Friday, 11 September 2026
(10.09 am)
THE CHAIR: Good morning, have a seat. Yes, Mr Dawson, good morning.
MR DAWSON: Good morning, sir. The first witness this morning is Professor Frank Smith.
THE CHAIR: Thank you and this witness is giving evidence remotely, I understand.
MR DAWSON: He is, indeed.
PROFESSOR FRANK SMITH (called)
THE CHAIR: Professor Smith. Good morning, can you see and hear me all right?
A. Good morning, sir. Thank you very much for accommodating me virtually. I can see and hear you perfectly.
THE CHAIR: I think we can at this end. If anyone has any difficulty they can obviously let me know.
PROFESSOR FRANK SMITH (sworn)
Questions by COUNSEL TO THE INQUIRY
MR DAWSON: Good morning, Professor. Can you see me okay and hear me okay?
A. I can hear you perfectly, thank you.
Q. Excellent. Thank you very much. You are Professor Frank Smith?
A. Correct.

Q. And you have provided a witness statement to the Inquiry as I understand it; is that correct?
A. That's correct, yes.
Q. And you've done so on behalf of the Royal College of Surgeons of England?
A. Yes, that's correct.
Q. Could we have RCS-00021 up on the screen, please. Is that an electronic copy of your statement?
A. Yes.
Q. Could we go to page 32, please. Is that where your signature appears on the original version?
A. Yes, that's correct.
Q. And the statement is dated 26 February 2026?
A. Yes.
Q. And are the contents of this statement true, as far as you're concerned?
A. Yes.
Q. Could we just have a look at page 33 as well. I think you've also signed there; is that correct?
A. Yes.
Q. Confirming that you have -- the Royal College has provided all documents which we hold to the Inquiry under appendix C, is that right?
A. That's correct.
Q. And appendix C was effectively a request for you to

provide certain categories of documents relevant to matters covered in the statement, was that right?
A. That's correct.
Q. Thank you. Professor, by way of professional background your qualifications are BSc, MBChB, MSc, MD. You're a fellow of the Royal College of Surgeons of England, of Edinburgh, of Glasgow and of Ireland and a fellow of the European Board of Vascular Surgery, as well as a fellow of the Higher Education Academy; is that correct?
A. That's correct.
Q. We've had some evidence to the Inquiry recently about the role of the Royal Colleges and fellowship, in particular someone from the Royal College of Surgeons of Edinburgh. Am I correct in thinking that you are a fellow of all of the Royal Colleges that operate in Britain and Ireland, in the surgical field?
A. That's correct.
Q. My understanding is that those four colleges work together to provide standards and examinations. Could you give us a rough outline as to the sort of work that they do in a collegiate sense with all four working together?
A. Yes. The presidents of the four Royal Colleges, the vice-presidents and the chief executives meet four times a year at the joint surgical colleges meeting which

rotates around those four colleges, to discuss matters which pertain to the conduct of surgery in the United Kingdom particularly the development of training, sometimes to do with working conditions and towards developments in surgery and indeed concerns arising in surgery.
Q. I think we also heard some evidence about there being a joint examination system; is that correct?
A. That's absolutely correct. One of the pivotal functions of the Royal Colleges is to ensure the quality of the surgeons who practice within the United Kingdom and Ireland and one of the pivotal sub-functions is to ensure that there's an appropriate standard of examinations both at the basic surgical examination level, the MRCS, and also at the higher surgical examination at the time before a trainee would expect to become a consultant and that's the FRCS examination. Between the four colleges those examinations are maintained through two organisations, the intercollegiate basic surgical examinations committee, and the joint colleges intercollegiate examination committee, JCIE.
Q. Thank you very much. To return to your CV, you are Emeritus Professor of Vascular Surgery and Surgical Education at the University of Bristol; is that correct?

A. That's correct.
Q. And you trained in vascular surgery in the West Midlands, Edinburgh and the Southwest, undertaking travelling fellowships in Boston, Denver, Los Angeles and Seattle; is that correct?
A. That's correct.
Q. We were interested in the fact you'd spent some time in your training in Edinburgh, when was that?
A. I spent one year in training having completed what was then my house jobs. In those days that was a one-year period, the house job, now it's the two years foundation programme. Following that in order to prepare myself for the surgical examinations I undertook a year teaching anatomy at Edinburgh University Medical School in the role of demonstrator in anatomy.
THE CHAIR: Mr Dawson, I'm just going to pause. I think we might want to turn the volume up very slightly. It's capable of doing that and I think if those who are in control of these matters can hear me and can attend to that, that would be appreciated. Right, assuming the message was heard, perhaps you can continue.
MR DAWSON: Thank you very much, sir. We heard some evidence yesterday from the Medical Director of what was NHS Education for Scotland who told us about the importance, in particular the surgical field was the

context in which we were discussing it, of moving around to different places to get different surgical experiences because where one might be based might not offer all of the surgical experience that one would need to be able to pass the examinations. As someone who appears to have travelled around to various places, is that a phenomena that you recognise and how important is that in surgical training?
A. I think it's important to get a perspective from a broad spectrum of sources across the healthcare system as a trainee so that you don't just become imbued with the practices from one particular institution and indeed certainly currently, and in the past, one applied for training posts. Nowadays there's a system of national selection in which there may be relatively random allocation of trainees to particular posts and then they will rotate around several hospitals within a region, picking up various aspects of different experiences.
Q. And the perspective that you talk about, does that cover both a technical perspective on surgery, perhaps what one might describe as non-technical approach to the way a surgeon should conduct him or herself?
A. Yes, I think that is true. Certainly it's vital for surgeons to develop their technical skills and non-technical skills, of course, are just as important

in terms of how one deals with patients, how one deals with one's peers and one's colleagues, learning things like communication skills. So you've hit upon an important point there, thank you.
Q. There's a word that's come up in some of the evidence that we've heard so far which is been used in the context of standards being applied to surgeons and I've seen it appear in some of the documentation you've supplied, which is the word "probity". Is that an important quality in a surgeon and could you give us a brief definition of what the Royal College of Surgeons of England would think that means?
A. Yes, you've highlighted an important point. In fact, I had never come across probity until -- the word "probity" until it began to appear in appraisals along the way. And it really refers to the intrinsic honesty and conduct of any clinician with respect to how they look after their patients, how they deal with their colleagues with respect to honesty and, in effect, it encompasses the quality of surgical care as well as just integrity and honesty.
Q. So it would be a feature of a good surgeon's relationship with patients, with his colleagues, his or her colleagues, with other professionals and organisations with whom he or she comes into contact?

A. Absolutely.
Q. Thank you. You have, I think, been nominated to provide this evidence on behalf of the Royal College because of the fact that you hold the position of the Chair of the Royal Colleges' Invited Review Mechanism and have held that since July 2023; is that correct?
A. That's correct.
Q. Could you tell us broadly what the Invited Review Mechanism is and what it's designed to achieve?
A. Yes. I can. The Invited Review Mechanism was set up in the late 1990s in order to provide a mechanism which could assist hospitals, trusts, where necessary or where wished for by the trusts, to improve the services that those trusts provided to patients and to the public and underpinning everything that the Royal College of Surgeons does really are quality improvement measures to improve outcomes from patients and the public.
And the Invited Review Mechanism, it has to be -- it's what it says on the can, it is invited by a trust to come in and carry out one of three sorts of review. Where a trust has particular concerns over an individual practising surgeon, they may invite the IRM to come in to perform an investigation on aspects of that individual surgeon's practice. They can also carry out a case review and that may be of an individual case or

a series of cases where there have been concerns about outcomes or, for instance, the trust may have received complaints that have promoted concerns and they then might invite the review mechanism in to investigate those complaints.

And finally, in trusts in which it's perceived there may be some dysfunctional problems in a service or some problems that may need to be improved in a particular service, the IRM can be requested by the chief executive or Medical Director of that hospital trust to come in and to perform an investigation of the particular service in question and to provide a report on that.

So those are the three areas in which the IRM helps.

I should emphasise, even at this point of the Inquiry, that the Invited Review Mechanism is an advisory body. It sets up terms of reference for any particular investigation very carefully with the trust. It is hired by the trust, so in effect we're a private body, and bear in mind the Royal College of Surgeons is a membership organisation and a charity, and therefore the IRM and the college have no regulatory or statutory powers, and I think that's important to understand in the context of the IRM. I hope that does answer your question.

Q. Thank you. That's very helpful indeed, Professor. You

mentioned there the possibility of a trust approaching the Royal College to instigate the Invited Review Mechanism. Although at one stage we did have health trusts in Scotland, the operation largely over the period we're looking at is run by the health boards rather than trusts, although the initial periods there were health trusts in Scotland. Do I take it such a mechanism was as freely available to health boards in Scotland as it was to trusts in England?

A. It was. It's available, in fact, to any of the devolved nations in the United Kingdom to the Channel Islands and indeed to Ireland as well and to private healthcare systems as well as NHS systems.

Q. Thank you. And do I take from that, that the bodies who are able to invoke the service of the Invited Review Mechanism are healthcare providers broadly in both the public and private sector?

A. That's correct.

Q. Rather than individuals, for example?

A. Individuals can ask for an invited review but, to be quite honest, in the context of the many reviews that we have carried out I am unaware of any contracted individual reviews, they're almost -- well, inevitably undertaken by either, as you say health boards perhaps in Scotland, or NHS trusts in the rest of the

United Kingdom.

Q. Thank you. And I think that in considering the various different types that you set out of the types of review one can look at, you mentioned, I think, a service review. One of the important features of our Inquiry is that rather than looking at clinical circumstances of cases we are looking at -- the word we tend to use is "systems". Would a service review -- would "system" be a synonym in those circumstances for service or is there a particular difference between the two?

A. No, I think you're quite right that it could be regarded as a system as well as a service. Indeed, services work on the basis of systems.

Q. Thank you. And I think the documentation that you've helpfully sent of the various sort of rules and regulations which govern the invited reviews over various different time periods indicate that there is a payment made for the review being undertaken, is that right?

A. That's correct, it's a private contractual arrangement between the trust and the Invited Review Mechanism. As the invited review oversight Chair, I actually rarely see any of the financial contracts, those are dealt with by the management team within the college who look after that.

But my understanding is that the fees are proportionate, depending upon the amount of perceived work that will be involved within the review.

Q. Right, and obviously we'll come to this in due course but there are reviewers who are appointed to undertake a review and do the -- does the payment which goes with the contractual arrangement go to the college or to the reviewers or split between them, how does that work?

A. Again, I'm not fully conversant with that but the payment, the overall payment for the review, goes to the college. The reviewers are either individually remunerated to the tune of £450 per day if they are attending a review, and it's done -- undertaken in their private time. If they are undertaking a review -- and these are all experienced volunteers who volunteer for a review but are screened to become reviewers, if they undertake it within NHS time that £450 fee is paid to the trust.

Q. Thank you. And is it, based on your understanding of the system, an important feature of it or perhaps an attraction to it for boards or trusts that wish to have an invited review, that it is independent?

A. My feeling is that it's completely independent. The people who tend to be put forward or asked to undertake these reviews are all experienced clinicians. In terms

of remuneration, although it may sound like a lot of money to be paid £450 per day, the work involved in these reviews is significant. They are there are often significant travelling implications and the people who undertake these reviews by and large do it for altruistic purposes and because they want to see improved standards for patients and public across the healthcare spectrum. So we would look at reviewers and we would make sure that any reviewer who was appointed to a specific review had a completely independent process, there were no conflicts in terms of their commitment to the review, that they had no, for instance, role within the healthcare organisation that they're investigating or indeed any personal contact with any individuals who might be under review.

Q. Thank you. You've helpfully, in your statement, set out a history of how the Invited Review Mechanism came about and I think you describe that it was something that was set up for the reasons that you've already given evidence about in the aftermath of the Bristol Royal Infirmary Inquiry; is that correct?

A. That's correct, yes, the Royal College and the Federation of Surgical Specialty Associations, and there are ten surgical specialties, met and felt that they should convene a body which would be helpful in advising

hospitals, trusts or boards on how to improve services where there were perceived problems within those services.

Q. That Inquiry, I think, was an Inquiry about deaths in the paediatric cardiac unit at the Bristol Royal Infirmary, is that correct?

A. That's correct.

Q. Could I ask please to have up on the screen paragraph 4.2 of the statement -- sorry, paragraph 7.2 of the statement?

A. If you'll forgive me, I have my papers in front of me. I find it hard to read on the screen, but I will try and focus on my papers in front of me.

Q. I have exactly the same next to me, Professor. So there's no apology required at all.

In this paragraph you provide, I think, what is another important feature of the Invited Review Mechanism because you tell us that:

"[It] provides a fair, independent professional review which will support, but not replace, a healthcare organisation's existing local procedures for dealing with such matters (or the processes of any United Kingdom formal regulatory body). In certain circumstances where a healthcare organisation needs an external opinion, an invited review can provide

expert independent and objective advice. An invited review supplements -- but does not replace -- a healthcare organisation's existing procedures for managing surgical performance or the processes of any formal regulatory body."

So you're making clear there, as I think you do on a number of occasions in the report, I think that it is an important thing to understand about this review mechanism that it does not, in any way, remove or diminish any responsibility that the healthcare provider asking for it would have in connection with the subject matter of the review?

A. That's correct.

Q. And indeed I think you allude to the fact that, in the event that there were matters that were being looked at which gave rise to the need for it, it wouldn't, in any way, replace or diminish the requirement for the General Medical Council to become involved in certain circumstances?

A. That's correct as well.

Q. Indeed, I think you tell us in your statement, and the material shows, that the Royal College requires that for a review to take place one of the conditions is that the healthcare body requesting it requires to provide an indemnity for the college, associated bodies, any

specialist association involved and the reviewers; is that correct?

A. That's correct as well.

Q. Thank you. And I think you've touched on this already, Professor, but my overall impression from the materials you've provided is this is really a service provided in association with the college's commitment to high surgical standards, public service and indeed what you tell us in your report is one of its core values which is "putting the interests of patients at the heart of all we do". Is that correct?

A. That's correct.

Q. And those are important elements of the college's philosophy and function?

A. Yes, absolutely.

Q. Thank you. Could I just ask you please could we get paragraph 3.9 up. A particular feature of the RCS as a body which is of interest to us that you say:

"RCS England is a professional membership organisation and registered charity ... funded through membership fees, income generated from its activities and investments and charitable donations, grants and legacies."

This is the bit I wanted to focus on:

"RCS England is independent of the UK NHS and

government."
So it is independent full stop, if you like, but it is also independent in particular of those two organisations. Perhaps putting it in -- to put aside its vast resources and experience in surgery, it also is independent of those institutions?
A. That's correct, yes.
Q. Thank you.
Could I ask you to look at paragraph 4.3, please?
A. I have that, thank you.
Q. Just getting it up on our screen. One aspect that I was just wanting to pick up with you is you helpfully have tried, I think, to put the statement in a Scottish context for us which is extremely helpful. You mention there that:
"Healthcare Improvement Scotland ... (founded [in] 2011) is the systems regulator for healthcare in Scotland and inspects, reviews and enforces standards in Scottish Health Boards."
If I might, Professor, I might suggest a slight correction to that because Healthcare Improvement Scotland is in fact not the regulator of public healthcare deliverers but it is of private healthcare deliverers in Scotland. In England, is there a body that regulates public healthcare providers?

A. Well, the GMC and CQC would be bodies that influence and regulate healthcare, certainly.
Q. As far as the providers are concerned, the Care Quality Commission that you've mentioned would have a role in the regulation of those?
A. Yes, and in monitoring standards within trusts.
Q. Yes, because although Healthcare Improvement Scotland is a national agency for improving health and social care in Scotland, and has been since 2011, it is not a regulator in that sense.
A. I stand corrected.
Q. Thank you. There is a wider significance of that aspect of the evidence to the Inquiry so I thought it important to make that slight correction and also thank you of the clarification of the position in England which, I think, is different.
Could we go to paragraph 5.1, going back to the Invited Review Mechanism again.
A. Yes, thank you.
Q. You tell us there that:
"The structure of RCS England and a list of key individuals and their roles within RCS England over the relevant period (i.e. the period in which the invited review took place) are included in the RCS Annual Reports ..."

Which you've helpfully provided to the Inquiry:
"Internal oversight and governance of the IRM was provided by the Invited Review Mechanism Joint Standing Committee ... subsequently known as the Invited Review Oversight Group ... from November 2015."
Now, in relation to these oversight groups, one aspect that I wanted just clarify with you, does that mean that those groups oversee the operation of the mechanism in general or that they oversee specific reviews?
A. People within the group would oversee specific reviews but we have meetings of that group too, to have a look at the process in general, to pick out learning points from the reviews we're involved in. And not every person on that committee would be involved in specific reviews. The chair of the Invited Review Mechanism and the individual members of the invited review group who represent their own surgical specialties would be involved in any specific reviews related to a specific specialty.
Q. The reason I ask is just because, as we will come to in a moment, Professor, we're trying to piece together, with perhaps not all available information, what happened in the timeline, if you like, related to the invited review which was undertaken by the Royal College

in relation to Mr Eljamel's practice, and to an extent wider matters in 2013. And a matter of interest in that regard is the process which was gone through and therefore I'm interested to know whether part of that process would have involved some level of oversight by someone beyond the three reviewers whom we know undertook the actual review and whether time in the process -- I'm not suggesting in any way time that was not well spent, but time would be taken for someone in an oversight role to be checking a report, or being involved in some way?
A. If I could just sort of elucidate that a little bit. It works now, as it did then, I believe. A request would come in from the chief executive or the medical director of a trust to -- which would initially be vetted by the chair of what it would have been at that time, the IRMJSC that you refer to now, that would be myself as chair of the invited review oversight group. Together with the manager of invited reviews, who is a college employee, that request would be vetted carefully, a formal request would be accompanied by a covering letter and vetted. And the specialty involved would then be contacted by both the manager and the chair of the invited review oversight group and each specialty had a specific lead and at that time, that was

an eminent surgeon, Mr Richard Kerr, he would have been involved and once the Invited Review Oversight Group had decided to accept the review, and terms of reference had been drawn up by the trust involved and the manager and of the Invited Review Mechanism, then the chair of the invited review and the lead for the particular specialty would confer to produce a list of potential reviewers that could be invited to undertake that review.

Q. And as the review then progressed beyond that stage, would the oversight group have any further role or would it just be in relation to the set-up and acceptance of the remit?

A. Certainly at this time, and I have no reason to think it was any different when Dame Clare Marx, who was the chair of the Invited Review Mechanism at that time, the chair reviews all correspondence as it comes in and it quality assures any correspondence going out, making sure that any correspondence from the colleges make it back to the trust.

Q. There is mention of quality assurance in the statement and that's a function that the chair undertakes at every stage; is that correct?

A. Yes, that's correct.

Q. Thank you. You mention in the statement that it would be possible -- and given that it's a private contractual

arrangement this is perhaps not surprising -- for the Royal College to, I think, the word used is to "decline" to undertake a review. In what sorts of circumstances might that happen, hypothetically?

A. Well, I can give you an example of an unnamed review which we were solicited for recently. To put it quite frankly, the workload would have just been unsustainable by what is relatively a small organisation and that review has to be undertaken by the NHS itself.

Q. And would it be fair to say, based on your experience of the system, that when an invited review is commissioned from the Royal College by a healthcare provider, that the circumstances tend to be quite serious?

A. That would be the perception. There's always something that stimulates concern, otherwise an invited review would not be requested. It may be as simple as a single case that has caused concern within an institution who feels that they wanted an external review, or it may be perceived to be a specific problem. So the very request of an invited review tends to suggest that the organisation is aware of a potential problem which it wants resolved, or at least clarified.

Q. And given the fact that the purpose of seeking the review is to seek the expert advisory independent assistance of the Royal College, does it tend to suggest

that the healthcare provider feels that it needs some sort of assistance with resolving the problem?

A. I think that's, you know, a correct perception. It may be that the individual healthcare provider is not quite sure at what level a problem exists, for instance in a systems-type review as you referred to. Or it may, as in other reviews, have been responding to complaints from the patient -- from patients or public that they feel they need a response to and an independent assessment of the underlying problem. So yes, that is correct.

Q. Thank you. You've helpfully -- just for our purposes, you've helpfully provided to us a set of regulations I think were in place at the time. For our records it's RCS-00012. I don't think I need to go to the particulars. But one of the things you've already mentioned in terms of the processes involved is that part of the contractual arrangement, if you like, is that there is a set of terms of reference fixed; is that correct?

A. Yes, that is correct.

Q. I think you mentioned a moment ago part of the oversight function is to be involved in that and that that would be agreed with the -- is it the lead of the group that's actually carrying out the review and the healthcare

provider?

A. Yes. The way it would work usually -- for instance I have a number of functions in the college, so I don't get involved in setting up the terms of the review or negotiating directly with the chief executive or medical director of the trust. The invited review manager whose sole role in the college is to deal with invited reviews and has a great deal of experience would meet with the medical director or the chief executive, and they would form a concise framework of the terms of reference into what the invited reviewers would investigate.

They would not stray outside those terms of reference. It's really important that because reviews usually take place over two or three days, that there is a very concise framework and that the questions perceived to be really important to the trust or the board are dealt with, and that can only be done through a concise framework rather than, if you like, a meandering through a variety of other circumstances that the college has not been informed about.

Q. I see, so the process then, in case there was a misconception about what agreement of the terms of reference means, effectively it is getting the healthcare provider to be clear about the questions that are being asked, is that right, in the first instance?

