings were within the committee
13 because it looked at public inquiries in some detail and
14 indeed looked at systems abroad as well as in Scotland.
15 **A. Indeed.**
16 Q. I'm interested in understanding what the committee
17 broadly made of the evidence it had about the extent to
18 which its recommendations about limiting, at the start,
19 the budget and timescale for an inquiry might interfere
20 with the essential principle of an inquiry's
21 independence?
22 **A. I think it's a very interesting question. I mean, the**
23 **evidence that we took particularly from some**
24 **jurisdictions abroad was quite compelling in a way that**
25 **they limit the timescale for any particular public**

1 **inquiry and therefore the cost of that public inquiry is**
2 **not necessarily as extensive as it might be if you let**
3 **the time run on and I think up to a point there is**
4 **an interesting debate about that, but -- and I think**
5 **it's a big but -- there are really big public inquiries**
6 **like this one whereby I think it is very important that**
7 **you -- particularly as it's on quite a long historical**
8 **period, where you -- the judge would not necessarily be**
9 **able to come to a full comprehensive conclusion without**
10 **very extensive time with witnesses, particularly if it's**
11 **a situation like this where there are so many**
12 **stakeholders involved. And therefore you could ask the**
13 **question: if you don't allow the time to take place with**
14 **that in mind, do you hear all the evidence that is**
15 **necessary to come to the right conclusion?**
16 **So we had this put to us, quite interestingly**
17 **actually by witnesses who represented New Zealand and**
18 **Sweden, and we also looked at some situations in England**
19 **and there was a case -- I think, from the Finance**
20 **Committee's point of view, there is -- we are**
21 **responsible for scrutinising the fiscal side of**
22 **Parliament and there was a real concern that the cost of**
23 **public inquiries is way up to £260 million over, you**
24 **know, quite a short period of time that increase has**
25 **taken place. And therefore that begged the question**

1 about why that cost had risen and why in essence there
2 was this increasing demand for public inquiries. And
3 that really focused our mind I think as a committee to
4 try to provide the evidence about what we thought was
5 causing a lot of concern there.
6 And then I can well understand the administration
7 costs that go along with a public inquiry. I fully
8 understand and I'm very grateful to all the people in
9 your team who do the support work with bits of
10 documentation and filing and that's essential. But
11 naturally witnesses need to be represented legally and
12 if that goes on for a long period of time, the legal
13 fees obviously increase understandably and sometimes
14 these legal fees were getting pretty big and so there
15 was a bit of a concern in the Finance Committee that,
16 you know, public inquiries -- and if you do allow them
17 to extend to whatever timescale the judge decrees then,
18 you know, that could go on for quite a long period of
19 time. And you know there have been calls -- I can think
20 of four or five former colleagues in the last session of
21 Parliament who were wanting to put forward motions for
22 a new commissioners and the reason for wanting new
23 commissioners was because they felt that some of the
24 public agencies were not doing their job properly and
25 that I think is all tied up in the same sort of

1 argument.
2 Q. Thank you. So to understand there's a couple of
3 elements there. Would you say that it was either you
4 and/or the committee's view that for "inquiries like
5 this" as you've put it those sort of limits shouldn't
6 apply?
7 A. I would argue that -- I'm not sure I could speak on
8 behalf of all the committee members but I think there
9 was quite a strong feeling that -- I think there was
10 this dilemma about trying to ensure that the costs of
11 public inquiries were at least under control. I think
12 that was a strong commitment within the committee
13 members but also that we had to get to the answers and
14 I think the public feel quite strongly that public
15 inquiries should have a judge who leads the whole
16 inquiry because there's great respect for a judge in
17 that situation and that witnesses are compelled to give
18 evidence under oath which I personally think is very
19 important. So there's a big debate about public
20 inquiries, I don't doubt that for a minute, but there is
21 a cost problem.
22 Q. Was it assumed -- and I can understand if one reads the
23 statute why it might be -- that the Chairs of inquiries
24 have a complete control over how much they cost?
25 A. Well, it was some interesting divisions within the legal

1 authorities within Scotland about that. Do you take
2 a stance -- would you have to change any of the
3 legislation in the 2005 Act, for a start? You know,
4 does that have to be reformed? That's one question.
5 Then: do you have to have a situation whereby public
6 inquiries are controlled in terms of their timescale and
7 should they all be judge-led, or can you have a mixture
8 of public inquiries, some that are judge-led and some
9 that are much less legalistic, if you like?
10 And so I think there's lots of arguments going on
11 about that but you know if I'm a member of the public
12 I want to know that a public inquiry is going to be able
13 to answer the questions that the, in this case, patients
14 have been asking for a long time who have tried all
15 sorts of other means. And so public inquiries are
16 absolutely necessary sometimes to get to the root of the
17 truth of what happened.
18 Q. Because based on even the experiences you raised in
19 parliament about this Inquiry earlier in this year, it
20 should perhaps be apparent that chairs of the inquiries
21 do not completely control how much inquiries cost in
22 particular relating to things like tenancy of a property
23 which might be used?
24 A. Indeed.
25 Q. So therefore to set those financial limits or to set