A. Yes, absolutely.
Q. But beyond that, it's not for the Royal College to say: well, perhaps you should ask some other questions. It's for the Royal College to say: yes, that looks acceptable to us?
A. The college says: that looks acceptable. They may add a clause that if concerns arise during the course of the review that, if the trust wishes to, the remit of that review could be extended. And I think that happened in this particular review, there was some mention of the potential to extend a certain part of the review if necessary. But usually the terms are fairly concise. And obviously if anything relating to patient concerns arises during the review, that's communicated to the director and then the trust can commission further work if that's necessary.
Q. I see. So if the initial material suggested that there were patient concerns beyond the preliminary or initial remit, it might be that the college would suggest this mechanism whereby further work could be commissioned, because those concerns look like they perhaps should also be addressed; is that correct?
A. That's correct.
Q. Thank you. I think actually it would be helpful to look at some of the components of RCS-00012, please. Could

we have that up. Page 6, paragraph 3.6 which relates to terms of reference and supporting documentation.
A. I'm sorry, if you could just -- this is in the bundle ...?
Q. It is.
A. Which page would that be?
Q. I'm on page 6 at paragraph 3.6.2.
A. Thank you very much, I'll find that. No, in my bundle I have the General Medical Council's "Good Medical Practice" document. So it may be that -- sorry, I'm not going to the document you've referenced, first of all. Which document was that?
Q. This is the document of the regulations that were in place at the time. I can read you out the passage, if you like?
A. Yes, if you could, that would be very helpful.
Q. The passage that I'm talking about, this is in a section of the regulations that were applicable at the time. You provided us with a number of different versions but we think this is the one that was applicable at the time.
A. Right.
Q. This is the section which deals with terms of reference and supporting documentation. Paragraph 3.6.2 says:
"When identifying the personnel to be seen by the

reviewers, the Chief Executive or Medical Director is asked to ensure that, in the interests of fairness, the surgeon being reviewed has the opportunity to comment on the list before it is submitted to the reviewers. If, within reason, the surgeon believes that there are other members of the clinical team that should be part of the review, he/she must inform the hospital which will, in turn, inform the reviewers. If the surgeon concerned has any strong objections to any person on the list, he/she will be asked to explain the nature of the objection."
So there is a mechanism whereby the surgeon can become involved, the surgeon who is under investigation or under review can become involved, but it would appear to a relatively limited extent; is that correct?
A. It's as it states in the paragraph, you're quite right.
Q. Yes, and as far as -- there is then, it says at paragraph 3.6.3, after that opportunity for the surgeon to produce any comments on matters in particular in relation to whether other members of the clinical team should be part of the review, it says:
"In finalising the terms of reference for the review with the hospital, the reviewers will have the opportunity to request from the hospital or from the surgeon being reviewed additional information they

believe necessary to further the review process."
And it says that:
"The Chief Executive or Medical Director of the hospital is required to make available all relevant documentation relating to the terms of reference for the review and the questions the reviewers are asked to consider, subject to compliance with its obligations on patient confidentiality and any other obligations of confidence and obligations under the Data Protection Act, 1998."
So, in effect, the terms of reference are finalised after the surgeon has this limited opportunity to input; is that correct?
A. Yes, that's correct.
Q. And then beyond that, which one can understand is important, it is not in general terms for the hospital or the healthcare provider to determine what materials should be provided because what requires to be provided is all available relevant documentation, subject to the patient confidentiality and data protection issues, is that right?
A. Yes, all available relevant documents.
Q. Yes. That's obviously important to enable the reviewers to be able to conduct as thorough a review as possible?
A. That's correct.

Q. And I think also, you've mentioned already in your evidence, Professor, that there can be travelling involved in being a reviewer and they can take a few days. There is a mechanism whereby effectively what lawyers might call oral testimony can be adduced and people involved or connected to the matter and the terms of reference can be interviewed. Does that happen in every case or is that a matter for the reviewers to determine?

A. Almost in every review that I've had any dealings with there are some face-to-face interviews.

Q. Why is it deemed important that face-to-face interviews like that take place?

A. It's important to ensure that a full range of views, concerning either the system or the individual being investigated, are solicited. I think it's part of fairness, and it's part of an equitable approach to gaining all the data necessary to get a picture of either an individual or a system.

Q. Thank you. And as far as which individuals might be interviewed or involved in that way. Obviously the reviewers will not know who the individuals in a particular hospital might be and so who decides, effectively, who gets on to the list?

A. The trust itself would have responsibility for compiling

a list of all of those engaged -- let's say, we're talking for this purpose of an individual, all of those engaged with or having practice relevant around that individual, usually members of the team, members who work with the individual, managers for instance who are involved with the individual, and right down to theatre staff, to other professionals within the hospital who have a professional role that would have been concerned with the individual's role.

Q. But in the same way as the reviewers are entitled, under the contractual relationship, to have access to all available relevant documentation, would it be expected that the reviewers would be able to have access to all available relevant individuals, perhaps not knowing them who they are personally, but the type of individual if you like, colleagues you've mentioned, that sort of thing?

A. Yes, that's correct and indeed, often there's quite an extensive list of people who will be interviewed by the reviewers.

Q. What about the practice or protocol around interviewing, in the type of case we're talking about where an individual is involved, the individual surgeon themselves? Would that always happen or is that, again, a sort of discretionary matter?

A. No, in my experience, it always happens.

Q. I suppose that would be in connection with considerations of comprehensiveness of evidence but also fairness to the surgeon?

A. Absolutely.

Q. To be able to give an explanation or a point of view?

A. And indeed, the reports reflect both aspects of commentary on a particular surgeon, those positive and those that are not perceived to be positive.

Q. For either administrative or procedural reasons, is it normal in the reviews for an attempt to be made, first of all, for people to be interviewed where they work, if you like, within the hospital?

A. It would almost inevitably take place in a hospital but to my knowledge, the reviewers don't usually move around. The trust is asked to provide an environment in which they can confidentially meet those that they are interviewing, so it would usually take place within a hospital.

Q. So because it might be important that in order to be able to provide explanation or an account of things, it could be useful to do it in the very environment in which work was delivered, I would imagine?

A. Yes, and although in this case it doesn't happen, occasionally of course somebody is away because of

annual leave or they're indisposed and then, if considered necessary by the reviewers, a further interview can be undertaken, either on a face-to-face basis but nowadays occasionally virtually.

Q. As we'll probably touch on, we'll get into the details of the particular review, of course, in a moment. But one thing that might be useful just to clarify at this stage is the documentation that's been available to you in connection with this. You, of course, were not personally involved in the review in 2013, were you?

A. No, I was not and indeed, in terms of my statement today and the only document that I had seen, with the exception of the two bits of correspondence that I have been provided with this morning, has been the original review report. Because, as you well know and I'm sure you will touch upon, all other documentation, once a report has been completed and given to the trust or the board concerned, is subsequently destroyed within a set timeframe that appears within the handbook of both the 2013 period and subsequently in the 2014 and later period.

Q. Indeed. So the position is I think it's actually the case from your statement that you've been asked by various different agencies, including the police at one stage, for access to any additional documentation you

might have beyond the report itself, is that right?
A. Yes, that is correct.
Q. And over the timeframe in which these requests have been made, your consistent position, as it is today, has been that the only piece of paper that the college retained, as in accordance with its practices, was the report itself, is that right?
A. That's absolutely correct. You will have the email trail I think between the college and the police.
Q. We do.
A. And the original request for information. The handbook -- both the 2013/14 and '18 handbooks, and I have dug that up, looks at a specific paragraph on data retention, which states:
"There are no legal requirements regarding the minimum period of time that college and reviewers should retain documents related to invited reviews. The college will normally retain documents relating to a review for four years, after which they will be confidentially destroyed." (As read)
I think the review in question took place in 2013. So I don't know when these documents were destroyed and indeed, I can't find records of that and we don't have records of that. But I believe the four-year period would have been around 2017 to 2018 and that would have

been prior to any notification by the police that they wished to access records.
Q. Thank you, that's very clear. Just while we're still on the subject of the documents, the review is conducted under the rules, as I understand it, under rules of confidentiality broadly, is that right?
A. That's correct, yes.
Q. But although it is the case that in almost all circumstances the college will be bound by confidentiality in that it won't reveal any of the contents of the review or the review itself to anyone, the opposite does not apply to the healthcare provider, does it?
A. I'd have to look at the precise terms but there's certainly advice in the handbook that advises the healthcare regulator of the board, the trust, that full confidentiality should be maintained within that organisation, where appropriate and necessary.
Q. But as far as -- I think you say in the statement that at the end of the review the materials and the report become the property of the healthcare provider, is that right?
A. Absolutely correct.
Q. So if we're to take the circumstances we're in here, it would be perfectly open to a health board to make the

review available to any organisation or individual that it thought appropriate to make it available to; is that correct?
A. That's correct and indeed to anybody investigated in the review themselves.
Q. Yes. So for example, in the case we're looking at, NHS Tayside, or the medical director of NHS Tayside who requested the review, could have made the review findings available to, say, Scottish Government?
A. That's correct.
Q. Could have made it available to other members of staff who were involved in the review who may be touched upon by matters concerned with it?
A. I -- I would have to enquire of the organisation itself as to -- my understanding is they would only make the report available to those for whom it had direct implications in improving safety standards.
Q. So it could've been made available to the General Medical Council, for example?
A. Indeed, if necessary, that would be the advice that it should be and that would be done through the General Medical Council liaison officers who liaise with individual trusts.
Q. Yes, thank you. And therefore, I suppose within that definition, would also be bodies like Healthcare

Improvement Scotland who have an important role in that?
A. Yes.
Q. Thank you. So on a particular general point, again the rules -- I'll just read them out to you, again, relate -- this is from the regulations in place at the time. This is to do with the subject of the extent to which it would be possible for -- in any circumstances, for the college itself to divulge any of the contents of the information to anyone. It says:
"The College ..."
This is paragraph 3.7.8 of the document I was looking at before which is RCS-00012. It says there:
"The College, the Association and/or the reviewers reserve to themselves the right to disclose in the public interest but still in confidence to a regulatory body such as the General Medical Council, the National Patient Safety Agency or the Care Quality Commission or any other appropriate recipient, the results of any investigation and/or of any advice or recommendation made by the College, the Association and/or the reviewers to the hospital. The College will only disclose this information on rare occasions, when it is apparent that the hospital has not taken appropriate action following receipt of the report.
"The hospital must within six months of receipt of

the report provide feedback to the College on the progress made on implementing the recommendations from the report."

So the position is -- at least at that time, the position was that it was possible in the public interest on rare occasions for the outcome of a review to be made available to the General Medical Council or other bodies involved in healthcare improvement and safety, but that that would only happen effectively at the end of the process when the report had been received; is that correct?

A. That's correct.

Q. I suppose one might ask the question, as to how that sits with the obligations of the college and bodies and members of it with regard to reporting matters of concern to the General Medical Council when they are, themselves, subject to its jurisdiction. Could you explain to me how that is resolved? Presumably the private arrangement says something different to that but there are those obligations which one might suggest would mean that things might have to be divulged during the course of an investigation, for example?

A. Well, as you say, it's a private contract between the Royal College of Surgeons and the trust. However, of course, when there is an immediate concern of potential

patient danger that has not been resolved or addressed by other methods or other communication with the trust, then there is the option for the Royal College of Surgeons directly to contact the General Medical Council as indeed there is for any individual or body where they have concerns.

This is rarely invoked, indeed hardly ever invoked, because the advice comes to the trust on completion of the review at three different stages. When the review is completed, and before the reviewers depart the institution, we have a face-to-face meeting with whoever commissioned the view, either the trust medical director or the chief executive and their initial and immediate advice is given at that stage.

There then follows an interim letter which comes very shortly after the review has been completed and that's to provide some paper guidance and then the full review is completed, quality assured, before it goes back to the trust and that may add further recommendations.

So the college rarely would be in a situation where they had not communicated their concerns to the medical director and the chief executive and had assurances that those individuals and the trust board itself would act on those initial recommendations, and I think in the

nature of reviews, because the trust or board had concerns in the interim one, would hope that they would act on that and indeed the college seeks evidence that they will act on that. They follow up at feedback shortly after the review and then subsequently at six-month periods until they remove themselves from the review process.

But rarely would we be in a position in which allowing somebody, for instance as an example practice for another 24 hours, would necessitate some sort of induction or cessation of the practice instigated by the GMC.

Q. Thank you.

A. I'm sorry if that was a little convoluted.

THE CHAIR: Mr Dawson, could I just ask a point of clarification which -- Professor, the paragraph that we just looked at, I'm not sure if you have it in front of you but it's the one that's concerned with feedback: the hospital must, within six months of receipt of the report, provide feedback to the college on the progress made on implementing the recommendations in the report.

Can I take it from an answer that you gave just a moment ago that it doesn't follow from that, that a period of six months will elapse before the college would receive any such feedback?

A. No.

THE CHAIR: Because I think I understood you to suggest that there may be communication within that period of time and indeed potentially shortly after the report was finalised?

A. Absolutely, sir.

THE CHAIR: Yes, thank you.

MR DAWSON: So the general position would be -- the normal experience would be that at the end of the process the concerns, if they had been found, would be communicated and there would be a process whereby the healthcare provider would provide an explanation to the Royal College about what they intended to do about those concerns and in most cases one would imagine that undertakings given that certain steps will be taken would be taken at face value and one would hope that they would be satisfactory to address the concerns, presumably often in line with what had been recommended?

A. Yes, and it would usually go further than just a verbal assurance. We would expect to see a written action plan and indeed, in the follow-ups we would expect to see some sort of written evidence. Now specifically, again I'm afraid within this case, I can't state what evidence we did or didn't see at the time because I only have the report to go by but it would be usual that it's not just

a verbal assurance, that we would want to see some evidence of improvements and meeting minutes, for instance, or those sort of things.

Q. Understood, thank you. The reason why I'm interested in this area, Professor, is you mentioned a moment ago, I think, that it's possible at the beginning of the process for the Royal College to suggest that a stipulation could be included within the terms of reference that further work could be commissioned, in particular where there were evidence of perhaps wider patient concerns than was the focus of the necessarily focused terms of reference.

What I wondered about was a situation in which a review was undertaken but at the end of it, the circumstances of the review gave rise to concern that perhaps, given perhaps the gravity of the concerns or the particular matters that had been reviewed, this could perhaps be the tip of the iceberg and not be the entirety, although the terms of reference said that this was the entirety of what required to be looked at, may not be the entirety of what in fact has been going on in an individual's practice.

In fact, in circumstances where even the evidence available may provide hints that there have been more long-standing problems than the very focused nature of

the review on, say, certain cases, would it be open, at least, for the college to make further investigations or make further suggestions more proactively than would normally be the case, given, of course, the overriding importance of public interest in patient safety?

A. I think if there was an underlying concern of any further risk or harm to patients that had not been encountered within the specific cases, for instance within a review, then that message would come across in the recommendations of the report. And I think, if you'll forgive me, in the context of this specific report recommendations were made to investigate a wider practice.

Q. Yes. I suppose what I might suggest is that the recommendations could have, in fact, gone even further than that and recommended an investigation into the full practice of the individual involved. The focus, I think, of the particular review here was on a number of complaints predominantly in the area of spinal surgery. But the report makes it clear, I think as we know, that the surgeon concerned had a much wider practice than just spinal surgery?

A. We could come to the report if --

Q. Yes. Well, perhaps that would be useful at this stage. The report is RCS-00014.

A. And I believe it would be in the recommendations which I will have to find.

Q. Yes.

A. And I will just mention that either I have frozen up a couple of times or you have, so I hope that the message is coming across clearly.

Q. Yes, absolutely. Thank you.

A. In my bundle it would be page 425, page 27 of the IRM report.

Q. Yes. That, for us, just for our record is RCS-00014, 27. Just to put it up on the screen for everybody in the room here. Page 27.

A. And I think it's under item 9, "Recommendations".

Q. Yes.

A. If I may just read from that report:

"It was also recommended that a review of Mr Eljamel's ..."

THE CHAIR: Sorry, Professor, if you could just pause while we get the document in front of us in a form that is readable. Thank you.

MR DAWSON: We have that. Thank you, Professor.

A. So comes under recommendations provided immediately following the review visit and it goes to the third paragraph. There are three bullet points and then the third paragraph:

"It was also recommended that a review of Professor Eljamel's spinal surgery cases be undertaken to ensure there were no wrong site surgeries that have gone unaddressed. An appropriate timescale for this review would be for the past three years, unless problems are found to have been evident for longer, in which case the scope should be extended."

Q. Thank you. If you have the document there, Professor, if we could look at page 4, just to give some context to what I was telling you about earlier. It's page 402, perhaps on --

A. Yes, I have that.

Q. So this is the initial summary, broad summary, of the circumstances, it comes just after the terms of reference, where it tells you a little bit about Professor Eljamel's -- it says "Professor Eljamel" on the documents -- background and it says:

"His surgical sub-specialities include: spinal surgery, neuro-oncology, skull base surgery and functional neurosurgery."

And it says that:

"Since 2012, he [had] been the lead surgeon on the Scottish Adult Neuro-oncology Network (SANON) board."

So, the matter I was raising, I entirely understand, Professor, that you've helpfully analysed the only

document you had available to you to analyse and you are telling us that one of the important recommendations that was made was that there should be this wider review as a result of what was found of his spinal cases.

There are other aspects, of course, other than just technical flaws, if one could put it so crudely, in Professor Eljamel, Mr Eljamel's, spinal surgical techniques. Those tend to suggest in certain places that there are other aspects, for example, that he had perhaps not been as candid as he might have been with colleagues in a more historic sense in relation to undefined surgeries.

So, given what I understand in neurosurgical context to be a particularly broad practice, I was simply asking you earlier in theory -- whether it was appropriate in this case or not, in theory, would it have been possible for the college to have made wider recommendations based on concerns that it might not just be in the spinal surgery that concerns about the practice may have impacted on the safety of patients?

A. Thank you, I think that's a very valid question. But you have to remember the college was asked specifically to comment on spinal surgery and many of the problems that arose in the review cases were related specifically to spinal surgery, particularly the case of the level of

surgery. And I'm a vascular surgeon, I'm afraid, I'm a plumber, so I don't see much neurosurgery. But I have asked colleagues -- particularly experienced colleagues, past, presidents of the Society of British Neurosurgery -- about how spinal surgery levels are determined during surgery. And a lot of the cases, I think, that we were looking at here were particularly to do with spinal surgery.

Q. Indeed.

A. We, and the college, has no remit nor access to understand the full extent of Professor Eljamel's surgery or indeed whether concerns had arisen about other cases in his broader practice. Were we asked to deal with that by the trust, then that's something, of course, we could have done. But a lot of the cases that were looked at in this specific review, as I understand, were due specifically to problems with spinal surgery and even more specifically the level at which this was undertaken.

My colleagues in neurosurgery tell me that standards in neurosurgery would involve firstly, interpreting imaging to determine the level of the problem, for instance with a spinal disc or a specific nerve route. Then at surgery, you would be expected to mark the skin to know that the level that you were working at with

respect to anatomical markers and locations. And having marked the skin during the operation, it would be good practice -- and indeed, there are recommendations, I believe, from the neurosurgical organisations -- to undertake some sort of imaging, either lateral fluoroscopy or X-ray with a metal marker placed at the site of the intended surgery. And nowadays it would be good practice, even before continuing with surgery at the specific level, to have a pause in theatre so that the whole team could agree that the level of surgery was the correct level of which this was undertaken.

I'm sorry if that's very specific but that's my understanding as to why we haven't tried to broaden the investigation with respect to, for instance, brain tumours or anything else.

Q. That's very helpful. Thank you, Professor. We'll take a break in a moment and we'll return to this after the break but there's just one technical aspect of that answer I'd like to follow up on. You mentioned the specialist association which I think plays a part in the Invited Review Mechanism which, in this case, I think was the Society for British Neurological Surgeons; is that correct?

A. That's correct.

Q. Could you explain, first of all, what the role of the

specialist associations is in the mechanism and also what the role of that body is with regard to, as this was, a neurosurgical review?

A. There are ten surgical specialties, neurosurgery is one of them. Every specialty has a specialty association; mine is the Vascular Society of Great Britain and Ireland. The Society of British Neurosurgery, the SBNS, represents the neurosurgeons in the United Kingdom and is their professional association, which all matters pertaining to the practice of surgery, surgical science and research are discussed. And indeed, they would -- or members of that society would form a part of the specialist advisory committees who determine the curriculum and examinations within neurosurgery which lead to professional qualifications.

In terms of an invited review, we would have liaised with the president of the SBNS to determine an appropriate senior reviewer to represent the SBNS on the Invited Review Oversight Group and at that time that was council member of the Royal College of Surgeons, Mr Richard Kerr, who provided a very authoritative and helpful service.

Q. Thank you. Just on the subject, while we're on it, of a liaison with the president of the Society of British Neurological Surgeons, you tell us in your report that

you, I think, very helpfully got in contact with the current president of the organisation, who I think is Professor Peter Hutchinson, in order to try to ascertain whether, in light of your organisation having a single document, whether they held anything further. But my understanding is that unfortunately they held no documentation at all relating to this review; is that correct?

A. Yes, unfortunately or not unfortunately, because they would have been advised by -- once a review is concluded, the review manager will send out a missive to all those involved to ensure that all documentation is destroyed to prevent any inadvertent data lying around on hospital or personal computers that could be accessed and could breach the Data Protection Act.

Q. I see. So unfortunate for our investigative purposes but fortunate for their data protection obligations?

A. Yes.

MR DAWSON: Right, okay. Sir, that would be a convenient moment for a break.

THE CHAIR: Yes, Professor. Thank you very much. We're going to take a 15-minute break now. To keep matters regular, we do ask that you don't discuss your evidence over that period of time. I have no concerns in that regard and we'll aim to start again just after half past

the hour. Thank you.

(11.18 am)

(A short break)

(11.33 am)

THE CHAIR: Right, if we could have the witness back, please. Thank you, Professor. I think we're ready to resume.

MR DAWSON: Hello, Professor. Can you hear me again?

A. Yes, I can. Thank you.

Q. We'd just started to talk about in some more detail, the 2013 invited review, and you have provided us, despite the fact you were working only from the review report, with some helpful evidence about exactly what you can make out from it. In particular, although you've provided more detailed evidence, at paragraph 18.1 of your statement, you've provided a chronology of the Royal College's involvement. If we could go to that, please, RCS-00021 at page 14, paragraph 18.1.

A. Thank you I have that.

Q. Great, we're just putting it up on our screen. And you tell us there that:

"A chronology of the involvement of RCS England with, or knowledge of, the professional practice of Mr Eljamel is as follows:

"26 June 2013 -- Request for an individual invited

review of Mr Eljamel's practice received from [Mr] Andrew Russell, Medical Director at NHS Tayside.

"16-17 September 2013 -- Invited review visit at NHS Tayside took place. The members of the invited review team and those interviewed in the review are detailed in the invited review report [which is RCS-00014]. The review team consisted of Mr Neil Kitchen, FRCS representing RCS England, Mr Nicholas Phillips, FRCS representing SBNS (jointly 'the clinical reviewers') and Ms Helen Carter ('the lay reviewer').

"2 October 2013 -- Mr Eljamel was interviewed by the invited review team.

"4 October 2013 -- An interim immediate advice letter was issued to the Medical Director of NHS Tayside, the details of which are summarised in the report.

"6 December 2013 -- Invited review report issued to NHS Tayside.

"28 January 2014 & 22 July 2014 -- Our review tracking system indicates that updates on the recommendations in the report were received from NHS Tayside.

"[And] 20 November 2014 -- RCS England IRM's involvement in the review concluded."

Just on a couple of technical details, as far as that second-last entry was concerned, you talk about some information being available in relation to the follow-up, if you like, on the recommendations from something called your "review tracking system". What is that and what information were you able to access there?

A. I'm not actually sure what the review tracking system refers to. I understand, from discussions with our head of invited reviews and our head of quality assurance, that there is just a spreadsheet of dates of correspondence. I have not seen that and I think the major correspondence or the evidence arising from the tracking system relates mainly to the correspondence with CID Dundee and the RCS head of invited reviews.

Q. I see, yes. You subsequently tell us about the correspondence that we've referred to already with CID Dundee, but we'll focus on the correspondence and actions related to the review itself. Another aspect of the chronology which I wanted to ask you about was there was obviously, as one can tell from the report, a really quite extensive investigation interviewing of a number of individuals within the hospital, as we discussed earlier, who had obviously some sort of connection to Mr Eljamel's practice between 16 and 17 September 2013. But it's interesting to note that Mr Eljamel himself was

interviewed, not when everybody else, was but on 2 October 2013. Given what you said earlier, would it be normal for there to be a separate interview or it's not part of the process or anything that the surgeon is reviewed separately, is it?

A. No, it isn't. You would expect the surgeon to be interviewed at the same time. I have absolutely no evidence I was informed that by head of quality standards that Mr Eljamel was not available until 2 October and that that was why he was not interviewed initially, but I don't have any evidence for that.

Q. And do you know anything about the interview that took place on 2 October, other than aspects --

A. I have no details at all, I'm afraid. I'm restricted to the report.

Q. Yes. There are, of course, aspects of what one assumes he must have said which are evident from the report but there isn't a sort of summary of what happened on that day or anything like that?

A. No.

Q. No. The other aspect that I just wanted to ask you about, which we'll come on to in more detail in a second, is what is an "interim immediate advice letter"?

A. As I sort of iterated earlier on, there's the verbal

advice at the end of the inquiry and then as soon as the team have left and have access to the review process and management team, an interim advice letter goes out which is quality assured by the head of invited review. So for instance, if one were to go out for one being undertaken at the moment, I would review that. Really just to make sure that, you know, typographically it's okay, it was constructed properly and that the essential advice makes sense.

Q. And so there are -- as I understand it then, there are two potential occasions in the normal process before a final report is issued where some sort of interim advice could be given, or immediate view or something, that would be verbally at the end of the visit, is that right?

A. Yes, that's correct.

Q. And the visit here would be the visit in September, I'm assuming?

A. That's correct, yes.

Q. And then is it always the case that an interim advice letter is issued or is it only in cases where there is something to be said in the interim?

A. No, it's always the case that an interim letter would be sent out just to put on paper. It really just amplifies the initial advice given verbally and puts that on

record for the individual trusts so they have something to work to.

Q. One of the concepts that we lawyers are familiar with when we talk about getting interim orders from courts -- so what we'd call here something like an interim interdict, or you might call an interim injunction -- is the need to try to persuade a judge that an order should be taken -- should be pronounced that would restrict someone's otherwise available rights, usually on the basis of limited information. And so usually, the means by which one does that is to try to persuade a judge of what's called a prima facie legal case and the second hurdle is that the judge considers it to be, on the balance of convenience, appropriate to grant the order. Effectively meaning that the benefits of granting the order in the interim would outweigh the downside of doing so.

Is it possible, even theoretically, even when the basic information is available to a Royal College before an investigation is undertaken -- I'm talking theoretically here -- that the prima facie information might be so alarming that it would recommend that something needs to be done immediately, as a judge might do in the circumstances that I have described?

A. I would think, if the review team encountered anything

that they felt was putting patients at risk at that instant basically, then they would make those recommendations -- and thank you very much for clarifying interim with respect to its legal context. I'm afraid we have a much looser context and it just meant a letter that came out in between.

THE CHAIR: I thought the Professor was very succinct as well.

A. But it was very informative, thank you. But I think the interim letter was sent took into context what the trust were already doing to protect patients from any further harm and the final recommendations had to be worked out and produced in the final letter, but the interim letter covered the initial recommendations which were designed to protect patients from any further harm within the context of what was happening already.

I believe Professor Eljamel's practice had already been placed under supervision by the trust which was hopefully protecting patients and indeed, it's a matter of complete conjecture and I have no idea but my hope would be that no patients were subjected to further harm under that period of supervision. And I'm not -- but I have no evidence of that.

MR DAWSON: Thank you. The reason I ask, Professor, is we because heard some evidence yesterday from the patient

safety commissioner for Scotland -- there's an equivalent role I'm sure you're familiar with in England -- and one of the dilemmas that she faced in her role was she only looks at systemic issues rather than at individual cases, so perhaps one of the two broad types much review that could be invited in the college, a similar sort of distinction.

But I asked her whether there would be circumstances in which a systemic issue could become apparent as a result of a single approach or a single patient case and she thought that that could be the case and also, I suggested to her that her remit might make it difficult to act on things quickly enough to protect patients. And the phrase she used to describe circumstances in which things -- there needed to be urgent action was a "now" issue.

Is it theoretically possible that there could be enough evidence, as I say, even before an investigation that is put before the Royal College that it could be a "now" issue such that interim recommendations could be made and I'm deliberately asking you before they even go to do the visit?

A. I think the role of the college is to assess the evidence and it's impossible to do that without undertaking the review. Broad recommendations, with

respect to generalisations, are that the college will always do whatever it could to protect patients. But in this case you will understand the trust or the board had an understanding of the practice of the individual surgeon and it was -- the college has no statutory or regulatory duties, but the trust does, of course, have a duty through its responsible officer to act on any concerns and if necessary to restrict practice themselves. And that might happen before an invited review took place. The invited review can only act on the basis of the evidence that it sources.

Q. But the first evidence it receives is the written evidence, isn't that right?

A. Yes.

Q. So what I'm contemplating is the possibility, given of course the dynamic between the two bodies, as we discussed earlier, I think you accepted that it would be normal if a healthcare provider were seeking the counsel of the college in this regard, he would be doing so because the people who were dealing with the review in the college would be very much more expert in the specific area and perhaps might have access to greater knowledge and expertise as to what to do about it. It is therefore possible, in those circumstances, that the healthcare provider might not know what to do and that

the experts, if you like, would look at it and go: oh, my goodness, this is a really very serious situation, you perhaps don't realise how quite serious this is, even on the written material we've seen, this is a "now" issue, if I can use the phrase. I'm simply exploring the theoretical possibility of that because obviously you have not seen all of the documentation provided. And indeed, even if you had seen it, you might not have seen all of the documentation that might have been provided.

So, I'm not asking you about the specific case, I'm simply asking, in the generality, given the dynamics, as to whether that is a possibility?

A. I'd go back to what I'd say really that our initial documentation is the express letter of concern seeking an invited review which does set out the concerns of the trust themselves. Our own option really is then to accept that invited review and to undertake that as swiftly and efficiently as we could. I understand the concept of the "now" scenario, but that isn't entirely relevant, I think, to an invited review until the evidence has been assessed.

Q. But of course, as you've made very clear in your statement and you made very clear today, the ultimate responsibility remains with the healthcare provider

could who could treat it as a "now" issue irrespective of what the invited review says or does, isn't that right?

A. In response to that I think -- if I could take us back to this case, I think the medical director had already had meetings within the healthcare board to restrict the practice of Mr Eljamel before the request for an invited review was made. So there were already restrictions or supervision arrangements in place when the invited review was requested.

Q. Thank you. We may return to that momentarily. Could we have a look, please, at NHST-00071. This is the letter dated 4 October 2013, a copy of which you were sent this morning, Professor.

A. Thank you.

Q. So this is a letter from the RCS -- is this the interim letter that we discussed?

A. This is the 4 October letter.

Q. 4 October, that's correct.

A. And it's a two-page letter?

Q. That's correct.

A. This is the interim letter.

Q. The interim letter. We'll just go through it. This is a letter from the Royal College from an individual called Steven Wakeling, IRM manager, I think you

mentioned the role earlier, to Dr Andrew Russell, the medical director at NHS Tayside, dated 4 October 2013. It says:

"Private and confidential

"Dear Dr Russell

"I am writing to you regarding the individual review of the clinical work of Professor Sam Eljamel, a Consultant Neurosurgeon Surgeon at NHS Tayside. As you are aware the review visit took place on 16 and 17 September, with the review team providing initial feedback to you and Dr Phillip McLoughlin, Clinical Director for Specialist Services. Following the interview with Professor Eljamel, which was held on 2 October 2013, the review team would like to convey the following points."

So, just to pause there, that indicates that there was some initial feedback about the visit provided in the September period, the September dates, 16 and 17 September; is that right?

A. Yes, there would have been oral feedback within the review team left the hospital to the medical director. This constitutes the interim letter which was sent two days after the interview with Eljamel.

Q. Yes, I'm simply just using that as a means of confirming that there was such oral advice in accordance with the

normal process provided and it was provided at the September visit, is that right?

A. Yes, that is correct.

Q. The difficulty that I set out earlier, Professor, is that we are trying to piece together what happened over this very important period for a particular aspect of our Terms of Reference, as you have helpfully done, by looking at very limited amount of documentation. And it is very helpful to us to have someone who is familiar both with the review but a very experienced surgeon to try to give us an impression of what, perhaps by inference or reasonable inference, may have been going on here.

One of the things obviously that we're interested to try to resolve if we can, based on what evidence is available, and any view that you might reasonably feel you could provide, would be what the nature of that oral advice might have been. Now, I think the first part of that is, what is the nature of the oral advice that's normally provided? Does that depend on what's been found, or is it always in a sort of general area or standard form?

A. It would be on the basis of what had been found, discussed by the reviewers and felt to be relevant to the practice of the individual surgeon and it would flag

up any concerns. I think this interim letter probably summarises -- and it's conjecture because I don't know what the discussions were -- but to my mind, would be a summary of the oral discussions that had already been had. I think, having reviewed the notes and interviewed the witnesses, the review team would have come to an opinion already, it's my view -- again, as I say it's conjecture -- and of course they would have listened to Professor Eljamel's responses to the queries and if necessary, altered their views. But my feeling, from looking at all the correspondence and the final report, is that they would probably have indicated to the trust director, or board director, that -- much the same as the contents of this interim letter.

Q. That's very helpful, thank you. And the letter goes on to say, to look at the actual content:

"Based on all the information provided to the team, there are concerns about Professor Eljamel's clinical practice with regards to spinal surgery. A number of wrong site surgeries have been carried out, which raise concerns about Professor Eljamel's approach to pre-operative marking and post-operative care. In addition, for a number of cases where wrong level surgery had been performed Professor Eljamel acknowledged that he may not have been absolutely open

with his colleagues about the outcomes of these operations. Additionally, the review team could not be sure if he had been open with patients who had undergone wrong site procedures.

"The Trust will need to consider whether it feels further action should be taken to review Professor Eljamel's spinal surgery cases to ensure that that there were no wrong site surgeries that have gone unaddressed.

"The review team has been informed that supervision of [Mr] Eljamel is in place. In order to ensure that spinal surgery is undertaken safely it would be appropriate for this supervision to ensure that; Professor Eljamel follows departmental guidelines for pre-operative marking, that all of Professor Eljamel's spinal cases receive post-operative imaging to ensure the procedure has been performed successfully and at the right level and that Professor Eljamel's cases are subsequently audited.

"We will now prepare the review report, which it is anticipated will be completed within six to eight weeks. If at any time would you like to contact me about the production of the report, please do not hesitate to do so."

So these sorts of issues that were raised in -- some

of these, of course, are followed through into the final report which is much more detailed, but there are a number of interim matters expressed. Could you help us, please, with the -- although you're not a neurosurgeon, with the pre-operative marking concept? I think you told us a little about it earlier, but if you could just clarify, that would be very helpful.

He's lost the connection?

A. Sorry, I have unmuted myself. I think I have to be permitted to unmute, so my apologies.

It's my understanding, from discussions, as I said, with my colleagues, that wrong-site surgery is a problem across all surgery and it's one of the things we're really concerned about. You would know that a wrong-site or wrong-side operation is termed a "never event" by NHS classifications. It should never happen. They're inappropriately named because they do happen. And all facilities that are available to avoid that happening are really important.

Now, operating on the spine is characteristically difficult, it's -- operating at the wrong level is a recognised complication and one which I understand the neurological spinal associations, both here and in the United States and other parts of the world, have gone to a great deal of trouble to try and eliminate. And there

are sets of recommendations and as I said, I consulted a previous past SBNS Chair, who had a practice in spinal surgery even yesterday, and his advice was that even at 2013, recommended standard practice would be to mark, with an indelible felt-tip pen, the approximate level of spinal surgery, possibly the short incision that might be needed, that might be a 2 to 3-centimetre incision. If the symptoms or the surgical approach needed to be lateralised to one particular side, they might have placed an arrow towards the side and that would have been confirmed by pre-operative -- by looking at pre-operative imaging, either x-rays or lateral fluoroscopy.

Lateral fluoroscopy refers to taking an x-ray from the side of the patient -- and this is undertaken once the patient is on the table as well -- which would, of course, show the spine. Once the patient is anaesthetised and has gone to sleep and the initial incision has been undertaken, and before an approach to the potentially very damaging procedure of interfering with the spinal cord, or the spinal column, is undertaken confirmation that that was being undertaken at the correct site would be really important. For instance, we talk about the lumbar vertebrae as the L vertebrae and you might have a problem with, say,

a disc at the fourth lumbar level, L4, or a disc between the L4 and L5 vertebrae. If there was a problem there that needed to be resolved, it would be vital that the correct disc was approached, not the disc, for instance, at the L2/3 level, upon which, if there was a procedure undertaken, that might complicate proceedings but also would not resolve the problem about which the patient was complaining.

The way I understand the neurosurgeons to do that is to take a further image before any potentially damaging surgery is carried out on the spinal column. And that might involve placing a piece of metal, either a very specific narrow retractor or even a hypodermic needle at the level that the pathology is presumed to be at, taking a further set of imaging to confirm the location of the needle at the right level of the pathology before undertaking a specific surgery which might be, for instance, to remove a bit of bone, or to go in and remove part of a damaged disc, potentially even to insert a new disc, an artificial disc. That would be a microdiscectomy or a procedure to remove a bit of bone that might be compressing a nerve root would be a laminectomy and these are all done through small incisions.

So nowadays, a further level of safety would be, as

I indicated earlier, to introduce a pause, to make sure not only that the surgeon himself was happy but that his assistants and everybody in theatre was happy that he or she was going to approach the right level. So all of these act to reduce the risk of inadvertent incorrect level surgery which, as I said, is a significant potential complication.

I'm sorry if that's drawn it out.

Q. No, that's extremely helpful. I think you mentioned having had a discussion as recently as yesterday with a former president of the SBNS. Could you tell us who that was?

A. I'm not sure -- well, I can respond to that and he would not -- that would be Mr Rick Nelson, FRCS, but that advice was provided in an informal context and not as specific advice and not on behalf of the Royal College of Surgeons although he was also the chair of the neurosurgery specialist advisory committee.

Q. Thank you, that's very clear, Professor. Another aspect of the interim letter touches on a matter that we've discussed before, I think. You mentioned before the importance, in surgical practice, of being what Professor Eljamel was found not to have been which was absolutely open with his colleagues about the outcome of these operations. Could you give some insight into the

sort of severity, if you like, of when one juxtaposes the particular issues and the outcomes for those operations that you have just been helpfully describing and then not raising those matters candidly with colleagues afterwards, the extent to which, I suppose, the original error is compounded by the failure to raise it. Could you give us some insight, from a surgical perspective, as to how bad that is, if I can put it that way?

A. Again, I can only really refer to the report and the report doesn't describe in detail any complications -- minor description of complications, but any complications arriving from this. In broad context, my understanding of problems with neurosurgery -- and I understand the principal cause for operating would frequently be pain, or incapacity, for instance impaired leg function, and the people in the court will probably understand that of, for instance, sciatic-type pain radiating down the back of the leg because of a prolapsed disc pressing on the nerves that run down to the leg.

So the types of operations that neurosurgeons would undertake might be to deal with prolapsed discs, to remove the pressure on the nerves and that may mean taking away part of the disc, could involve fusing the

spine, I understand in some cases that spacers are inserted, prostheses to maintain the integrity of the spine. Or in some cases due to degenerative disease, by that I mean arthritic-type disease in which a nerve is emerging from the spinal column to run to the legs or, in the cervical spine, in the neck to the arms.

Sometimes the degenerative process, the arthritis, can narrow the space, the foramen through which a nerve emerges, pressing on that nerve and causing either problems with sensation -- and usually that would take the form of pain -- or impaired motor activity, in other words the nerve did not drive the muscles as it should do. And that can result in weakness of a limb and wasting.

Now, firstly, if you operate at the wrong level on a disc that is potentially healthy and doesn't need an operation, then potentially you are pre-disposing the patient to a whole different set of symptoms, either further pain in that region or further nerve impairment.

If you then find that the symptoms are not resolved, as I understand from this report, and that requires a further intervention, it may be that the surgeon has to go back and operate for a second time at the correct level. Now, of course, any operation involves a certain amount of risk, there are the general risks of, for

instance, anaesthesia and potential specific complications, which would include things like wound infection, bleeding, causing haematomas, or fluid accumulation, a serious leak, for instance. Then any unnecessary operation puts patients at risk of that complication.

It would be normal for any complicated surgery to be discussed at a multidisciplinary team meeting or a morbidity and mortality meeting and the aim of that, of course, is to improve all approaches to making sure that our patients are looked after properly. And often nowadays we accept that we get a much better standard of advice if a problem is discussed amongst a group of professionals -- that's what a multidisciplinary team meeting implies -- we might have -- for instance, in a neurosurgical multidisciplinary team meeting you might have the neurosurgeons who are there, say three or four neurosurgeons, you would have neurosurgical radiologists, the doctors who interpret the films, and you may have a neurologist who is able to interpret the symptoms that the patient is complaining of. And once all of those experts come to concordance, then you're much more likely to have a feasible and a safe treatment plan.

If surgeons operate solely, those are obviously more

potential for problem and it's entirely appropriate for any complicated surgery, or any surgery giving rise to complications, to be discussed so that everyone learns from this. Complications do occur. You know, they can occur, they are, to some extent, inevitable in surgical practice but it's vital that everybody learns from complications so that potential problems are avoided in the future. And so not communicating is probably is -- I would accept as part of the issue of probity, the word you referred to at the very beginning of this session. And again, that's quite a long exposition. I'm sorry about that.

Q. Thank you. That's very helpful indeed. Of course, the lack of communication. You focused there on the importance of communicating that in a colleague to colleague sense for the multiple reasons you set out but also the suggestion set out here that the review team could not be sure if he had been open with patients who had undergone wrong-site procedures. You mentioned, I think, a moment ago, the possibility one would have to have a second procedure in these type of situations which would expose a patient to the risks inherent in surgery.

How would one go about doing that if the patient didn't know that the reason was that the original

surgery had been done at the wrong site? One would need to explain to some extent why the second surgery was happening, wouldn't you?

A. Every surgeon has had complications and you, of course, will know that the surgeon has a duty of candour in the event of complications to have a full and frank discussion with the patient to explain the situation, to explain why a potential complication might have occurred, and to have a fully informed consent process to discuss with the patient any remedial action.

So, say I had undertaken an operation in which, inadvertently, I had approached the surgery at a wrong level, operating on a spine, and the patient's problems were not resolved, they remained in pain and I felt that the best thing to do would be to undertake a further procedure, then I would have an absolute obligation to discuss with the patient why their pain had not been resolved, how, inadvertently, I had operated at the wrong level, and indeed, what I would think would be the resolution and indeed, to discuss with the patient potentially whether they still had confidence in me or would like to speak to somebody else about it, to obtain a second opinion. Often that could be done within a unit but the key to that, from the professional side, would be that if I had this mistake I would be expected

to discuss this with my colleagues to bring it to a multidisciplinary team or a morbidity and mortality meeting and obtain consensus from the unit to proceed with the patient's best outcome in mind.

Q. Thank you very much indeed. There are some references in the passages that I have read out to -- which you have mentioned yourself, to the understanding of the reviewers that there was already a suspension -- there was a -- there were clinical conditions in place relating to Mr Eljamel's practice already and that effectively he was under a sort of supervision, I think is the word that's used. So my understanding from the criticisms that are made here is that part of what's being criticised not, all of what's being criticised, is to do with the actual performance of the surgery. It was done at the wrong site, rather than just being to do with communication or what one deals with before, or after or imaging, the actual surgery has been done incorrectly. In those circumstances, would it be thought to be appropriate, given that the risk is the actual conduct, the technical operation itself, that the supervision should involve supervision in the conduct of any further surgeries itself, rather than other aspects of clinical practice?

A. That is what I had understood by "supervision". It was

certainly my feeling is that the surgery should have been supervised itself.