1 time limits does, I think, rather work on an assumption
2 that the Chair is completely in control of those matters
3 which I think perhaps we've discovered, would you not
4 agree, is not the case?
5 A. And I think that's correct. I think one of the
6 interesting debates that we had in the first sessions we
7 took is that for some public inquiries -- and I think it
8 was Lord Hardie who said this to us -- there was a lot
9 of duplication of some of the facilities in servicing
10 that goes into a public inquiry that, you know, every
11 time that a public inquiry is set up you have to go
12 through the whole process of setting up all of the
13 administration of that. And he was making the point
14 that actually you could probably get some economies of
15 scale to try to combine some of that administrative
16 background that's so important and you know I think he's
17 got a good point there. But I'm no expert in you know
18 how these costs are administered but I do think
19 parliament is going to have to take a view on how to
20 proceed with public inquiries.
21 Q. I think it was perhaps Lord Hardie who said that,
22 Ms Smith, not least because he wrote an entire
23 chapter in the Edinburgh Tram Inquiry report on exactly
24 that subject?
25 A. Indeed.

1 Q. Did you ascertain in the investigation whether the
2 Scottish Government had done anything to take into
3 account of what you'd set out in so much detail in that
4 report?
5 **A. No, we didn't get any information about that side of**
6 **things. I think our timescale for the public inquiry**
7 **was actually in itself a little bit limited because you**
8 **were doing a lot of things relating to the budget,**
9 **fiscal framework, all sorts of things. But I think we**
10 **had four or five evidence sessions with the legal**
11 **profession, all of them extremely interesting, I may**
12 **say, and we tried our level best to get to the nub of,**
13 **you know, if there were going to be cost savings where**
14 **might some of these cost savings be made and Lord Hardie**
15 **was very direct in his evidence about that.**
16 Q. Thank you. Those are all the questions I have for you,
17 Ms Smith. As will become the tradition at the end of
18 this part of the evidence, I'm going to ask you now
19 whether there's anything that you would like to add?
20 **A. No, sir, I don't think so. As you probably can tell**
21 **from my evidence, I'm just very keen that one day we'll**
22 **get to the truth about what happened and why so many**
23 **patients feel so badly let down and nobody has been held**
24 **accountable.**
25 MR DAWSON: Thank you. I'm afraid you're not quite off the

1 hook yet. We'll have a short break now and there'll now
2 be an opportunity for the core participant legal
3 representatives to suggest some further questions which
4 hopefully won't take too long.
5 THE CHAIR: Well, that necessarily means that it's perhaps
6 unclear how long that will take, but if those in the
7 public gallery just bear in mind that it's probably
8 sensible not to travel too far from the hearing room and
9 you can let me know when we're ready to resume.
10 MR DAWSON: Thank you, sir.
11 (4.15 pm)
12 (A short break)
13 (4.22 pm)
14 MR DAWSON: Sir, just for the sake of clarity for those who
15 are in attendance this will be a normal pattern whereby
16 at the end of my questions we'll have a short break, as
17 I explained this morning, and then the core
18 participants' legal representatives are afforded the
19 opportunity to ask further questions in addition to the
20 ones they've already proposed. So that's for everyone's
21 information the process we've gone through.
22 Ms Smith, to return to the subject area of calls for
23 a public inquiry, there's one area I have been asked
24 a question about which I had actually intended to ask
25 myself but I forgot. I know this is a subject that you

1 know about, and again for others it might be helpful to
2 contextualise it. When a Scottish public inquiry is set
3 up the statute makes clear that there are jurisdictional
4 limitations on what a Scottish Inquiry, as it's called
5 in the Act, can look at. And it can only look at
6 matters within the remit of the Scottish Parliament, ie
7 which are not reserved to the Westminster Parliament
8 under the devolution settlement.
9 As I know you know, there were significant concerns
10 expressed by a number of patients that as a result of
11 this being a Scottish Inquiry there were certain bodies
12 which fall within Westminster's exclusive jurisdiction,
13 including for example the General Medical Council and
14 the Health and Safety Executive, that would not be able
15 to be investigated in the same way as other bodies like
16 NHS Tayside. So that in that context which I know you
17 understand you are aware of there having been any
18 consideration given at any stage within Scottish
19 Government of seeking to have this Inquiry made into
20 a joint Inquiry which would have enabled that full range
21 of bodies to be examined?
22 **A. Yes, on an informal basis I completely understand the**
23 **legislation and Mr Marra and Mr Rennie and myself, we**
24 **wrote on behalf of the patients regarding the Terms of**
25 **Reference that we were slightly concerned that HSE and**