Q. By --

A. I had understood that this had been done. I'm not sure if that's the case.

Q. By another suitably qualified professional colleague?

A. By a peer, a colleague. We, in complex surgery nowadays, in many cases, we operate as dual consultant roles so that we can assist, we can come to decisions together and can undertake different parts of the procedure together. That's not done, of course, in all contexts but in complex surgery that's now a well-held value within surgery.

Q. Thank you. Just a couple of technical questions about the review, again, to get back to your role as the head of the review. My understanding, just to get the timeline here, is that I think the review which was requested on 26 June then led to the visits on 16 and 17 September. In the period between those two dates, I think we've covered this already, but there are various things that need to happen, I think, including the terms of reference being finalised and discussed in accordance with the processes that we've put together. There would need to be some initial discussion, one would imagine, amongst the reviewers as to how they

intended to approach matters. Organisational matters such as arranging a visit would have to be put in place, availability would have to be checked, travel and all that kind of thing.

Are there any other aspects that I'm missing or is that what happens in the period between effectively June and September?

A. No, you've summarised that very well. I mean, the key aspect is availability of evidence. So the trust would have to identify, for instance, the index cases that they wanted to review, they would have to identify all the evidence associated with those cases, the case notes, imaging, letters, that sort of thing. And of course, they'd have to identify the witnesses they wanted to appear before the review panel. And they would, presumably, have to assure themselves of the availability of those witnesses as well. So it's quite a big logistical exercise and that would explain any delay between the discussion of the initial terms of reference and the date for the arranged review.

Q. And that might, perhaps particularly, be the case because as we'll see in a moment when we look at the actual report, there are a large number of individuals interviewed and involved. It wasn't one, two colleagues it was a huge list of different people, isn't that

right?
A. That's correct.
Q. One aspect, perhaps quite a technical aspect but it's something that's been raised with me and it's of some interest to some individuals who are part of our participant group, is to do with -- you mentioned earlier that there was perhaps some sort of system whereby you could track certain things being done, including I think particularly we were talking about the recommendations, communication after the report had been done. One of the things that I have been asked to address is whether there are any records, perhaps as part of that tracking system, as to how, in particular, the interim letter and how the final report were communicated.
We have the two letters, we'll go to the second one in a moment, but do you know what the normal method of communication at that time would be, just putting it in the post, or would there be some record in the tracker perhaps as to how that would work? It may be too technical a matter for you to address just now.
A. Well, to be quite honest, with respect to the tracking -- and I'm grateful to you -- but you've provided me with those two letters this morning, we didn't have access to those. They're not within our

records and they've presumably come from the trust or elsewhere.
Q. Yes, they have.
A. Whilst the letters are typed, they are of course, sent by email so there's an instantaneous delivery as soon as they've been produced.
Q. Right, so these letters, the ones that I gave you this morning, 4 October and 6 December, although they are letters, they would have been emailed and of course --
A. They certainly would be now and I hope in 2013 we would have had sufficient technology to be able to do that.
Q. And presumably, it would be logical that the 6 December letter would also have had the report attached to it as the letter narrates?
A. Yes, that would be --
Q. By email?
A. I believe so, yes.
Q. Yes, thank you. So can we have a look at that just now. It's NHST-01581. This is the 6 December letter which -- again, this time it's been written by Ms Clare Marx, whom you've mentioned, the chairman of the Invited Review Mechanism, to Dr Andrew Russell. Again, strictly private and confidential:
" ... Dr Russell
"Please find enclosed the ..."

THE CHAIR: Sorry, Mr Dawson, could I get the reference again?
MR DAWSON: Certainly, it's NHST-01581.
THE CHAIR: Thank you.
MR DAWSON: Do you have that, Professor?
A. I do, 6 December.
Q. That's right:
"Please find enclosed the final signed report prepared by Mr Neil Kitchen ... Mr Nicholas Philips ... and Helen Carter ... who undertook the individual review of the clinical work of Professor Sam Eljamel, a Consultant Neurosurgeon Surgeon at the NHS Tayside, under the Invited Review Mechanism.
"Please could you ensure that a copy of the report is made available to and discussed with all those directly involved in the review especially Professor Eljamel at the earliest opportunity.
"As part of the Invited Review Mechanism process, the college will send an evaluation form to the Trust after the review has taken place. The purpose of this exercise is to provide general feedback to the College on the process and to ensure that the arrangements for the Invited Review Mechanism are kept under review.
"I would be most grateful for any feedback you wish to send to the College and I enclose an evaluation form

for this purpose. I appreciate that you may wish to comment confidentially and, of course, this will be respected."
We do actually have access to correspondence where a form is -- which includes a form, so there is the form but unfortunately there's no completed copy, as far as I'm aware. The aspect of this I just wanted to address with you was, in particular, the significance of "ensuring that a copy of the report is made available to and discussed with all those directly involved in the review especially Professor Eljamel at the earliest opportunity" is that normal practice and why is it important that all those directly involved in the review are informed of its precise terms as soon as possible?
A. Well, I think it's in the interest of clarity and openness within the trust that those who have contributed to the review should be able to learn from it. And, of course, it's only fair to the subject of the review that that individual has complete access to anything that's been written about them. And I believe, of course, that might form the basis for further discussions within the trust between the individual and those in authority, the chief executive and medical director.
Q. Because presumably, even beyond Mr Eljamel himself,

others who are involved may learn and their practice may be improved by aspects of what's said, presumably that's part of the purpose of it as well?
A. Yes.
Q. But it seems at that stage, given our earlier discussion about the fact that it becomes the property at that stage of the trust or the board, that at that point, arrangements as regards the confidentiality rather fall away, at least from one side, and what you're seeking to do there is to promote promulgation of its contents, if I can put it that way?
A. I think we would promote learning. It's vital to preserve anonymity of patients and clinical material. We'd always promote that aspect of learning and indeed, the invited reviews form a significant part of the work that we do to assure and develop quality assurance processes. But as you have emphasised yourself, the report becomes the property of the trust or the board. In the handbook on invited reviews, I think there is emphasis made that confidentiality is preserved where is appropriate. But the whole point of an invited review is that it is a learning process and an informative and helpful, authoritative process.
Q. Thank you for that. If we might have a look at the review report itself, at least certain aspects of it.

For us, that's RCS-00014.
A. I have my paper copy.
Q. Thank you very much. I'm looking at page 3, in particular. Thank you very much. The report is long and detailed. I'm not going to go through -- it's not necessary for our current relatively introductory purposes to go through all of this. But you have helpfully done so and reflected your views on its contents and what they mean, helpfully, in the written report. But the background to the review is narrated:
"On 26 June 2013, Dr Andrew Russell, Medical Director at NHS Tayside wrote to the Chair of the Invited Review Mechanism ... to request an invited individual review of Professor Muftah Salem ('Sam') Eljamel, consultant neurosurgeon, in particular to review Professor Eljamel's clinical knowledge, technical skills and judgment as well as his interpersonal skills. This request was considered by the Chair of the RCS IRM and a representative of the Society of British Neurological Surgeons, where it was agreed that an invited individual review would take place."
I just wanted to focus on the different aspects here of "clinical knowledge, technical skills, judgement as well as interpersonal skills". I'm assuming, given what we've said about the terms of reference, that those

aspects wouldn't automatically be included in an individual review but they have been specifically requested by the board and presumably accepted by the reviewers and the college that it would be appropriate for them to be looked at and that they could look at them usefully?
A. Within an individual review, there would always be terms of reference, all -- whether a service clinical records or an individual review, there would always be a structured set of terms of reference which provides a framework to workaround.
Q. But would all of these components of Mr Eljamel's practice necessarily be part of the review?
A. No. They're only as ones specified and agreed between the board and the invited review manager.
Q. Understood. And as far as the terms of reference -- the specific terms of reference are concerned, we can see them there. A specific aspect that I wanted to raise with you was, under (b), one can see under paragraph 2, that there are various aspects which are a fuller explanation of what we just talked about under (a) relating to Professor Eljamel himself, but then, under (b) it says:
"If applicable: NHS Tayside would be receptive to recommendations in relation to wider aspects of service

delivery and team cohesiveness within the Neurosurgery Department that may emerge from the context of the review."
And that at the bottom of the box one can see there, skipping past (c) for the moment, it says:
"The reviewers will then make recommendations for the consideration of the Chief Executive and Medical Director of NHS Tayside as to:
"Whether there is a basis for concern about Professor Sam Eljamel's practice in light of the findings of the review;
"Possible courses of action which may be taken to address any specific areas of concern which have been identified."
So, there is, in section (a), specific terms of reference relating to Professor Eljamel. Section (b) if applicable, communications about the wider service within NHS Tayside. But the recommendations that are asked for only relate to Mr Eljamel and not to the board. Is that an accurate interpretation of what this says?
A. I interpret it as slightly differently, if I may, because (b), as you say, says that NHS Tayside would be receptive to recommendations with respect to the wider aspects of service delivery. And I think if we go to

the conclusions of the report, and the recommendations, you will see there were some specific recommendations with respect to Mr Eljamel's practice but there were also some broader recommendations with respect to the trust and with respect to the conduct of neurosurgery.

Q. So, my understanding from the report is that you explained earlier the different types of review one can have and this was classed as an individual review, is that right?

A. Yes.

Q. But it might -- rather than a service review?

A. Yes.

Q. But it might be: an individual review and if you happen to find anything that would be useful to us to know about the service, we'd be happy to know about that too?

A. Absolutely, and the trust, and of course the IRM mechanism, would have been at liberty -- most of these -- or the findings that gave rise to the recommendations with respect to the service, which are relatively limited, have arisen out of the direct investigation of Mr Eljamel's practice and would have come from the witness statements which have described the practice of neurosurgery at NHS Tayside slightly more broadly.

So, there are some recommendations with respect to

the practice of neurosurgery. Had the trust and the IRM wished to take that further, it would have been within the capacity of the trust to request a formal service review but that was not undertaken at that stage.

Q. Yes, so that was the choice of the trust, to have this individual review with this sort of slight add-on, if you like?

A. Yes. I think some of the problems had been flagged up and the hope -- and indeed, I'm sure the correspondence, although I have not seen the correspondence, would -- in terms of the follow-up, would have looked at the changes that the trust was instituting.

Q. So, a service review -- the board could have requested a service review which could have requested that there be a review of clinical governance procedures within the trust; is that correct?

A. Yes.

Q. It could have requested a service review that included a review of its professional governance processes?

A. Yes.

Q. It could have requested a review that included a request that the reviewers look at questions relating to issues pertaining to document management?

A. That's correct.

Q. Record-keeping?

A. Yes.

Q. It could have requested a service review relating to the adequacy of the suspension provisions?

A. Yes.

Q. It could have requested --

A. If I may though, you'll have to -- you'll have to accept that all of these would have had to have been agreed between the two parties.

Q. Of course.

A. But those are all things that the Royal College of Surgeons and the IRM mechanism would have had the facility to investigate.

Q. I'm specifically asking you whether they could have requested these things, of course, because the college would have had to have agreed to it, but I want to be sure what could have been included in the service review.

A. All of those could have been requested.

Q. Could it have requested -- could they have requested a review relating to the systems they had for clinical supervision, as we've mentioned already?

A. Yes, and that would very much form part of a review process for a specific, for instance, directorate or specialty.

Q. Yes, because of the fact that, as we know, this was

underpinned by a significant number and an increasing number of patient complaints, could it have requested a review into the complaint system?

A. Yes, yes, it could have done, with respect to the specific things they were concerned about.

Q. Yes and particularly, also perhaps, a review into how the complaints had been handled and responded to by the trust or Mr Eljamel or others?

A. Yes.

Q. That might particularly be the sort of thing that the college could help with?

A. Yes.

Q. Because it's about professional improvement and improvement of service and improvement of patient care?

A. Yes and we do, of course -- if I may just add, the trainees and resident doctors are, of course, a particular focus for all the Royal College of Surgeons. They're the future of British surgery and we have to ensure their working conditions and their training is appropriate and satisfactory.

Q. You definitely haven't seen my list in advance, but I was going to ask you whether the review could have requested -- I think you've already confirmed -- an analysis of the training regime of surgeons in training?

A. Yes.
Q. And it, perhaps in the particular, could have requested the way a review of Mr Eljamel's treatment of and interaction with his trainees?
A. Yes, and my feeling is that some of that has been covered in the report and that was part of the concerns that were flagged up.
Q. That might be actually quite a good example of where you've looked at Mr Eljamel particularly but then some systemic elements have been shaken out of that, if you like, that they have looked at, is that right?
A. Yes.
Q. And just on one final aspect as to whether the review could have included it, I wanted to know whether the review could have included the reviewers commenting on the system operated by NHS Tayside as to their communication and getting involvement of the GMC?
A. That could have been undertaken. It's not something, as you would expect, that is carried out in most invited reviews but had the reviewers been asked to investigate that, they should have had the facility to be able to do that.
Q. Because one of the things that does come out of this is suggestions to do with the GMC and what I'm focusing on is it's possible, isn't it, that it might be a systemic

failure within a board or a trust that leads to issues not being forwarded on to the GMC in the way that they should, such that it might be possible for an independent reviewer to come in and say: well, the problem here is the system rather than the individuals within the system. And so that's something that could have arisen in this context and on which NHS Tayside could have requested a review?
A. That is the case.
Q. Thank you. I just wanted to ask you, if we could go over the page on to page 5, please. I have mentioned this already but there does seem to be a very large number of people interviewed over a two-day period. Is that normal in a review, that this number of people would be spoken to?
A. It is, yes.
Q. Right. And it does seem -- is the number of people that are selected from -- presumably a list provided by the board as we discussed earlier in accordance with the sorts of people that the reviewers would want to speak to, is the list finally decided upon based on how many people they think they will need to speak to to be able to answer the review comprehensively?
A. I mean, I think the answer is that the review team need to gather broad evidence and looking down this list of

interviewees, it seems entirely appropriate that there were the senior medical administrators, medical director, clinical director. There were trainees, there were anaesthetists who worked with the neurosurgical practice, the senior nurses, who of course, have an important role to play in theatre, associated specialties, ENT surgery which sometimes works with neurosurgery, psychiatry, which is involved with outcomes and dealing with potential psychiatric conditions, neurosurgery, radiologists and then some of the administrative managers.
So it's a fairly comprehensive group of people but all of those people would provide evidence that would allow the review team to build up a comprehensive view of the practice of Mr Eljamel and indeed, the neurosurgical service.
Q. I'm just wondering -- that's very helpful, but you mentioned doctors in training. Does it include any trainee doctors?
A. Yes, it does. Those termed "specialist registrar in neurosurgery" are trainees --
Q. Thank you. On the previous page where it sets out the broad number of staff, it talks about four middle-grade staff, including one clinical fellow at specialist registrar etc. So there is that -- that's covered off

as well in the list.
As I say, Professor, I don't intend to go through the full content of the conclusions here and you have reflected, I think, the key themes in your report. One aspect that I did -- and indeed, we've touched on aspects of the ultimate findings which were reflected in the interim letter about Mr Eljamel's own practice. There are a couple of aspects that I wanted to raise with you that I thought would be worth bringing up. The first is at page 18, which is at page 416.
A. Yes, I have that, thank you.
Q. This -- going down to the bottom, please, on our screen. Thank you. This is where -- you mentioned this earlier that having dealt with, for numerous pages, Mr Eljamel's review, if one can put it that way, there's a section here to do with clinical governance, where it says:
"Through the course of this individual review a number of issues came to light regarding the clinical governance within the Neurosurgery department and the surgical directorate as a whole.
"During the interviews it was heard that there had been problems with Professor Eljamel's performance in the past but that these had been dealt with informally. It was stated that no documented concerns or formal complaints from other staff about Professor Eljamel's

behaviour had been submitted. The reason given for this was that there were concerns about the possibility of a re-structuring of neurosurgical services in Scotland and that any unrest within the department might [be] put ... at risk."

So the conclusion that they appear to have drawn from the ancillary aspects of the visit was that there had been problems with Mr Eljamel's performance in the past but these had been dealt with informally, that they -- there were no concerns or complaints within the formal system about his behaviour, but that the reason for the fact that there had not been any formal complaints were their concerns about the possibility that any unrest within the department might put the neurosurgical department at risk. I wonder if you have any reflections on that passage as regards whether that constitutes a responsible way to run a neurosurgical unit?

A. I'm afraid, I can't take that into context. I have no idea about the structuring of neurosurgical services in Scotland but this was obviously a topic that had arisen in some of the witnesses' commentary, otherwise the reviewers wouldn't have mentioned that.

There are two aspects. There's the informal treatment of potential complaints but in the absence of

specific evidence in this report, it's difficult to comment on that in any detail. There are always -- or a consistent thing, I have to say throughout many of the reports we deal with, are that all services have areas of weakness and sometimes an individual review will bring out those areas of weakness. Certainly restructuring of services generally can be a cause for concern and it's happened across many specialties. As we try to improve the NHS, it's vital that we do restructure services but that can cause concern to both individuals and departments as well, who may not always perceive their role in any future re-organisation.

Q. But surely the systems that exist for complaints or concerns being raised about colleagues' behaviour is designed for patient safety reasons ultimately and that although I would accept that the concerns about the viability of the service would be unsettling, those should never stop someone raising a concern or it being made formal because otherwise patient safety would be put at risk?

A. Well, my information here, I'm afraid, is that paragraph is so conjecturing as to what specifically these witness statements were concerned about is difficult to do. And I was just trying to put that in terms of generality. Of course, patient safety should promote feedback about

concerns of an individual's behaviour.

Q. Thank you. One aspect of this report -- I just wondered if this would be the norm, perhaps this is slightly historic based on your involvement as the chair, but one thing that is, certainly for a lawyer, quite frustrating is that we have this very interesting list of people at the beginning and then a commentary of the factual evidence without any attribution as to who actually said any of these things. Is that normal? Because there might be reasons as to why that's done deliberately.

A. That's completely normal and in view of the fact this report goes back to the trust, unless an individual specifically wants to be attributed with comments, which sometimes happens, then, in order to preserve the anonymity of the people who have contributed, then the comments are often taken as correct but we don't attribute them to individuals.

Q. Thank you. Just further down that page there's one other aspect of this which I wonder if you might be able to help us with. It's under "job planning", just that first paragraph. It says -- this again, is under the "clinical governance" section:

"There were also a number of issues relating to the Consultant Neurosurgeons' job plans which were raised during the course of the interviews. The review team

heard that the department had taken on a lot of degenerative spinal cases from East Fife, which had added to the surgeons' workload and changed their scope of practice to being predominantly spinal work. Professor Eljamel stated that he felt that his workload was too high and that he had been pressurised to take on more patients and that he now undertook additional evening clinics of six to seven patients all of which were spinal cases."

Just in the generality, without going into specifics, of course, because you don't have a lot of information about that, but I suppose that that might be a phenomenon that one encounters in the modern world in any part of medicine, that the pressures on hospitals and the need -- perhaps the diminution of services elsewhere and the need to take in extra areas that weren't previously covered and the pressures on individuals. The key thing I wanted to ask you was whether, given the fact that although not inevitable, it's entirely possible that that might happen in the modern world, there should be systems to try to make sure that individual surgeons like Mr Eljamel and others are not put under undue workload pressures in order to maintain patient safety?

A. Of course there should be and you're reflecting on

an ideal situation and you've summarised the problem very succinctly. But I think this is a generalised problem across the whole of the health service and it's really beyond the scope of my response to talk about philosophy of funding of health services and re-organisations. But, yes, of course, increased workload always potentially puts stress on people. I have to say, if you do extra clinics, then usually that's with the agreement of the individual involved. Nobody would be forced to do extra clinics. It might well be suggested and discussed with hospital management. But increased workload, particularly in a sphere which I think it's commented on, that he did not particularly want to undertake, might have induced some stress.

Having said that, if I may just as a generalised comment, every surgeon is bound to do the best for their patients and despite stresses, the bottom line is that you organise those stresses to try and manage the best outcome for your patients and if necessary, have the discussions with management that look at a re-organisation for the patient's benefit.

Q. Thank you very much. Just one final passage, I wonder if I could take you to, which is on page 24. Just at the bottom under "Recent changes".

A. Yes, I have that.

Q. Thank you. This is a particular passage relating to Professor Eljamel again:

"In response to the concerns that had been raised the Trust put in place supervision of Professor Eljamel's practice, which consisted of joint ward round and subsequent discussion with the clinical lead for neurosurgery."

First of all, when we discussed this supervision earlier my understanding of your evidence was that that would be expected, in the circumstances, to cover the actual technical performance of the surgery itself rather than just joint ward round and subsequent discussion with the clinical need for neurosurgery. Am I understanding correctly what your evidence was, that that is different?

A. My understanding of "joint supervision" would be that the operative procedures were also supervised. I'm unable to tell, from that particular paragraph, as to whether operative supervision felt into this remit but I believe it was the intention of the review team to make sure that was the case.

Q. Thank you. It then goes on to say:

"Professor Eljamel stated that the concerns had also prompted him to make a number of changes to his practice. This included undertaking his own clinics, personally consenting his patients during ward rounds, conducting his own procedures and making entries into patient records himself. He also stated that he would now bring any wrong site cases to the M&M meeting for discussion."

Our, at least initial, interpretation is that pretty much all of those things, if not all of those things, are things he should have been doing anyway, possibly with the exception of conducting his own procedures in circumstances where they had been delegated appropriately to a junior surgeon. Would that be fair?

A. All of those things would have been, or are regarded, as part of normal clinical practice.

Q. Thank you very much. I wonder if I could, momentarily, sir, a couple of minor matters just as the Professor has very helpfully helped us with some conclusions and reflections at the end of his report. So if I could go back to the report please, RCS-00021.

You've helpfully provided us, Professor, with a couple of interesting reflections on surgical practice which are certainly of interest to us. I'm at page 31, paragraph 39.1, right at the bottom of the page.

A. I have that, thank you.

Q. Thank you. And you were asking here whether there were any reflections on the work that you had done and you helpfully told us that:

"Although NHS clinical governance processes and wider systems safety processes have substantially improved during my time as an NHS consultant surgeon, it remains the case that responses to potential and actual patient concerns across [over the page] the NHS and wider healthcare could substantially improve. RCS England is committed to working with all relevant advisory and regulatory bodies as part of this process and to achieve our core aim of excellent surgical care for everyone who needs it. Our invited reviews, which are advisory, enable expert teams, including a lay person representing the patient and public interest, to determine whether there is cause for concern about surgical practice or a surgical service, and/or individual episodes of care, and to make recommendations for improvement. Our unwavering commitment to patient care is why we offer healthcare organisations an invited review service."

So your position is that there has been a general improvement but an area where one might, on the report card, say "must do better" is in relation to the important matter of responding to potential and actual patient concerns. Could you tell us a little bit more

about why that is something where you think more improvement is required?

A. Well, as indicated, I think there has been a general ethos to try and improve healthcare across the United Kingdom and that was stimulated largely by, as we heard, index events such as the Bristol Children's Cardiac Inquiry and the recognition of the deficiencies there.

We recognise in many areas that there are still deficiencies and that is probably reflected by the number of invited reviews we undertake, for instance in '25 to '26, six reviews have been undertaken, nine reports issued and ten are still in the planning process. And even between 2008 to 2017, we undertook 240 invited reviews and produced a document entitled "Learning from invited reviews" which looked at 100 selected reviews and tried to bring out the key issues.

Now, NHS England patient safety will be concentrating on that. A number of other areas that patient safety -- the government reviews, for instance, into "never events" and the work of the Centre for Perioperative Care, the work of the National Patient Safety Response panel, all of those areas and organisations are working together to try to improve

patient safety. And it's beholden on the college to do that. We have produced guidance -- guidance which mirrors "Good Medical Practice" produced by the GMC, "Good Surgical Practice" of the Royal College of Surgeons, we run periodic workshops for medical directors and clinical directors, to share learning and a lot of that is done at multiple specialty conferences.

We've produced good practice guides, things that -- they are entitled things like "High performing surgical team", "Surgical leadership", "Managing disruptive behaviours", "The duty of candour and consent".

So not us alone, all the Royal Colleges are pursuing a patient safety agenda. I believe NHS Scotland, NHS England and the healthcare systems in all the devolved nations recognise that there's still more to do and this particular are, the case you've been working on assiduously over this period is just illustrative of the fact that we need to improve standards.

Q. Thank you very much, Professor. One final question I have for you is that you, very helpfully on the basis of only the report itself and the couple of letters you've seen, reviewed this case and obviously you are the chair of the Invited Review Mechanism and a very experienced surgeon yourself. It is difficult, I think, for us to get an understanding as we are not surgeons,

or certainly not, and we hear from surgeons, but it's important to try to understand things from a surgical perspective.

The review that you've undertaken of the limited materials available to you, are you able to give us an indication, based on what you have seen in the report conducted by colleagues of yours, effectively, and based on your experience of looking at many, many other cases as you've just outlined, as to how bad the review of Mr Eljamel is? Does it stand out as something that you think that's a really enormous issue, or is that the sort of thing one unfortunately sees quite often?

A. I would certainly hope it isn't something one sees quite often. Every procedure has an acknowledged risk rate. I would defer to my colleagues, for instance the spinal surgeons, to tell you what an appropriate risk of inadvertent surgery at the wrong level is, but to be presented with four cases out of 14 and acknowledgement by Professor Eljamel that in a further 70 cases he may have had -- he acknowledges that he may have had four or five other cases of wrong-site surgery -- is an excessive number of complications. And my belief and my hope is that across the wide area of surgery in the United Kingdom, that standards are much higher and those standards are held to and that we are trying to improve

them across all specialties all the time.

Q. Thank you very much indeed. That concludes my questioning, other than to ask you, Professor, whether you have anything else you feel you would like to add in addition to what you have already told us?

A. I don't. When we have these inquiries -- this is the first Inquiry I have appeared at, but I'm very much aware that there will be a number of patients and relatives who have been profoundly affected by this and my sympathy goes out to them.

Q. Thank you very much. We'll take a very short break now in order to try and see whether our core participants have any questions for you.

THE CHAIR: Yes, indeed. Professor, we normally have a short break just in case there are any other questions that will be proposed. So if I could ask for your indulgence and not leave us quite yet. We'll take a few minutes break, if you don't go too far, we'll let he know when we're ready to resume.

A. No, I will stay here.

THE CHAIR: Thank you.

(12.49 pm)

(A short break)

(1.03 pm)

MR DAWSON: Thank you, sir. There are a couple of

questions.
THE CHAIR: Can we have the witness back, please.
Thank you, Professor. There are, I think, one or two more questions. Mr Dawson, when you're ready.
MR DAWSON: Thank you, sir. Can you hear me okay, Professor?
A. Yes, I can.
Q. Great. I have just a couple of questions for you. I wonder whether we can have the statement up again, RCS-00021 at page 25. I'm looking, this time, at paragraph 27.1.
A. Thank you, I have that.
Q. This was in response to a specific question that the Inquiry had asked you in relation to the 2013 review as to whether evidence from the point of view of former patients of Mr Eljamel or their relatives were taken into account in the 2013 review and if not, why not. Again, of course, recognising that you were working from the report and the two letters and nothing more, you said:
"No patients were interviewed in the 2013 review. Patients are not routinely interviewed in invited reviews because invited reviews are peer reviews of surgeons and/or surgical services and/or episodes of patient care by surgeons. Patient perspectives are

considered in an invited review according to a review's terms of reference. In this 2013 review patient complaints were reviewed as per the terms of reference and as listed in the documents reviewed as set out on page 6 and 7 of the report."
So I suppose there's a number of components to that and the subject of whether patients have been or should be consulted. Obviously, as we've said already, the ultimate objective here is to try to promote patient care, isn't that right?
A. Correct.
Q. And as far as the particular circumstances here are concerned, or I suppose, in the generality, it's open to a healthcare provider to specify that they would like patient perspectives or any particular material to be taken into account and if that's agreed to, then that would be part of the assessment; isn't that right?
A. Yes, if that was agreed to as part of the terms of reference.
Q. Yes, and presumably, given the interest in promoting patient care, it would be agreed to. As long as it wasn't an excessive or unusual amount of material, that presumably would be if it were asked for?
A. If it were asked for, we would do that. As had been indicated in this paragraph, that isn't routinely part

of the IRM process which looked very specifically at the evidence from clinical records and direct witness statements.
Q. Yes, and in the circumstances of this case, you've helpfully pointed out on your review that because patient complaints were part of it, there was, I suppose albeit indirectly, an aspect of the patient voice that was heard in the analysis?
A. Absolutely, and indeed our inclusion of a lay reviewer is in effect to look and evaluate the evidence but from a patient and public perspective as well.
Q. I suppose that provision of having a lay reviewer seeks to negate the possibility that surgeons looking at other surgeons might miss things that might be important to patients completely innocently perhaps but they would still be deemed to be important?
A. It provides a global perspective and a balance I think, yes.
Q. Thank you. If I could just go over to the next page, please, paragraph 28.2. This was in response to a question as to what extent was the 2013 review undermined by a lack of available documents or reasonably accurate written information. This is a specific part of the Inquiry's Terms of Reference to look at that issue. And you explain that you have gone

through the process of analysing the limited material and you very helpfully provided both a report and reflections on the report in your oral evidence today. You say that you did not seek input and advice from the invited review team in relation to the issue as you did not consider it will assist the Inquiry.
Are you able to tell us whether members of the invited review team are at least theoretically, could they still be contacted by the Inquiry in case they had any reflections or memories, given in particular the paucity of document that appears to be available?
A. I don't think that that would be helpful at this time. I don't know either of the clinical invited reviewers. I'm not sure where they are now at this specific time. The report is a summary of our evidence at the time and I feel that -- I will be, to be blunt, the part of getting people to undertake this process in the initial you know circumstances is the feeling that somebody will represent them and represent their opinions further down the line, and I happen to be that person on this occasion, and I hope I have provided a fair representation of their views. I do not think that anything further would be gleaned by asking them to appear.
Q. Thank you very much indeed and thank you for your

evidence, it's very much appreciated.
A. Thank you.
THE CHAIR: Professor Smith, just before you go I hope you will allow me to extend the thanks of the Inquiry for your very considerable assistance, and I mean that not just by reference to the statement that was produced and the ancillary materials to which it relates but also your interesting and helpful reflections and insights which you've provided to us over what has been quite a long session this morning and early this afternoon. So, in telling you now that you are free to go, you leave also with my very personal thanks for your efforts on behalf of the Inquiry, so thank you.
A. Thank you very much indeed, sir, and goodbye to everybody.
THE CHAIR: Would 2 o'clock be convenient, Mr Dawson?
MR DAWSON: It would indeed. Thank you, sir.
THE CHAIR: Thank you.
(1.10 pm)
(The short adjournment)
(2.07 pm)
THE CHAIR: Yes, Mr Dawson.
MR DAWSON: The next witness, sir, is Tracey Gillies.
THE CHAIR: Thank you.

MS TRACEY GILLIES (sworn)
Questions by COUNSEL TO THE INQUIRY
MR DAWSON: Good afternoon, Ms Gillies.
A. Good afternoon.
Q. As I say to all the witnesses, could you just try to speak into those microphones as best you can so everyone can pick up everything you say. Thank you very much. You are Tracey Gillies?
A. I am.
Q. And you have provided the Inquiry with a statement on behalf of NHS Lothian?
A. Yes.
Q. Could we have up, please, document NHSL-00088. Is that your statement?
A. It is.
Q. And it's, on the front, dated 25 February 2026. If we could go to page 16, please. Have you signed it there?
A. I have.
Q. In fact, the date of the signature is 27 February 2026, is that right?
A. Yes.
Q. And can you confirm the contents of this statement are true as far as you're concerned?
A. Yes.
Q. Thank you very much. You are the executive medical

director of NHS Lothian, I understand?
A. Yes.
Q. And you have been in that position since 1 February 2017?
A. Yes.
Q. By way of qualifications, you hold MBChB from the University of Bristol and a fellowship of the Royal College of Surgeons; is that correct?
A. Yes.
Q. One of the aspects of your evidence in which we're interested is to try and understand a little bit more about what medical directors do. One of the roles which seems to go along with being a medical director, or part of it, is being a responsible officer for a health board.
A. Yes.
Q. Could you tell us a little bit about what that means?
A. So the role of the responsible officer is about creating a system that allows doctors to practice safely and with participation in the expectations of the GMC around appraisal which supports their revalidation. So those are two important separate aspects but they are linked together.
Q. So just to tease that out, there's the creation of a system within which doctors are able to fulfil their

revalidation requirements, are those the two parts?
A. No, the two parts -- so people tend to think about the responsible officer role as just overseeing participation in appraisal because the GMC has an expectation of doctors to participate in appraisal annually and once every five years in the cycle, to undertake feedback from colleagues and from patients. But just as important is that there is an adequate system of clinical governance in place which allows concerns about a doctor's practice to be identified and acted on and the role of the responsible officer really pertains to both those parts and to bringing those together and undertaking appropriate actions.
Q. Thank you. So within that then there's a responsibility, as the responsible officer, towards the high performance, or good performance of the clinical governance system, but a particular component of that is overseeing and being responsible for the appraisal system that I think you've told us is required by the GMC, is that right?
A. Yes.
Q. We've seen the phrase "medical revalidation and appraisal", is that the same as appraisal, or --
A. It is, yes. It was -- I think I have said in my statement when the responsible officer regulations were

introduced, appraisal was in place some years before that, and the action of the GMC was to then say that once every five years, the responsible officer made a recommendation that the doctor's licence should be renewed but quite important within that system is that one doesn't wait for the date of revalidation before acting on any concerns. Concerns should be acted on as they are raised.

Q. Yes, so that by the time one reaches the five years, everything is satisfactory and any concerns have been addressed, I assume?

A. Yes, exactly.

Q. Thank you. Are the doctors who work for the health board NHS Lothian accountable to you then?

A. They are accountable to me in the sense that that's that professional line of governance around the behaviours of a doctor in line with the expectations of the GMC.

Q. I understood from a witness we heard from yesterday that perhaps when one has, within a health board, resident doctors in training, their medical director is a different medical director who works within an organisation called NHS Education for Scotland which is now Public Services Delivery Scotland; is that correct?

A. Yes.

Q. So, insofar as I'm asking you about doctors being accountable, it's the other doctors that --

A. It's the doctors that are employed by Lothian, yes.

Q. Yes, and it was also suggested that it might be possible for certain doctors who work with a health board to have different conditions of employment in terms of their accountability to the medical officer. Is that a phenomenon you recognise or is that not something you've seen?

A. The only doctors that I could think of that that might apply to might be those employed by the military. So we do have a small number of doctors who are employed by the Ministry of Defence but who are placed to work with us and their responsible officer is somebody within that military system. But there's a regular exchange of information and if we appraise the doctor, the doctor would provide the documentation about that appraisal back into the military system. If they were appraised in the military system, we would get that information back.

Q. Thank you, but one might say, putting that to one side, in the general run of things, doctors are accountable to use the medical directorate; that's the way the system works?

A. Yes.

Q. Thank you. NHS Lothian is a health board which is part of the overall operation of NHS Scotland; is that correct?

A. Yes.

Q. And NHS Scotland is effectively, as I understand it, a bit of a delivery system of healthcare, and is the means by which the Scottish Government exercises its responsibility for promoting the health of the nation?

A. Yes.

Q. And ultimately, health boards are responsible to the Scottish Government?

A. Yes.

Q. And specifically, does that mean that they report in to the directorate for Health and Social Care?

A. I suppose, I would just wonder what you mean by "report in". In terms of the chief executive, that would be the most obvious reporting line. In terms of my own professional supporting line, my responsible officer is the chief medical officer in Scotland.

Q. Right, but I suppose the chief executive would report into the directorate of Health and Social Care more directly?

A. Absolutely.

Q. Yes, but you are nevertheless, as is the case with all medical directors, accountable to the chief medical

officer; is that correct?

A. Professionally, they are my responsible officer but in terms of my employment as a medical director, I'm accountable to the chief executive.

Q. Okay and health boards are, as I have said, in the business of improvement of health and the provision of healthcare for their local area, is that right?

A. Yes.

Q. And do health boards, given that system, collaborate with each other in order to try to raise the overall standard of health within Scotland?

A. I would think that -- yes, I would agree with that.

Q. Yes, there presumably are initiatives that exist to try to share information and to try to improve things where there might be learning that could be passed around within NHS Scotland as a whole, would that be right?

A. Yes, yes, that's definitely true.

Q. I mean, on a personal level or a professional level, do you collaborate with other medical directors in order to try to achieve those aims?

A. Yes.

Q. Is there a formal mechanism by which that's done?

A. There is an Association of Medical Directors in Scotland which -- the membership of is slightly broader than just the executive medical directors, and there are

important, I guess, connections that are made in that that allow one to understand who might be facing similar problems, who might have dealt with something else that was similar in the past, as well as for us to work collectively to say how could we approach a particular problem.

Q. Understood, thank you. And just in terms of your career, I think your statement tells us that you were appointed as a consultant general surgeon at NHS Lothian in 2004; is that correct?

A. Yes.

Q. And that you left Lothian in 2014 to take up the post of executive medical director in NHS Forth Valley?

A. Yes.

Q. And you were there until 2017, is that right?

A. Yes.

Q. When you took up your current post?

A. Yes.

Q. Can you just tell us what a general surgeon does?

A. I can. I think a general surgeon.

Q. As succinctly as possible.

A. Of course, of course. The term has changed a bit over time but it really means surgeons who deal, most commonly now, with diseases in the abdominal cavity.

Q. Okay. You didn't provide us with a CV. You didn't have

to, we asked you whether you would like to. Where did you do your undergraduate degree?

A. In Bristol.

Q. And where did you train before you became a consultant general surgeon in 2004?

A. So I spent five years training in Bristol. Once I had graduated, so I did what my were then pre-registration House Officer jobs in Bristol. I taught anatomy for a year and I did two and a half years as a Senior House Officer there and then I moved to Edinburgh and undertook my -- a period of time in research and then my higher surgical training in Edinburgh.

Q. Thank you. We asked you, as we ask everyone, whether you had any involvement in the provision of services in NHS Tayside, in particular Ninewells Hospital and I think you told us you don't have any such experience?

A. I have never worked in Ninewells.

Q. Thank you. We asked you some questions about how various systems work within NHS Lothian to try to improve our understanding of the way things work within the NHS more generally and in your response you've given us a number of documents and in some places you've been able to provide enlightenment based on your own experience but in some other places you, I think, don't know enough about it and in some others you've sought

help from some people.

I wondered whether -- if you could tell us why it was determined that you should provide the response that the Inquiry sent to NHS Lothian?

A. I suppose because a piece of work that was done that led to me being incorporated into the Inquiry's Terms of Reference was done within NHS Lothian's time and in my role as NHS Lothian's Medical Director, but really, I wouldn't say that there was any involvement from anybody else within NHS Lothian in producing the report that I did and therefore, when you asked those questions I sought information and help from a number of people in NHS Lothian to try to answer the questions. The timescale of the Inquiry's Terms of Reference obviously pre-dates me as a consultant and then as a more senior member of staff. Therefore, I didn't have detailed knowledge about some of the things that were in the earlier timescale.

Q. Yes, thank you. As I say, you point out in the statement in certainly at least one place that you got some help with someone on the complaints policy, I think at one stage. I presume you got some people to help gathering in policies and documents that you sent, through administrative services or something like that?

A. Yes, a board secretary helpfully gathered the documents that were available.

Q. Thank you very much. If I could have a look at your statement, please, it's NHSL-00088. Again, there's some aspects of your evidence about the way that the systems work that are of interest to us and very helpfully explained. Paragraph 3.2 please, page 2. One aspect of the way that healthcare has developed, you helpfully set out, at 3.2, a kind of historical narrative which does pre-date your time, I think, but it's useful for us to get our minds around at this stage. You say:

"The concept of NHS Trusts was introduced in the NHS Community Care Act 1990. This gave power to create Trusts, and to devolve functions of Health Boards to Trusts. Trusts were autonomous organisations, with their own Boards reporting to the Scottish Executive (as then called). Health Boards were responsible for commissioning services from Trusts public health, health promotions, service co-ordinations and strategic planning. The Trusts were responsible for implementing the strategic plans of the Health Board by organising and providing healthcare services, under the direction of Trust Management Team. The Trusts were operationally responsible for the delivery of healthcare services."

And then you go on, in paragraph 3.4 over the page, to tell us that:

"In 2003 national guidance was issued via the Health Department Letter ... with the intention to bring this diverse model of health provisions to an end and replace it with a single system of health provision. This resulted in the dissolution of Trusts and staff, property, rights and liabilities transferred back to the Health Board. This essentially created the model of delivery of healthcare similar to what we see today of a Health Board responsible for the strategic planning, governance, performance management, and operational responsibility for the delivery of healthcare."

Then you tell us how that manifested itself in Lothian. It's the generality of that that interests us because obviously the period, as you've said, that we are looking at goes back quite far to 1995. So do I understand it from that, that there was a period, which ended in 2003, in which rather than health boards delivering operational healthcare services, there were things called "trusts"?

A. Yes. Yes, there were and the trusts did the delivery and what was called the health board at the time was the overarching, more strategic commissioner.

Q. Yes, and is that -- we will come across this in the Tayside context in the coming days so it's useful context to us, if this is an area that you have some

understanding of. Effectively -- the services of the trusts were effectively commissioned by the board to deliver the healthcare operations, whereas as you say, strategic and financial directions still stayed with the trust, is that broadly the pattern?

A. That is my understanding. It does pre-date my time as a consultant, so my understanding would be more limited, I would say.

Q. Yes, but you've obviously helpfully done a little bit of research here which is helpful to us to provide some context.

THE CHAIR: Sorry, just to allow me absolute clarity on what can, to some, seem like a complex arrangement. At its most basic level, the trusts employed the doctors and nurses and the health boards, effectively commissioned their services?

A. Yes. So the trusts employed the doctors and nurses and were independently, essentially, delivering those services according it what the health board was asking them to do.

THE CHAIR: Right. Thank you.

MR DAWSON: Thank you very much. Yes, you were asked some questions about the way in which neurosurgical care was delivered in the period in the Lothian area and in doing so you've provided us some interesting concepts that

we'll become familiar with later at paragraph 5.1, page 5. This is in the context of telling us about the way in which services and structures around neurosurgery were delivered in Lothian, but you say, about halfway through:

"Care of neurosurgical patients would be on a case by case basis but could include the following associated disciplines of neurology, neuroradiology, interventional neuroradiology, neuro-anaesthesia and critical care within medicine and from professional groups including nurses, allied health professionals, radiographers and physiologists."

In considering the question about how neurosurgical care was delivered, you're making the helpful observation that there are actually a number of other medical disciplines that tend to be associated with neurosurgery but also need to be delivered within a health board to provide all the different aspects of care that are required?

A. I think I am trying to say that, yes.

Q. Yes, and you've helpfully pointed out for us some of the disciplines that would be most closely associated, perhaps, with neurosurgery. I wonder if you could broadly just tell us what these different types of services are. So if we start with neurology?

A. Yes, so neurology would be the medical specials about neurological diseases, so a sort of partner specialty to neurosurgery, where there's a consideration of surgical interventions for those diseases. Neuroradiology is a specialised area looking at particularly cross-sectional imaging related to the brain and the spine. Interventional neuroradiology is a subset of that and involves, in particular -- so the interventional part is usually delivered by a catheter into a blood vessel to access vessels within the brain. That can be to deal with a small -- a bleb on a blood vessel which is at risk of causing bleeding. It can be to deal with arteriovenous malformations that occur within the very small blood vessels within the brain and more recently has extended to mechanical thrombectomy to remove clots which are not amenable to dissolution with drugs, that are present early in the onset of a stroke, which lead to significant improvement in the patient's symptoms.

Q. Sorry to interrupt, but just on that, that would then be a situation in which those types of interventions that you've mentioned would be done by the neuroradiologist rather than by another type of medical professional, is that right?