1 **the General Medical Council could not be investigated on**
2 **the same basis that some others might be. The reason**
3 **being, particularly with HSE which you know in future**
4 **parliaments I'd like to see a bit of further work done**
5 **on this, because there is a responsibility through**
6 **Westminster when it comes to HSE's operation but when**
7 **it's a specific medical issue or a health matter that**
8 **has to be investigated by another health board, HSE does**
9 **not by statute have the right to do that. But there was**
10 **deep-seated concern, and I appreciated that and as did**
11 **my colleagues, that if you were looking as one of the**
12 **core issues within this public inquiry that the**
13 **oversight had not been effective and HSE does have**
14 **a role to work with other bodies like HIS in Scotland --**
15 **and in a letter that Jeane Freeman had sent to me she**
16 **made clear that HSE does have a responsibility to look**
17 **at various issues there -- there was a concern that the**
18 **oversight of some of the health organisations would not**
19 **necessarily come to the attention of the public inquiry**
20 **unless HSE and the General Medical Council could be**
21 **properly investigated. But in his letter back to us**
22 **Lord Weir made it clear that it is within his remits to**
23 **call witnesses who might provide the assistance that is**
24 **required in answering some of these key questions and**
25 **I hope that that might be the case in the future because**

1 **I think there are some genuine questions that were**
2 **raised by patients when it came to HSE and to the**
3 **General Medical Council, but you know the legislation of**
4 **2005 is very clear about that.**
5 **Then just in relation to what the Scottish**
6 **Government might have done with the Westminster**
7 **Parliament, there were moves made by MPs, by**
8 **Richard Baker being one, to make the Westminster**
9 **Parliament aware of some of the issues that might**
10 **actually be common to some aspects of public inquiries**
11 **south of the border. Particularly at the time when it**
12 **was revealed that Eljamel might have had connections**
13 **with other hospitals south of the border, there was**
14 **a very clear reason why it might have been appropriate**
15 **to delve further into that because obviously that could**
16 **have some way of uncovering some of the most important**
17 **material.**
18 **So yes, we were aware of some of the -- letters were**
19 **written. It was Wes Streeting who was the Secretary of**
20 **State for Health at the time and that discussions had**
21 **taken place on that. And the Scottish Government wasn't**
22 **shutting that down but -- it's not a matter for me but**
23 **I think there is a strong case that in some cases HSE**
24 **and the GMC do have a role to play on this.**
25 Q. Just to focus on the time periods, my understanding

1 certainly is the time period you were talking about
2 there when Mr Baker was writing letters and that sort of
3 thing was in the period after this Inquiry had come into
4 being?
5 **A. Yes.**
6 Q. So it would still be open to the Scottish Government at
7 that stage to say: well, we could now make it into
8 a joint Inquiry and you said they weren't shutting that
9 down?
10 **A. They weren't shutting it down.**
11 Q. What about in the period before this Inquiry was raised,
12 was there anything available to you that the Scottish
13 Government considered the possibility of a joint inquiry
14 before the Inquiry was actually announced?
15 **A. Not to my knowledge and that was not part of any formal**
16 **discussions I had had. We were probing on the HSE**
17 **situation and to a lesser extent on the GMC but did it**
18 **come to formal discussions about -- before the Inquiry**
19 **was announced about trying to have a joint basis to**
20 **this? No, not in terms of formal discussion.**
21 Q. When you say you were probing about HSE and GMC that was
22 before the Inquiry and subsequently?
23 **A. Yes, correct, and in Mrs Rose's evidence and also in**
24 **Mr Kelly's evidence, they set out the reasons, very**
25 **strong reasons why they felt that HSE did have a role**

1 **despite the fact that there were certain things that HSE**
2 **could not do by dint of legislation but they set out**
3 **very clearly why they felt they had a responsibility**
4 **when it came to patient safety about what might be**
5 **required. And that's where I have sympathy that if Lord Weir**
6 **has the powers to call witnesses that might obviously**
7 **address that problem.**
8 Q. Just to be clear, I know you'll understand but just for
9 the sake of people who are listening, it would never
10 have been within the Scottish Government's gift to
11 announce an Inquiry that went into these areas, that's
12 right?
13 **A. Yes.**
14 Q. But the Scottish Government could have sought talks with
15 the UK Government to try to see whether they would like
16 to enter into a joint inquiry arrangement?
17 **A. Indeed.**
18 Q. For the sake of clarity we will be hearing oral evidence
19 later in this session from two representatives of the
20 GMC. We have a written statement from them in this
21 section and we also have a written statement from the
22 HSE as well as very voluminous documentation, I can
23 assure you, from them which either has been or will be
24 disclosed to our core participants in due course.
25 **A. Thank you.**

1 Q. Thank you. That's everything, sir.
2 THE CHAIR: Thank you very much. Ms Smith, it's obvious
3 from your evidence that you have been a prominent and
4 valued representative of many patients in connection
5 with this matter and it's in that context that I'd like
6 to thank you very much for coming to the Inquiry this
7 afternoon as its first witness and to share not only
8 that evidence but also your insights and reflections on
9 the matters about which you've been asked. I'm very
10 grateful to you. You're now free to go.
11 **A. Thank you.**
12 THE CHAIR: Now I take it that there are no other matters
13 that I need to be undertaking this afternoon?
14 MR DAWSON: That's correct.
15 THE CHAIR: Thank you very much everybody. We'll see you at
16 10 o'clock tomorrow morning. Thank you.
17 (4.32 pm)
18 (The hearing concluded)
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