A. Yes. Categorically, yes.

Q. Right. Sorry, neuro-anaesthesia?
A. Neuro-anaesthesia is, as the title says, it's a provision of anaesthesia to patients undergoing neurosurgical procedures. It's particularly important to think about control of blood pressure and positioning of the patient in that and then critical care, as a separate discipline, is looking after patients who require that enhanced level of physiological support.
Q. Thank you very much. And as far as the structures were concerned, you also tell us in this section, paragraph 5.2 that the paediatric epilepsy service has been provided on a nationally commissioned basis for Scotland by NHS Lothian since 2012. So that remains the position, does it?
A. Yes.
Q. You were answering that question in the context of being asked about your surgical services, so paediatric epilepsy is something that would be associated again with neurosurgery but what you're telling us, I think, is that the service for that is delivered from a central hub rather than in each health board, is that right?
A. So a small number of highly specialised services are delivered for the whole population of Scotland and that, within neurosurgery, is the only nationally commissioned service that we would have.

Q. Okay, and that does remain the position to this day?
A. Yes.
Q. Thank you. Could I ask you, please, to go to page 8 of the report, paragraph 7.2. Right at the bottom of the page, thank you very much. You were asked there whether you could give an indication about the broad systems of clinical governance in place in NHS Lothian over the relevant period. And you tell us that:
"Clinical governance, both conceptually and in demonstration has changed significantly between 1995 and 2015. It is generally taken to have developed in the late 1990s."
I wondered whether you could tell us how, broadly speaking, given that clinical governance is a responsibility of yours as the medical director, what the key developments in clinical governance have been over that period since it developed in the late 1990s?
A. I think one would summarise those as a greater level of involvement of other disciplines. So considering clinical governance events in a multi-disciplinary way rather than only within single professional groups, being more open and transparent with patients about events that have gone on and a greater focus within thinking about effectiveness in benchmarking information with other delivery units providing similar services

rather than just looking internally.
Q. Okay, thank you. We'll come on to, perhaps, some other specific aspects you mention in a moment. One might have expected, perhaps from a patient's perspective, that those type of systems would have been in place for a lot longer than the period you have suggested they have come in, in the late 1990s. The fact that this has come in suggested there was something different before. What is the history before that? Were these things delivered in a different way, or were they simply in the part of the way that medicine was approached?
A. I think they were probably less formalised and less reported on. Many people would consider the inquiry into the Bristol cardiac surgery events as really the start of a more formalised process around clinical governance.
Q. You may not realise this, but you're the second witness from Bristol today and the second witness to mention that particular inquiry. So the particular aspect that you go on to mention, as an innovation within clinical governance at paragraph 7.3, is:
"[The] protection of whistle blowers came in in 1999 [as a result of] the Public Interest Disclosure Act 1998 with the further developments in Scotland as detailed below."

And you suggest that a "PIN Whistleblowing Policy" came in, in 2011. What was the PIN whistleblowing policy?
A. These are policies that -- sorry, I have gone blank as to what "PIN" stands for. It commonly refers to policies that are delivered within Scotland where essentially there's a desire to have policies that are the same for all employees within Scotland. They're developed in partnership -- I have a sense that the "P" may relate to being developed in partnership. I suppose the purpose of those policies is to provide appropriate protection to those who raise concerns where they fear there may be detriment to them through raising concerns. But the evolution of the policies really relate to that really broader need to hear where there are concerns and understand what those concerns are and to look at those concerns appropriately and to act on the findings.
Q. And then you say in 2015 there was another invasion in the appointment of "whistleblowing champions". Is that a concept that you could explain to us?
A. My understanding is this was a Scottish Government proposal that there was a non-executive member of the board who really led -- or oversaw rather than lead, oversaw the processes relating to whistleblowing and prior to that, the whistleblowing champions within

boards were individuals who were highlighted as appropriate people who could be approached with a concern where that wasn't being listened to and understood within any staff member's normal mechanisms for raising concern, which would be with their line manager.

Q. Okay, thank you.

THE CHAIR: What sort of people are we talking about who could occupy that?

A. In terms of the whistleblowing champions?

THE CHAIR: Yes.

A. So it was usually reasonably senior members of staff, who could be --

THE CHAIR: Medical staff?

A. All different types of members of staff actually, not just medical staff, but nursing staff, colleagues in general management roles, as identified as people who concerns could be brought to.

THE CHAIR: Okay, thank you.

MR DAWSON: Is it correct to say that, as you say, the protection of whistleblowers seems to have started in 1999 but the policy that you've mentioned there as being a significant landmark in Scotland didn't come in until 2011. There seems to be something of a gap there. Is there any reason for that or any significance in it?

A. I don't have any knowledge of that.

Q. Right, it does also seem that, even over the later period, that the key landmarks that you've pointed out show perhaps a slow evolution of that aspect of clinical governance; would that be a fair impression?

A. I see the gaps in the timeline, so I understand why you're pointing that out. The INWO, the officer is the same as the Public Services Ombudsman, they are the same individual and I don't really have any knowledge about what discussion there was behind the scenes that led to that post being created.

Q. I see, thank you. You also were asked and give us a view in paragraph 7.4 on professional governance and that touches on the matters we discussed earlier about the introduction of the responsible officer and the appraisal process that we discussed. Paragraph 7.5, you were asked about, again within NHS Lothian, systems about patterns and rule to do with work. An aspect of your response which is just interesting to us is that you suggested that job planning was introduced as part of a new consultant contract in 2004, the formal job planning framework was only developed in 2013 and you say you can't recall what formal documentation and arrangements were prior to that.

Again, the introduction of job planning as part of

a new consultant contract in 2004 seems to be something of a milestone. Could you give us some indication as to what that involved?

A. I can try. I was not employed as a consultant before 2004 so I was not one of the people who moved from the old contract to the new contract.

Q. I was just checking you, in fact, became a consultant in 2004?

A. That's right, so I did not have something that was a contract under the old contract, but my recollection is that the old contract involved 11 sessions and those were distributed differently across the days of the week. The new contract --

Q. Just to pause there, sorry. You mentioned sessions. What would a session be?

A. It would normally be a half day. So 11 sessions would be -- and obviously some people would choose not to take up all 11 sessions.

Q. Right.

A. But I am working on recall, rather than factual --

Q. Does that mean one required to work 11 half days in a week?

A. One could, if one had a full-time contract, work 11 half days in a week because obviously the way teams were structured then, it was much more common for

consultants to come in to see their own patients at weekends.

Q. Okay, and does that include what we now call "on-call obligations" or does that not?

A. That does -- well, I did not ever have anything on the old contract, so I couldn't answer for sure.

Q. Understood. But in terms of the changes, what you did experience what the new contract. So what did that look like?

A. So the new contract set out normal working hours, was based on ten sessions and the new contract specifies some time that are -- some times between 8 am and 8 pm that are considered normal working times and what are called "PAs", the time-block of four hours are fitted into those days. So some people might work a three-session day that would be from 8 am till 8 pm. That would be unusual but it does happen.

Q. I see, so is that what you mean by "job planning" as being the innovation?

A. So job planning as part of that contract, my understanding of the change of the contract there was greater visibility of where consultants were and what they were doing on a day-by-day and week-to-week basis.

Q. I see.

A. And a -- more formalisation around providing

an identified individual who was available in the out-of-hours period.
Q. I see, so something more akin to a rota that you might see somewhere else, you would know that a certain person would be in at a certain time, doing certain tasks?
A. Yes.
Q. Whereas before, one committed to doing a certain number of sessions but when one did that was one's own responsibility, is that right?
A. I suppose the old contract had been in evolution for some time. I don't know when it came in, I'm afraid. So I imagine that there was a change over time.
Q. Yes, but the move was more towards there being more visibility when people were working at any given time, as opposed to a freer system, perhaps?
A. That's exactly right, yes.
Q. That's very helpful, thank you.
THE CHAIR: And howsoever that was arranged, or whether when, during the working week, at again, it's most basic level, we're looking at a 40-hour week, are we?
A. Yes.
THE CHAIR: So 10 times four hours? Yes.
MR DAWSON: You were also asked -- this was the area I touched on earlier -- about what complaints systems might have looked like in NHS Lothian over the relevant

period which I think we defined as 1995 to 2015. And this was the area where you got some help from NHS Lothian's head of patient experience which, you say, was in line with your own experience anyway, where you say:
"'All staff are encouraged to deal with complaints and these should be investigated and responded to (where possible) within 20 working days. The NHS Lothian Complaints Policy, sets out roles and responsibilities for all staff who are involved in complaints handling, encourages team to learn [them to learn, I think probably] from complaints and the policy also offers advocacy services to support people to make complaints. DATIX is the complaints document management system. The NHS Lothian Complaints Team offered a 'single point of contact' to make it easier for the public to contact the organisation and this could be either in writing, face to face or by telephone.'"
So in that, you tell us that was a certain expectation that where complaints came in, they would be responded to by the staff member to which they related, or would be responded to by NHS Lothian?
A. They should be responded to by a senior member from NHS Lothian, that's who would ordinarily sign off the complaint. Ordinarily, that would be a site director or

someone with a similar level of responsibility, maybe a site lead nurse, but they should be signed off at a senior level.
Q. Another aspect of that which comes up in other places is "Datix"; what's that?
A. It's a system by which we manage complaints. It also holds information about adverse events and about litigation cases.
Q. Excellent, thank you very much. Is that used across all health boards in Scotland, as far as you're aware?
A. I think not all. I think nearly all, but not all.
Q. So it's one that's available, you can take it up if you want to, but you don't have to?
A. Yes, and then obviously all these systems -- there's a level of individual configuration. So how one board use as system might differ from how another board uses that system.
Q. I think Datix is something -- you sometimes see it in the context of "a Datix" or something is referred to as something where something has gone wrong or there's been, as you say, an adverse event. Effectively, what that means is it's been logged on the Datix system; is that right?
A. Yes.
Q. Paragraph 7.12. Again, you were asked questions about

the systems in place regarding investigations into the professional practice of consultants and you referred us, in particular, to:
"Policies regarding the investigation and disciplinary action against a doctor are set out in NHS Circular (1990) 8 with amendments in NHS Circular (1990) 32."
So would those have been documents issued by the government setting out the expectations as to how disciplinary matters and the investigation of them should be handled?
A. Yes.
Q. So there would be expected to have been a consistency in that regard across Scotland?
A. Yes.
Q. Thank you. You were also asked what policies may exist relating to particular facets of neurosurgical practice -- we get quite specific there, by the time we get to page 12. In paragraph 8.1, you told us that:
"[You weren't] aware of the policy to assess Neurosurgeons' technical surgical skills in NHS Lothian between 1995 and 2015."
But you do tell us that:
"During this time period, the systems in place within all areas of surgical practice were principally

local morbidity and mortality meetings. A clearer organisational approach to these meetings in NHS Lothian was not developed before 2015. The Scottish Audit of Surgical Mortality ran from 1994 to 2015 and included neurosurgery. NHS Lothian participated in this. ISD Scotland now Public Health Scotland [managed] the Scottish Audit of Surgical Mortality and are better placed to provide further information to the Inquiry.

"NHS Lothian currently works as part of the Neurosurgical MSN who audit outcomes against agreed standards ..."

So there's various components there, all parts of the system, as far as I can make out.

You say, in relation to the maintenance or the monitoring and the promotion of technical surgical skills, there were, over this period, local morbidity and mortality meetings but certainly, at NHS Lothian, the organisational structure of those may have been clarified at the end of the period we were looking at. When you say "local morbidity and mortality meetings" first of all, what do you mean by "local" and secondly, how did these meetings contribute towards trying to promote surgeons' technical skills?

A. So when I say "local", I really mean, in the main, within a particular team. So a team within general

surgery working within one hospital. On occasions, there can be meetings that are held to consider a longer time period between different -- involving more than one team. And they really are looking at complications that have occurred and some teams will look at those on a weekly basis. It is something that has come from a surgical discipline of practice but is now incorporated into other areas. So in particular, within interventional areas of practice, it's very important and tends to happen more frequently than within more medically-based specialties such as medicine of the elderly, where there are still important complications and poor experiences to discuss and learn from, but the way those cases are selected might be different. That really is the piece of work that I'm referring to that comes after 2015 but we have attempted to introduce a clearer structure around expectations within the organisation.

Q. So first of all, these meetings were, in the period that we are looking at, an important component of trying to discuss matters within a team and to promote the standard of surgery and technical skill; is that correct?

A. Well, that is where a complication would be discussed. And some complications may be attributable to

technical -- not necessarily skill, but to choices that have been made maybe around a particular approach, or a way something has been undertaken and that is the opportunity for the surgeon to try to articulate why they did what they did, and to hear views from other colleagues that might involve a different approach.

Q. So certainly, in surgery, where I think you said this concept started before it became applied more widely, this was an important component of the way surgical services were delivered, is that right?

A. It is. It's also important that that's how, if you were discussing wound infections, you, as a team you might pick up that there was a particular issues emerging about wound infections. That would make the team consider what was the interoperative practice, whether things related to any antibiotics that were being given, before procedures that needed to be changed, were there any elements of post-operative care that needed to be changed.

Q. Okay, thank you. And I think what you're telling us is that after, from about 2015, there was more organisational structure about how these meetings were organised but before that, they were more local, in the sense of being organised within a particular team. Different teams might have them, but they might run them

slightly different ways, would that be fair?

A. I think that is still actually likely to be the case. Different teams will still run those meetings differently because actually, this is a process that needs to be owned at a local level. It can't really be imposed from on high within the organisation, if you want to think of it like that. The actual team who are looking after the patients need to participate meaningfully in the process.

Q. Thank you and you then, in this paragraph that I read out, talk about some audits of surgical mortality that took place. What was the relevance of those to the question relating to policies about the promotion of surgical skill and quality?

A. Well, they are -- my recall of that system was that it didn't involve peer review. It only looked at cases where the individual had died, but there was a form that was completed by the surgeon, and that was then sent off for peer review, and that peer review had the potential to identify whether there was any technical shortcoming that was obvious to a peer from within that discipline.

Q. I see. And that took place between 1994 and 2015 so very much the period that we were looking at. And as far as peer review is concerned, would that be a peer within the same team or the same health board or someone

outside?
A. No, I think it was outside. I think it was outside the health board. It was organised through the College of Surgeons in Edinburgh, they had an office who administered the allocation to reviewers.
Q. And would that cover oral surgical mortality?
A. I can't recall whether there are any particular surgical disciplines which were excluded, but it did -- I'm as sure as I can be, to put it in my statement -- cover neurosurgery.
Q. That's very helpful, thank you. You then go on to say that:
"NHS Lothian currently works as part of the Neurosurgical MSN who audits outcomes against agreed standards ..."
This is something that I've mentioned earlier in the week is the Managed Service Network for neurosurgery, as I understand it. Could you tell us broadly what that is and if you know, how long it's been around?
A. I think the document that is referred to, or the following document, does reference the creation of the MSN, which -- the reason why I mention it in this paragraph is they do undertake benchmarking about individual neurosurgery consultant outcomes. So that information is -- that's why I was trying to point that

out as something -- although it's not an in-theatre assessment of a technical surgical skill, if there was an outlier in terms of their outcomes, that's where, as a medical director, I would expect to see that.
Q. And would that apply to all neurosurgeons?
A. In Scotland, yes.
Q. In Scotland, yes. And this, I think, as I understand the Managed Service Network, it was a system that came in to try to create more consistency and improve standards Scotland-wide, that would then filter down into individual the individual -- I think were delivered from four different places in Scotland. Is that broadly the pattern?
A. Yes.
THE CHAIR: Sorry, Mr Dawson, I wonder if I could just ask about the term "benchmarking" that you've used and it's cropped up a number of times. And you may have an idea as to what it means and I think your reference to an outlier might hint at what it means, but can you just make it clear to us what "benchmarking" is and what it achieves in the context of this organisation?
A. Yes. So by "benchmarking" we would normally mean we're trying to compare the same thing between different organisations to see whether the same, broadly speaking, outcomes within an acceptable range are achieved. And

so I do think that is exactly what the MSN is trying to achieve in this and that is to understand, from the outcomes that they look at, which may be limited, that: do you get comparable results between Edinburgh and Dundee, or Edinburgh and Aberdeen.
THE CHAIR: I don't want to distract you too far from your script, but when you're talking about outcomes, one example might be readmission after surgery; is that the sort of thing that one is looking at?
A. Yes, that type of thing.
THE CHAIR: Yes, right. Thank you.
MR DAWSON: And other set matters being monitored?
A. Well, the MSN set the standards that they monitor to.
Q. So you might include -- things like mortality, might be included in it?
A. You might. I think the important thing will be to be sure that you were clear about the definition of what you were measuring, so that you are measuring the same thing across organisations.
Q. Yes, to meet the benchmarking of value, at the end of the day?
A. Yes.
Q. You mentioned, I think, that as a medical director you would want to see that. Obviously it would provide useful data to try to, as I think you said, point out

whether any outliers or any patterns or issues that might require your attention. But is it the case that that can't be everything you look at to try to determine whether a service is being delivered to an appropriate standard, would that be fair?
A. Yes, that's fair.
Q. So what are the limitations of just looking at the data and not considering other aspects of the care that's being provided?
A. So obviously it sort of refers to the earlier comment really. That type of benchmark data is looking at a very small number of clearly measurable outcomes and that does not include things like experience, it doesn't usually include measures that might pertain to safety. It's really about the effectiveness or otherwise of interventions. There are a number of these type of measures that are well developed, so I could give you an example from transplant services where, for both liver and kidney transplant services at a UK level, there are particular measures that are monitored. But if one's own organisation comes up as an outlier within that monitoring, you very much need to look and understand why that has happened, what is going on. And it is almost always related to the whole team function rather than the individual surgical intervention from

the surgeon. That's why the delivery of the services is very much a function of the whole team, not just the one individual.

Q. Okay. Did you say that it doesn't measure safety?

A. It doesn't measure some of the more processed measures around safety that we would think about. So are antibiotics given on time? Do we have an appropriate bundle around looking after both peripheral and central lines? Some of those more processed matters.

Q. I'm just trying to think if it can be possible to sort of hypothesise an example because I think something I've seen in benchmarking in some surgical contexts would involve a situation where one of the matters that would be being monitored would be the amount of time that might -- or the number of people or the amount of time that might elapse for people who have to come back for further surgery, in a surgical context that. That might be a metric that would tell you something statistical, but it might not tell you very much about the reasons why that was happening. Would that be the sort of idea that it's not really telling you very much about safety; would that be correct?

A. Possibly. Maybe I phrased that poorly.

Q. This is an interesting phenomenon because it is -- benchmarking does come up quite a lot and it seems to

be -- would it be wrong, put it this way, to look at these benchmarking data and think, for example, as a medical director: that's all I need to look at and everything seems to be within the parameters, so everything is being delivered safely?

A. Yes, that would be far too limited. One needs to take into account many more things in understanding how well, or otherwise, a particular service or team or system is functioning.

Q. It's not irrelevant to that question but it is merely a part of a much bigger data set or information set one would need to look at; is that correct?

A. Yes.

Q. Thank you very much. And one other aspect that you mentioned helpfully here -- not something I have come across before, but I wondered if you could tell us something more about, if we're not stretching your neurosurgical understanding too far -- is in paragraph 8.2 where you tell us that:

"[You are] not aware of a policy to assess neurosurgeons' patient care including communication with patients in NHS Lothian ..."

Over the relevant period. But you do tell us that:

"Neurosurgeons in NHS Lothian used patient satisfaction questionnaires in line with the

expectations of the GMC for all doctors for revalidation purposes from 2012 onwards."

You say that before that, over the page:

" ... a questionnaire developed by the MSN from 2009 was used for out patients. Neurosurgical MSN may be able to provide this information to the Inquiry."

So just to understand, would that -- would a patient satisfaction questionnaire be expected to be given to every patient?

A. That's why I have referred, in my statement, to the MSN because I don't really have any more detailed information than that. The reference about patient satisfaction questionnaires more broadly relates to the expectations of the GMC, as I've said, but I did check with a neurosurgery colleague and that's where I got the information from that they were -- there was actually some testing of patients' experience of receiving care within neurosurgery before that.

Q. But as far as the general situation was concerned, from 2012, there was an expectation that patients would be sent patient satisfaction questionnaires. Is that all patients?

A. No it's not all patients. No. No. It's -- the GMC's expectation is that the views of about 25 patients are sought. Now, that is a very arbitrary number. It is

quite difficult to apply within small teams sometimes, where a patient may see many different team members and so we -- I think, as a responsible officer, I wouldn't be too fixated on the number. What is important to me is that the individual doctor has made an effort to understand how patients experience care coming from them, preferably directly them rather than as part of a team, and they've reflected on the findings of that to think about are there any things that they could or should do differently.

Q. Okay, thank you for that.

THE CHAIR: Is that a representative example across a period of, what, a year?

A. No, it's usually done in a shorter time period than that but sometimes it can be done over a few weeks depending on how many individuals a patient sees.

THE CHAIR: I see, but is this part of a process of reporting to the GMC that is regular and, if so, how regular?

A. The GMC has an expectation that it happens once in each five-year cycle.

THE CHAIR: That's what I heard you say earlier, I wondered if it was part of that timescale?

A. So.

THE CHAIR: I'm trying to put into context the relevance or

importance of the sampling of 25 patients in the questionnaires.
A. I think what I'm trying to say is that 25 is a rather arbitrary number and some doctors will see hundreds of patients in a year and other doctors will see far fewer.
THE CHAIR: But this is per doctor?
A. Yes. Yes.
THE CHAIR: Okay. All right, I'll leave it there.
MR DAWSON: But that's linked into regulatory requirements on doctors rather than it being something that's delivered through the sort of more service side of a hospital?
A. Yes.
Q. That's interest. Thank you. Obviously we have a number of questions for you about the 2018 report which is I think the reason why you told us you were nominated to answer the Rule 8 requests that were sent to the board. If we could go please to paragraph 9.1 of the report which is at page 13. You were commissioned, I think in 2018, in your capacity as Executive Medical Director of NHS Lothian, to write a report about matters relating to -- broadly relating to the position with Mr Sam Eljamel who was a consultant neurosurgeon in NHS Tayside, is that right?
A. Yes.

Q. And in this paragraph, you tell us how that commission came about. You tell us that:
"The report was commissioned by Malcolm Wright and Annie Ingram (the then NHS Tayside Chief Executive and depute Chief Executive respectively). I was approached by them following a meeting in September 2018 and asked to review how NHS Tayside had learnt from the concerns. The request was to me as a current Medical Director without any expectation of the involvement of any other reviewer ... the emphasis in the conversation was on the approach taken by NHS Tayside and whether there were any opportunities to improve that. There was no instructions provided to me beyond the Terms of Reference [letter of] 19 November 2018."
How did it come to be, as you understood it, that they approached you in particular to undertake this task?
A. Well, I was the Chair of the Scottish Association of Medical Directors at the time. So I'm not clear whether it was in that capacity or whether it was because I was a medical director of a board that involved neurosurgery or that I had a surgical background myself.
Q. Okay and there's mention here of there having been a meeting in September 2018, is that right?
A. That was a board Chief Executives meeting that I was attending in my capacity as Chair of Medical Directors.
Q. You say you were approached by them following a meeting, does that mean they spoke to you in the corridor or something or was there a more formal approach?
A. That would be basically it.
Q. Yes, okay. So they made an informal approach to you, saying that, in that context, they were interested in asking you to do this piece of work?
A. Yes.
Q. And I think you told us this already actually, but I think you said that the work was done sort of on NHS Lothian's time, if I could put it that way, very much in your capacity as the Medical Director of NHS Lothian; is that right?
A. Yes.
Q. Is this something you've ever been asked to do before or since?
A. I don't think I'd been asked to do it before. I actually would need to think quite carefully whether I have done -- I have never done anything that's sort of had the ramifications that this has had before or since, but it would be not uncommon, as a medical director, to be asked to, say, review a situation or participate in a broader group of people who were doing something.
Q. And so there's no formal system or anything like that for one health board in Scotland to approach the medical director of another health board to say: would you have a look at something that's happened and -- within our work and could you tell us what you think?
A. Well, there are medical director participants in groups looking at areas of service provision. Looking at areas where things have gone wrong or not happened in the way that's intended, I'm not aware of any formal system to identify somebody. But there may be a mechanism through Scottish Government to suggest people.
Q. And you mentioned earlier the possibility that -- I think you're speculating but it's possible they might have approached you because you're the medical director of a board which had neurosurgery within it and I think not all do because there's the four neurosurgical centres, so there are some places that do not offer surgery neurosurgery. But what was the significance of that, in light of what, at least in these initial stages, you understood they were going to ask you about? Because essentially they were, as I understand it, asking you to talk about really more of a clinical governance function, if you like, so how had they handled it?
A. My understanding of what they were asking me to do was to be quite specific about whether there were

opportunities that, at a senior level, Tayside could have done things differently, and to consider whether there was any learning that they needed to take from the way things had been handled.

Q. Are you aware of there being any other mechanisms by which a review of that nature could be instructed other than this slightly unusual approach?

A. So I'm obviously aware of the Royal College of Surgeons' invited review that was undertaken that was more specifically into areas of clinical practice.

Q. For example, I'm touching on something that's associated to that. We actually heard this morning in fact the review that was done, which I know you're aware of, in 2013, was an individual review, so as you say, it was more clinical in nature. But the Royal College of Surgeons also offers a different type of review which is called a "service review" which is more systemic, which I think would be more akin to the sort of thing they were suggesting that you should look into.

So, would that have been an appropriate mechanism for this sort of thing to be looked into?

A. So I am aware of that mechanism that the College of Surgeons in England now have because I have commissioned one of those myself, but whether that was available in 2013, I actually don't know. And I don't think that the

review that I was asked to do was as extensive as that. I would expect that to be.

Q. Was there any payment made at all in connection with the review that you did, to you or the board?

A. No. No.

Q. You say in the statement, the way -- the words you use are that the contemplated review that you were told about was to review "how NHS Tayside had learnt from the concerns". What did you take that to mean at that stage?

A. I took that to mean what they -- whether they had any understanding of the way events had played out and what they had changed as a result of that.

Q. Right. Were you aware, at this time or any time, whether there had been any particular trigger or reason for this being asked for at that particular period?

A. In 2018?

Q. Yes, as opposed to earlier, for example?

A. No, I was not and I don't know whether it related -- I don't know when Malcolm Wright started in that post, whether that related to him starting and wanting to be able to -- my recall of the words that were used is that they wanted to be able to demonstrate to the board that there had been consideration from somebody from outside about the way things were handled.

Q. When you say "somebody from our side" --

A. Somebody from outside, sorry.

Q. Sorry, that's quite an important distinction.

A. Yes.

Q. So did you understand that the mission, as it were, was to try to assist them in that task of being able to demonstrate to the board what had happened?

A. I understood that I was being asked to look at what had happened with fresh eyes. I did not really detect that it was to -- there wasn't really any sense of constraint over what I could say. It didn't have to be helpful in terms of assisting.

Q. So did you feel -- or did you understand that what they were commissioning was an independent report?

A. Well, as an independent, I am from within NHS Scotland. I'm not -- so within that sense, I'm aware that the word "independent" has a number of connotations.

Q. Well, that's very interesting you should say that because as a result of you understanding that context, coming out of a meeting, I think, with other medical directors from other health boards all from NHS Scotland, I think you told us, would it really have been possible for you to give a properly independent report, if I can put it that way, such as one might have got from an external agency with no contact from within NHS

Scotland?

A. So, no. Not if you look at it from outside like that. I suppose they knew what they were -- they knew who they were asking. I was not unknown to them. So I think it's -- the independence that I understood that they were seeking was somebody who was not part of NHS Tayside and not part of neurosurgery, rather than somebody from outside NHS Scotland altogether.

Q. I understand. And by this point in time, did you have an existing awareness of Mr Eljamel, what had happened, the current state of, sort of, political activity around the treatment he had given to his patients, anything like that?

A. Only from press coverage.

Q. And what was your understanding between the period you were originally approached and you took up the commission, about what the position was in that regard?

A. That it was extremely difficult. That there were a large number of patients who had had treatment that was not as they understood it had been, and that there were a large number of complaints that were coming forward.

Q. And did -- were you aware of certain key elements of Mr Eljamel's story, in the sense that were you aware of

the fact that he had been under a period of clinical supervision, for example?
A. Until I received the documentation that I was sent, no.
Q. And even more broad than that, were you aware of the fact he no longer worked at NHS Tayside, for example?
A. I think I was aware of, yes.
Q. Yes, okay. Were you aware of the fact that, for periods, on certain accounts some years before this, campaigners had been trying to push to have a public inquiry into matters relating to Mr Eljamel's professional practice?
A. In the time between the events I was asked to look at and that --
Q. In the time period between the events that took place up to 2013, '14, '15 and the time you were being commissioned, there had been calls for a public inquiry. Were you aware of that?
A. I'm not sure that I know that there was cause for a public inquiry. I do know that there was a lot of press coverage around really significant levels of concern.
Q. I see, amongst patients?
A. Yes.
Q. And did you join the two together and think that perhaps it was that public concern that they were asking you to

provide a report in response to?
A. No, I did not have any understanding. That's not what I understand I was being asked to look at.
Q. I understand, but there was no other reason proffered, I think you said at any time as to what the trigger was, if there was one, other than this need to show something to the board?
A. That was the only reason that was given to me.
Q. Understood. Sir, that would be a convenient moment for a break.
THE CHAIR: We're going to take a 15-minute break at this point. Ms Miller will just take you back to the witness room. If I could ask you, just for the sake of good order, not to discuss your evidence. We'll resume again in about 15 minutes time. Thank you.
(3.13 pm)
(A short break)
(3.25 pm)
THE CHAIR: Thank you, Mr Dawson.
MR DAWSON: Thank you, sir. Ms Gillies, we were looking at and talking about the circumstances of your instructions to conduct the 2018 review. Could we look, please, at NHSL-00006, please. I think this is an email that was forwarded to you for your information on 12 September 2018, is that right?

A. Yes.
Q. By Dr Annie Ingram, is that right?
A. Yes.
Q. Just scroll back a bit further. It says here:
"Hi there.
"Further to the recent enquiries regarding neurosurgery, the Chief Executive has confirmed that NHS Tayside need to ensure that there is organisation-wide learning from this case. To that end he has asked Miss Tracey Gillies, Executive Medical Director of NHS Lothian to review the process and decision-making in this case to determine if there are improvements that we could make going forward and if there is learning for the Board."
So this is being forwarded on to you, but I assume it's also providing you with a bit more information as to what it is they're looking for. Is that perhaps the purpose of it being forwarded to you?
A. I presume so, yes.
Q. Yes, because by this point, you have a kind of vague idea what it's about, but this is providing a bit more information?
A. Yeah.
Q. The principal intention, it would appear to be, was to try to ensure organisational learning; is that right?

Certainly expressed here?
A. Yes. That's what I understood, yeah.
Q. Indicating perhaps that there was some level of acceptance that things hadn't gone, in a clinical governance sense, quite as they should have, is that right?
A. I think it may have been broader than just the clinical governance aspects.
Q. The thing is that, by this stage of course, as we'll come on to see, and you were sent, there has been the Royal College of Surgeons' review. But what we know about that was it was principally an individual review into clinical matters relating to Mr Eljamel's practice, although there was some commentary on the clinical governance side.
A. Yes.
Q. So what I'm trying to investigate is perhaps whether what's happening here is they're trying to -- they've taken some time to realise that there may be clinical governance implications of this and that the original review they asked for someone else to do was more clinically focused and that perhaps that was the thinking behind this. Was that your impression or perhaps I'm reading too much into it?
A. That wasn't really the impression that I had. The

impression that I had was that they wanted me to look at whether, as a board -- ie a senior management team, really was how I interpreted the word "board" in that context -- they could and should have handled things differently related to the significant concerns related to Mr Eljamel's practice.

Q. Right, okay, but I suppose there are, out of that -- that's a very general position and out of that, there are, as you came to understand, multiple different components to the Eljamel situation that the board could perhaps have had a role in. So at this stage, it doesn't seem to be being defined with any clarity as to: you're to look at all of those, or some of those, or which ones, or why; is that fair?

A. I think that is fair and my recollection is that I asked for a terms of reference.

Q. Yes, indeed. We'll get to that in a second, but at this point, it then goes on to say:

"In a short meeting this morning with Peter Stonebridge, Lorna Wiggin and Alison Moss, I confirmed Malcolm's that Malcolm has asked me to co-ordinate our response and we agreed the following:

"Peter would speak with Lee Jordan to oversee the timeline being prepared by Tracey Passway, linking with the work previously undertaken by Audrey Warden and

David Mowle; with the complaints and legal claims team and with Christopher Smith in relation to HR matters; to develop a full description of events, including the patient complaints, trigger points, key decisions made and the circumstances of [Professor] Eljamel's suspension and retirement. This [would] provide a complete timeline and is required by the end of October 2018."

So efforts were ongoing, I think involving someone called Lee Jordan, who would be bringing forward a lot of information that presumably would then be given to you, to give you the material from which you could work, is that right?

A. Yes. Yes.

Q. Who is Lee Jordan?

A. So, my understanding, he was an associate medical director within the NHS Tayside structure.

Q. Okay. And there appear to have been -- and there were a number of other people involved there who have contributed, it appears in some way, to this process that he seems to be overseeing, including Audrey Warden and David Mowle. Did you know who they were, at this stage?

A. At that stage, no, but I obviously spoke to them, as is set out in my review.

Q. Yes, and David Mowle was one of the other consultant surgeons who had worked in the other unit as Professor Eljamel, I think, yes; is that right?

A. Yes.

Q. Could we look, please, at the terms of reference that you just mentioned. They're, I think, most clearly set out -- I think there's a letter where they're not set out very clearly, there's a sentence cut off or something like that. But I think they're probably most clearly set out in the report itself. So if we can go to that, it's NHSL-00012. And I think there it says that you're to:

"... undertake a desktop review of NHS Tayside's handling of the case involving Professor El-Jamel to determine whether the action taken by the Board was reasonable, timely and appropriate."

What did you understand that to mean in terms of, as I said earlier, which aspects of the case involving Professor Eljamel you should be considering?

A. So I understood it to involve the actions taken related to concerns being raised, addressed and then the exit of Professor Eljamel from NHS Tayside.

Q. Right, and insofar as particular components arose from the paperwork, you could address them as you thought appropriate, perhaps?

A. Yes.

Q. For example, there isn't -- you mentioned the exit of Professor Eljamel. There isn't a mention there of the exit of Professor Eljamel. It is something you looked at, but ...?

A. Well, I tried to.

Q. Yes, but the -- it's quite a general remit? Put it that way.

A. It is.

Q. And then it said that it:

"... should include a review of the timeline of events; a review of the Board's handling of complaints and the action taken."

And is the timeline effectively what we were talking about before, ie the material that was put together to show you what had happened, it was part of the material that you had been given?

A. That was what I understood, yes.

Q. Okay. And it said:

"The Review should identify any questions to address as a consequence and/or establish if any further data should be sought and should identify areas for improvement."

What did you take the reference to "further data" to mean?

A. I guess, "data" in its broader sense, further information, rather than necessarily numerical data.
Q. Yes. So does that mean they're saying: is there anything that you might need to see in addition to what you've already been given that would assist you, or how did you take that?
A. Well, I took that to say anything that was maybe missing that wasn't considered or wasn't available.
Q. I see, right. So does that sit well with the words "if any further data should be sought", it's suggesting in the present that something could be sought. You interpreted it as meaning whether something more should have been looked at, at the time?
A. Yes.
Q. Okay. And then, of course as had been indicated before, you should identify areas of improvement. Could we have a look, please -- we'll come back to this document, but could we have a look, please, at NHST-01656. Now, this is a document which you did not produce but has been produced by NHS Tayside which, I think, has been sent to you in a bundle of documents. And we've been trying to work out, as have others, what precisely was made available to you. There is a list, as we'll see, of things that were made available to you but defining, in particular, precisely what -- the timeline and other

materials made available by Mr Jordan, it's difficult to work that out because there are a number of different versions. So there appear, to us, to be two drafts of an initial version of an involving timeline, if I can put it that way, and there is this document which seems much fuller and perhaps represents what it was you were given. So what we'd be interested to know is whether you think this represents what you were given which was the product of the work which Lee Jordan had been asked to do?
A. So I was given both documents from Lee Jordan, at the time. There's one that is referenced there on the fourth line dated 26 October and then this one, from 16 November, because there are questions contained within the text of the document which appear to have been answered. In terms of the bundle of documents provided as part of the Inquiry, I don't think I received the one with the tracked changes from Annie Ingram on it but I did receive the 26 October and the 16 November documents from Lee Jordan which are subtly different.
Q. That is helpful, thank you very much. You say they are subtly different. Are there important aspects to the subtle differences?
A. I think what has happened between 26 October and

16 November is that there's been a further attempt to answer some of the questions which are marked and it may have originally been in a different colour, but they were not a different colour when I got them. But they're marked and then it says "response" and they mainly appear in brackets.
Q. Okay. Without, at this stage, getting into the details of this, was the information with which you were provided sufficient for you to carry out the task that you understood you had been asked to do?
A. The information was limited and I've tried to be very clear in my report, that's why I set out what I had been given so there was no ambiguity about that. I did not -- there is discussion about whether or not I should be provided with details about individual patient circumstances. So the only way that I was able to use the larger spreadsheet of patient complaints was in trying to map the time of the patient's original episode of care to the time when the complaint was raised, in order to try to frame that against when the concerns began to be acted on -- about Mr Eljamel's practice, if that makes sense.
Q. Okay, and one of the aspects of the materials that you've been -- you were provided with, indeed in this letter and indeed, you express a view on, relates to the

period of clinical suspension -- sorry, the period of clinical supervision which Mr Eljamel had in 2013. And without, at the moment, going into the detail of what material you did have about that, would it have been possible for you to try to speak to those who had been involved in the supervision process to try to understand more about what actually happened, what didn't, what the thinking was behind, how that had worked? Was that option available to you, to try to seek more -- to interview people, effectively, if I can put it that way?
A. So that's what I asked to do. So I went up and spoke to four people and I have set that out, who I spoke to on the day. The people that I spoke to were identified by NHS Tayside. I asked to speak to somebody who could tell me about educational governance, somebody who could tell me about clinical governance. And so they identified the people for me to speak to. So, the limited review that I did was significantly augmented by going to speak to people.
Q. Yes, okay. And who did you speak to?
A. So I spoke to Audrey Warden, I spoke to Tracey Passway, I spoke to David Mowle and I spoke to Eric Ballantyne.
Q. Okay. Mr Ballantyne was one of the other consultant neurosurgeons, I think?
A. Yes.

Q. Were these the people that you chose to speak to?
A. No, I asked to speak to somebody who could tell me about clinical governance, so Tayside provided those names.
Q. Right. So when you said: these are the sorts of things it looks to me I would like to know more about, you were given a list of the individuals and that didn't include someone who could speak to educational governance?
A. It did. That was Mr Ballantyne.
Q. All right, okay. Why did you think it was important to speak to someone about that aspect of things?
A. Because, for any consultant, a significant part of their practice involves working with doctors in training and understanding whether there were concerns that had been raised from those doctors in training. And their participation in that would be an important way to understand what was going on.
Q. The issue here though, is it not, that you're speaking to a small group of people who may be able to explain something to you, but you're not speaking to all of the people that might have been able to explain to you their various perspectives? So if we were to take that as an example, that particular one, you spoke to Mr Ballantyne who was one of the consultants, but in light of the fact there were some concerns in the paperwork that you were looking at about the way in

which Mr Eljamel had organised and interacted with trainee surgeons, it would be more logical, would it not, to try and understand what their perspective on matters was, rather than another consultant who didn't necessarily work within that close unit?
A. So I understand that point. I think that would be part of something that was much, much broader than I had been asked to do. And I would not -- that's not something that can be done by one person. That would need a team and an infrastructure to do that.
Q. So, one of the things that I know you've looked at because it was one of the documents that was sent to you was the report from 2013 where we know that the team -- the reviewing team from the Royal College of Surgeons attended in September 2013 over two days and spoke with a vast array of people.
A. Yes.
Q. And we understood, from the evidence of Professor Smith who is in charge of -- now in charge of that Invited Review Mechanism this morning, that the names of the people would have been a part of the dialogue were the sorts of people someone wanted to speak to would be proposed, names would be put forward and there would be an agreed list. And effectively, the Royal College would get to speak to whoever it was they wanted to

speak to, to answer the remit of the review.
Your position, I think, is that was not the sort of review that one person could undertake?
A. It is, and that review had already been done by the Royal College of Surgeons, and I was, in what I thought I was being asked to do, trying not to repeat, or to re-explore things that had been done already.
Q. So I'm not quite sure I follow that. You said had already been done but your remit was not to explore things that had already been done, is that right?
A. So the College of Surgeons had spoken to a large number of people and I did not understand that my remit was to reinvestigate the aspects that they had investigated. My remit, I understood to be very narrow and to consider how NHS Tayside, thinking of that as the senior management team, had reacted to the concerns as they were raised and the actions that had been taken. So it --
Q. Okay, but to put aside the question of the remit, at one stage there's a question of what material you have available to be able to conduct the remit. So for example, you didn't have access, did you, to any of the statements that had been taken by the review mechanism which might have contained narratives that would be relevant to the issues you were talking about? You

didn't have that, did you?
A. No, I did not.
Q. Nor did you have any facility to be able to gain any such factual material from individuals who had a perspective or an involvement in matters that you were looking at, other than the small group that you described?
A. Yes, and that's why I have been very careful to set out the very limited nature of what I did.
Q. Absolutely.
A. So that what -- I was trying to make it as clear as possible that what I did was limited and I was really trying to focus on that one question.
Q. I understand and accept that. That's very much appreciated that you've taken the care that you have in that regard. What I'm trying to understand is -- what the Chair of the Inquiry will ultimately have to decide upon is what this review is all about, what its purpose was, why it was that it was approached this way. And you've explained, you've given your evidence about why you might have been approached as an appropriate person to provide a report like this. But as regards what exactly it is or was set to achieve, what you could achieve by this was very much limited by the fact that you were just one person; is that correct?

A. Yes.
Q. And the fact that you had access to information which predominantly, albeit through different routes, in writing and through the interviews that you were able to have with certain individuals, effectively emanated from effectively the executive body that you were investigating, if I can put it that way?
A. Yes, I understand that.
Q. Is that -- do you accept that?
A. Yes. Yes, I do.
Q. Thank you. And in light of that, I understand your position, because you have been very clear and you've accepted in your statement that this was limited, but you did the best that you could, is your position, on the basis of the information that you had in order it try to assist; I think that was your motivation?
A. What was why I have tried to frame my observations and recommendations in a way that outlined things that Tayside could and should consider. Either they may already have changed but to make sure -- to test those out and make sure those were in place.
Q. Thank you. One of the passages in your statement that I just wanted to ask you about was at paragraph 12.3 which is on page 15 if we could just jump back to that. So this is in the context of you explaining what the

main findings, conclusions, recommendations of the report were, which you set out under reference to the report itself. Then you say:
"Additionally, in speaking to individuals within Tayside, it was very evident that there remained considerable distress about actions taken or not taken to the discernible impact onto individuals' health still some time later."
What did you understand that to mean?
A. So I was trying to say, in appropriate language for this type of setting, that actually in speaking to those four people, it was very clear that they were carrying a very significant burden of guilt and concern about the way they had not identified things earlier.
Q. And was that evident by their manner or in what they said, or did they accept failings, or what was the position?
A. Yes, there was a level of emotional distress within actually all four of the conversations.
Q. Well, I mean, if we look at the roles that were played by the four, I think you talked about, David Mowle obviously was another consultant. What was his approach to these questions in terms of telling you his recollections and reflections on matters?
A. So I found everyone to be straightforward and to give me

their recollections as best they could. It was clear that there'd been a number of previous questions asked to various individuals that couldn't necessarily recall exactly who said, but the sense came over quite strongly was that this was ground that had been rehearsed several times before. And that --
Q. Was that just Mr Mowle, or was that across the board?
A. No, that's what I'm trying to say. My impression -- and it's probably more impressionistic than something that I wrote down at the time, was that people had been asked a number of questions. I was trying to be as clear as I could in my recommendation about the burden of work, in particular, that was placed on Mr Mowle and Audrey Warden in terms of the patient recall exercise. And having -- the lack of organisational infrastructure support to support that.
Q. I see, but in terms of -- that was to do with their involvement in reviewing some of Mr Eljamel's cases after the event, if you like?
A. Yes, it was.
Q. Which was one of the steps that was taken, to try to look back and work out the extent of what had gone wrong, as I understand it?
A. Yes.
Q. But as far as their reflections or positions in relation

to the events themselves, rather than the burdens of the aftermath, which of course is not irrelevant, but the events relating to Mr Eljamel and what happened in that period, were the reflections on that what caused the distress that you describe?
A. I think there was a natural questioning about why concerns had not been identified previously.
Q. Yes, questioning of themselves, perhaps?
A. Yes. Questioning of themselves, yes.
Q. And when they asked those questions of themselves, did they tell you what answers they'd found?
A. So I think the answer that I would draw out relates to the honesty, it relates to honesty with patients because obviously what became apparent related to patient concerns that were raised is that they hadn't had a straight -- you know, they had not been given an honest account of what had happened to them. It related to honesty with colleagues. So within morbidity and mortality meetings, that there had not been honesty from Mr Eljamel about events that had happened. And then, I guess, my indirect observation would be that for all surgeons honesty with oneself is incredibly important about things that one could and should do differently.
Q. But was there reflection, then, on their own roles in

how they had involved themselves and they were perhaps reflecting in the way that you have suggested, that they were wondering whether they could have done more?
A. Yes.
Q. And had they come to any conclusions as to whether they felt they could?
A. I don't know that it would be fair for me to speak for them. I didn't ask that question absolutely explicitly and therefore, I don't think I could or should speak for them.
Q. But I'm not asking you to do that today, I'm asking you whether there were reflections expressed to you at the time in that regard. Because obviously that is all part, is it not, of the system that you were looking at because, you know for example, if there were meant to be parts of the system involving other consultants -- completely hypothetically, taking a more proactive role in trying to find out what was going on and there was a reflection in that regard, that would be part of a provisional governance system, would it not, that would, in theory, be designed to try to prevent this sort of thing happening?
A. Are you referring to the supervision?
Q. No, I'm not talking about the supervision, I'm just talking about generally relating to his practice.

I'm trying to tease out from you really what the information is because we don't know what it is that you were told, that's the problem. We don't know what information you worked on, other than certain written materials. These interviews, it would seem from your testimony today, are an important part of you gaining an understanding of what the corporate situation was. So I'm trying to tease out from you what it is that you were told in that regard and what learning you took from it?
A. So I was essentially told about their experience of Mr Eljamel as a colleague which I would say is entirely in line with the statements in the College of Surgeons review about peoples' experience of him as a colleague.
Q. Could I just point something out is that nobody has access to the statements in the college review. All we have access to is material indicating, in a broad sense, what they might have contained. You had access to individuals who did effectively give you statements, if you like, or they explained their position to you. So it's of value to this Inquiry to understand. Because it's highly likely that we will never see those statements because they've been destroyed. We can deduce what they contain in a broad sense, but I'm interested in the particular reflections that you

heard at the time and that influenced the methodology and the findings that you reached in the report. Because that's of incredible value to understanding, in this Inquiry, what went on.
A. So, I'm sorry, I hadn't understood it in that context. So when I'm saying the College of Surgeons review, I mean there are phrases that I used within that review that have obviously been drawn from the statements about experience as a colleague which were very similar to the phrases that were used with me. So there was a mixed picture that in some ways what was described was someone who was a colleague who was in some ways a good colleague, open to swapping on-call aspects but who had a difficult manner, both in terms of communicating with the broader team and in a rather hierarchical and autocratic manner, particularly in which they perceived and reacted to challenge.
And in particular, thinking about a very small team of neurosurgeons, the impression that I took was that there was a level of adjustment to an individual's behaviour that occurred over time and that there was a level of reflection and guilt that that manner had not been challenged more easily.
In particular, there was a description from Mr Mowle, who would have worked most closely, that their

job plans were opposite. So they were not usually in the same place at the same time other than on a Friday. And there was no sense that I took, from what was explained to me at the time, that they had any concept of the lack of probity that -- or lack of honesty that had been involved. So that was not something that -- as best as I could, in teasing out in terms of that experience up to June 2013, and then in particular from June 2013 onwards, that there had been an understanding prior to that about a lack of honesty.
Q. Okay, and I think -- I think your report, in paragraph 1, it does talk about this hierarchical manner. And I think it effectively talks about both of the neurosurgeons speaking about -- describing the same sort of thing, I think that's right?
A. Yes.
Q. And as far as -- so you attended interviews with these individuals. Did you record what they said? I don't mean on a tape recorder, but did you write notes?
A. I did, yes.
Q. Do you still have those?
A. I do.
Q. And those notes, I assume, can be made available to the Inquiry?
A. Yes, they could.

Q. Thank you. And as far as this impression of this hierarchical manner, and perhaps opportunities that might have been taken not being taken to be able to find out more about that and perhaps even more in a supportive sense than in an oversight sense, was that ascribed to any particular period of time, or was that something that should have existed throughout the working relationship with Professor Eljamel?

A. I didn't get a particular sense that it had changed. I think that what was described were some periods where that behaviours -- if we just generalise, in that sense -- may have deteriorated and then if there was any level of feedback provided, that that improved for a while but it was difficult to maintain that improvement.

Q. Right, so this had been -- when you talk about the period of improvement, had that been very latterly? I'm thinking of the possibility that -- we looked at a passage in the 2013 report reflecting Mr Eljamel's own position which suggested he had tried to make things better latterly in his career, but are you talking about a particular time period for that improvement, or --

A. No, I'm -- without actually looking at my summary of the things that were said to me -- but I have a sense that there was a period that was referred to of -- before

that, where there was, you know, potential to change behaviour -- not potential to change behaviour, that would be the wrong way to phrase it, that there was feedback provided and a minor correction in behaviour.

Q. Thank you. And you provide -- in your report, you address some specific issues that I would quite like to look at with you. There won't be the capacity at this stage, Ms Gillies, to get into the details of these aspects but we'll certainly be interested in getting more evidence for you about the particular details that you know about and the testimony that you had, in the context that I described, that there are other places where such evidence used to exist but it doesn't exist any more, and if you have access to that, that will be incredibly valuable to our understanding of what happened and indeed, what reflections there were on that in the period thereafter. So if I can take you to the report, this is again NHSL-00012.

And again, I'm looking at page 3 and one aspect of this which is of some interest to us is the fact that one of the issues which as -- I don't know whether we got to agreement on this, but I think the position, as I understand it, is you had a broad remit and you teased out issues from the materials available to you that seemed to be pertinent in relation to which you could

assist. I think that was the broad position, is that right?

A. Yes.

Q. And so, in number 3, you said:

"Professor [Eljamel] had a defined role of the Chair of the Clinical Governance Committee, and this influenced Board reporting, and allowed him to promulgate his own views. Additionally I note that Professor El-Jamel attended the Significant Adverse Review into the wrong site surgery of [a certain] patient ... It is clear from comments made that this influenced the direction of the discussion, and may have weakened the findings the SAER."

Your recommendation was that:

"NHS Tayside should consider its SAE policy and whether there are opportunities to strengthen this, and to consider the effect on the investigation of participation of individuals responsible for the care of the patient in a roundtable type approach."

In looking at that, you focused in on your recommendation on the specific SAE aspect of it. But there are, presumably, wider concerns about someone like Professor Eljamel having a role on an important body like the chair of the clinical governance committee. Would that not be a concern one would have in these

circumstances?

A. Yes.

Q. The clinical governance committee is a very important aspect of the way that the health board is run, isn't that right?

A. Yes. Can I just clarify that I may have described the chair of the clinical governance committee as -- with that being a management committee rather than a board formal sub-committee.

Q. I see, yes. I didn't mean that either in that sense. I just meant in the delivery of healthcare, a clinical governance committee is an important committee because it's a committee which is involved in trying to promote high standards of healthcare through the clinical governance mechanisms that we've discussed in the evidence already?

A. Yes, and that's also replicated at a more local level, that -- that really was part of my point earlier about local morbidity and mortality meetings. They do need to be places of appropriate, constructive challenge. But the tone is very important in enabling that discussion to remain constructive and so that people are not afraid to surface different views because those may well be appropriately different views.

Q. Yes, thank you. The next section is one that we touched

on before in discussions that you had covered which is to do with interactions with trainees. You make the important observation in the first sense that:

"Professor El-Jamel had significant opportunity to influence the career directions and development of trainees and had an expectation that he would always be provided with a more senior trainee when on-call."

That's a point we've come across in the evidence before which is to do with, in that role and in others, the capacity that Mr Eljamel's position had to be able to have a very wide-reaching effect on a lot of people, on a lot of patients, ultimately. Because it's not just about the patients he was treating himself, it was about the way in which he was educating others and if there had been deficiencies in that, those mistakes or issues could have been replicated many, many times over. Is that what you mean in that sentence?

A. I think -- so, I accept that point. I think what I mean is something broader than that and that is that, actually there's -- that the implication that was -- that I drew from what was said to me was of a rather unhealthy dynamic with individuals who were in training positions being expected to do things for him, to facilitate his way of working, including, you know, his expectation about always having a more senior trainee

when on-call. The implication of that is that he would be less likely to attend the hospital out of hours himself.

Q. I see, because that more senior trainee would be able to cover more complicated presentations?

A. Correct.

Q. Thank you. The narration goes on. Halfway through, it says:

"Examples were given of trainees expected to undertake additional on-call [and] an informal basis to over more junior trainees. Various pieces of feedback were given to Deanery colleagues regarding training opportunities and behaviours but given Professor El-Jamel's academic influence, trainees were fearful of causing offence. Neurosurgery is a small specialty at a UK level. Additionally, at various times there have been considerations about the number of neurosurgery units required in Scotland, and the viability of individual units is influenced by trainee experience and reports."

So there are a number of different elements there. The first question I wondered about is what was the source of evidence that you had about this, where did that come from?

A. So, you mean the whole of that section of the paragraph?

Q. All these various experiences that seem to be the examples were given of trainees covering, it would appear, different aspects of the relationship between Professor Eljamel and his trainees?

A. So, the part about the feedback, about trainees being fearful of causing offence, that came from those interviews with neurosurgical colleagues. The part that says, "Neurosurgery is a small specialty at a UK level", that is my observation added in on top of that.

Q. Yes, I was just meaning the sort of specific, on the ground -- it came from the other consultants?

A. It did.

Q. So it's sort of a second-hand, anecdotal -- but you do recognise that you've:

"... not undertaken detailed examination of any focus groups held with trainees, or individual pieces of feedback." (As read)

But you go on to recommend that:

"NHS Tayside has a clear system in place to ensure that any adverse or concerning comments identified by trainees regarding an individual consultant's behaviour in any speciality have a level of visibility within the organisation rather than solely within an educational line." (As read)

That aspect of things was -- there was a resonance

in that with some evidence we've heard before about the importance of there being a close interaction between educational governance and clinical governance. Is that the area that you're getting into there, that it should not be seen as something to be dealt with just in the educational side, but should perhaps indicate wider -- should be looked at in a wider context?

A. So the concept that trainees will often be amongst the first people to identify when there are concerns is, I think, quite well understood. The way to make sure that -- within an organisation, that there's a visibility of that feedback from trainees is to make sure that reports from the deanery are circulated, but also that there is an exchange of information about feedback that is coming from those educational routes with the -- broadly speaking, the hospital management system. It shouldn't just sit as a doctor thing.

Q. Right, okay. Thank you. The deanery, in that sense, would be people within the medical education within the hospital?

A. Yes. The "deanery" is a bit of an old-fashioned term for that.

Q. Yes, we've already been through deans with somebody else and they seem to crop up in various places. On page 5, you provide a narrative about the RCS report,

specifically. A bit further down, paragraph 7, thank you very much. You give a narrative of circumstances were familiar, and you say:

"It is not clear to me whether any verbal feedback was provided on the day but they did not speak to Professor El-Jamel himself until the 2nd October 2013."

We understand from this morning that it's likely that they did provide verbal feedback on the day. We've also seen a copy of the interim recommendation letter. Did you have that?

A. I did.

Q. And what was suggested by the chair of the current Invited Review Mechanism was he thought it likely that what had been said would be what was in the interim letter, which were components of the final report. So, in relation to the phrase, "They did not speak to Professor El-Jamel himself until the 2nd October", were you trying to make something of that point, or was it just a factual observation?

A. No, I was really trying to, I guess, provide some context to the fact they may not have provided verbal feedback on the day relating to -- ordinarily, what would happen in any type of review is if there are important things that need to be acted on immediately, they will be given as verbal feedback at the end of the

day. And so it was -- I actually -- I did mean I didn't know whether they did it or not because they may have wanted to wait until they had spoken to him.

Q. Yes. It appears that they didn't.

A. Right.

Q. They didn't wait, I mean they didn't wait.

A. Right.

Q. And also you say, in relation to that, that the point that you draw out for your recommendation is that:

"There was no verbal communication of the interim letter with its explicit recommendations to the clinical lead in the unit or the General Manager."

And I think that's something you say should happen?

A. Yes.

Q. On -- point 8 is one that we haven't dwelt on with many other witnesses so far, so I'll read this out. It says:

"Voluntary Erasure from the GMC Register and Cessation of the Internal Investigation.

"I have not been able to speak to Professor Russell ..."

Who was then the medical director of NHS Tayside:

"... and therefore it is difficult to know exactly in what order decisions were made. Whilst it can be difficult to complete a difficult internal investigation when an employee is not at work, and Professor El-Jamel

was suspended on 10th December 2013, I am not aware of any Occupational Health status that said he was not fit for an investigation to continue. Whilst the GMC had imposed interim conditions on his registration, once voluntary erasure proceeded, unopposed by NHS Tayside, the GMC has no legitimate locus to continue with a Fitness to Practice Hearing. The reasons why NHS Tayside did not oppose Professor El-Jamel's application for voluntary erasure are unclear as this could have been done when he subsequently indicated that he intended to apply for early retirement. There has been a significant change in personnel at NHS Tayside, and one would expect this level of decision to be made at an Executive level. The role of the Chair in any discussion is also not clear as he has been written to in a university capacity rather than as the Chair of the Board. The GMC have also reinforced their processes and if they are investigating concerns through their own processes, they will not process an application for voluntary erasure."

You say:

"The Responsible Officer in NHS Tayside is notified when any doctor connected to them applies for voluntary erasure through current processes and there is a short period (ten days) to indicate to the GMC that there are

concerns under investigation to ensure that voluntary erasure does not proceed. I recommend that the RO reviews internal processes to ensure that any necessary action to communicate with the GMC can be taken within the short timeline."

So this relates to another aspect of our Terms of Reference which is the circumstances in which Mr Eljamel was able, voluntarily, to remove his name from the GMC medical register. And the aspect of this in which we're particularly interested is the extent to which -- the role of NHS Tayside in that. And I think it's fair to say that your ability to understand precisely what happened you explain as being hampered by the fact that you didn't have access at that time to the medical director whom you understood could have given you more information, is that right?

A. Yes.

Q. But is it fair to say that your impression is that you didn't have any evidence to suggest that there was any reason why the formal investigation against him could not have continued, you didn't have any evidence?

A. I didn't have any evidence, yes. Yes.

Q. And what then on -- you may not be able to say this because you don't think you have enough evidence, but what -- I take that to mean that you consider it

important that health boards should make their views known or make their understanding of a situation known when they're notified about the possibility that a doctor is wishing to have voluntary removal from the GMC medical register; is at least that fact correct, do you consider it important?

A. It is important, yes, and it's the responsible officer specifically who is notified rather than the health board.

Q. Yes, okay. But in this circumstance you talk about it being somebody else. Or in a different capacity, no?

A. No.

Q. No. So the position here is that they were given -- they would have been given an opportunity to do that but they did not; is that correct?

A. That's my understanding. I accept I have been extremely -- well, not extremely, but I have been quite clear in what I think happens and then set out.

Q. Yes. So again, I was interested to know because we know that there was a lot of evidence lacking in this area, or potential evidence. Where did you get the evidence upon which you based that understanding, those simple facts that they didn't take the opportunity that was given to them?

A. So it's the absence of any evidence that they had and

that's why I have caveated by saying that I was not able to speak to the responsible officer, who is the medical director. Because he may have been able to tell me that actually there had been a verbal discussion, or something else. So it was the absence of any evidence, but with that caveat that I had not been able to speak to him.

Q. But in the circumstances of this case, given what you did know about it, albeit with perhaps limited information, were you surprised that a health board or the responsible officer wouldn't intervene in these circumstances?

A. Yes.

Q. Why?

A. Because one would expect that at least there would have been a lodging of the significant amount of concern in order to at least set out the position of the responsible officer who is acting on behalf of the health board that voluntary erasure in their view would have -- would not be considered -- I'm trying to avoid saying "appropriate". It would be interpreted in a very adverse way by those who had still ongoing very legitimate concerns, ie patients.

Q. Yes, indeed.

A. Sorry, that was clumsily phrased.

Q. No, no. But the main point here is you would have expected, based on the information that you had seen and was available by that time, that this would be a case where it would be almost a sort of archetypal case where -- would it, for where a health board would intervene to express its position on it?

A. Yes.

Q. Yes, thank you. As I've said, Ms Gillies, it will be necessary I think for us to collect some more detailed evidence from you on certain aspects of this, but that's a very helpful summary of at least your overall position on some of the key aspects. In those circumstances I don't have any further questions, sir. At this stage I offer the witness the opportunity to say anything that they would like to say and I'd like to invite to you do that?

A. Thank you. So I am -- I am sorry in a way that my report is so concise. I tried to write a very concise report because I wanted to indicate that the piece of work that I had done was extremely limited and in particular that I could have put in, with appropriate checks on the individuals concerned, more detail about the evidence that I had drawn my observations from. I was quite thoughtful about individuals' confidentiality given the very small number of people

that I had spoken to. But that that's the reason why it was so concise.

My understanding of the request was to really put myself in the position of: if I had been part of that health board what would I have expected to see and do? And so that's why I have tried to be clear in my recommendations for constructive action.

MR DAWSON: Thank you very much. I think we'll take a short break now, sir.

THE CHAIR: Yes. We'll just take a few minutes Ms Gillies. There may be some more questions but certain discussions may need to take place before that happens but we'll resume again shortly.

(4.17 pm)

(A short break)

(4.29 pm)

MR DAWSON: Briefly, sir.

THE CHAIR: Yes, certainly. Thank you. We're ready to resume, Ms Gillies.

MR DAWSON: Just very briefly I hope, Ms Gillies. We were discussing at the end of your evidence your views and the section of your report in relation to the question of the voluntary erasure of Mr Eljamel's name from the GMC medical register and in particular questions around the extent to which NHS Tayside could/should have been

involved in indicating something to do with that. You were clear I think that there were sources of evidence available to you/not available to you which would have been helpful to try to help you come to firmer conclusions about that; isn't that right?
A. Yes.
Q. And that included, for example, an explanation or further evidence from the medical director in particular?
A. Yes.
Q. Insofar as you have helpfully given us a view as to whether this is the sort of circumstance in which you would expect a health board to intervene or say something, you've expressed a view on that but just to be clear, that view proceeds on the assumption I think that the health board in 2015 knew that the voluntary erasure process was going on?
A. So what I tried to indicate is that ordinarily there is notification to the responsible officer that an individual has applied for voluntary erasure. So you have a ten day window after that notification to provide the GMC with any information for them to consider -- it's their decision -- about whether they support and complete that voluntary erasure or not.
Q. Yes. Yes.

A. So there is a mechanism in place so I receive notification when any doctor connected to me for whom I'm the responsible officer is seeking voluntary erasure so that if there are issues currently being investigated that I have not yet told the GMC about, or a reason why I don't believe that that voluntary erasure should proceed, I can notify -- I can provide that information to the GMC.
Q. Thank you.
A. Is that clearer?
Q. That's extremely clear. And so that's the ordinary course.
A. Yes.
Q. All I'm trying to understand is that you didn't have available to you any evidence that that ordinary course necessarily had followed, for example you didn't have an explanation from Dr Russell as to what had happened, nor did you see any documentation suggesting that the board had been called or the responsible officer had been called upon to express a view in that way. You didn't have access to that, you're just applying, I think, what you understand from your own experience the ordinary course to be; is that right?
A. Yes, there was an absence of evidence about anything that had happened in Tayside.

Q. Thank you very much, that's very helpful. Thank you very much for your evidence.
THE CHAIR: Thank you.
Well, Ms Gillies as you'll have gathered, that is the end of this afternoon's session and brings your evidence to an end. Before you leave the witness stand can I express on behalf of the Inquiry, and indeed on my own behalf, my thanks for your attendance today for the work I know goes into generating statements of the kind that you have been -- you have produced, the associated materials and indeed, if I have noted it correctly, the offer to look again at the possibility that there may be other material. If there's any dubiety about what that might be, then that can no doubt be dealt with in correspondence. But in the meantime, thank you very much, you are free to go.
MR DAWSON: I think sir, if I could just on that procedural point, I may be of some assistance. I think it's likely in your case, given the testimony you've given, and in particular the information about specific documents that you hold, that we probably issue another Rule 8 request in order to try to set out with more clarity what it is we're looking for and hopefully that will be of assistance.
THE CHAIR: That's helpful too, thank you, Mr Dawson.

You're free to go. Thank you.
Right, I take it that brings our considerations to a close for this week. I remind myself that we don't expect to sit on Monday so we'll see everybody again on Tuesday next week. Thank you.
MR DAWSON: Thank you, sir.
(4.34 pm)
(The hearing adjourned until 10.00 am on Tuesday, 15 September 2026)

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