

1 Thursday, 17 September 2026 2 (10.09 am) 3 THE CHAIR: Yes, Mr Dawson, good morning. 4 MR DAWSON: Good morning, sir. The first witnesses this 5 morning will be two witnesses appearing together 6 remotely. They are Charles Massey and Anthony Omo. 7 THE CHAIR: All right, thank you. Can we have Mr Massey and 8 Mr Omo. 9 MR CHARLES MASSEY and MR ANTHONY OMO (called) 10 THE CHAIR: Gentlemen, good morning. Can you see and hear 11 me all right? I infer that you can. 12 MR MASSEY: Yes, we can. Hopefully you can see and hear us? 13 THE CHAIR: That's very helpful. We just did. Certain 14 formalities, gentlemen, before you're asked questions by 15 Counsel to the Inquiry. First of all, Mr Massey may 16 I administer the oath to you. 17 MR CHARLES MASSEY (sworn) 18 THE CHAIR: Thank you very much. And Mr Omo, if I could ask 19 you to do the same. 20 MR ANTHONY OMO (sworn) 21 THE CHAIR: Thank you very much. The next voice you'll hear 22 is that of Counsel to the Inquiry. Mr Dawson, when 23 you're ready. 24 Questions by COUNSEL TO THE INQUIRY 25 MR DAWSON: Good morning. Can you see and hear me okay? Page 1	1 A. Let me just check my one. Yes, it does. 2 Q. And you executed the statement -- I think you signed the 3 statement on 2 June 2026, is that right? 4 A. That is correct, yes. 5 Q. And Mr Omo, did you also provide a witness statement to 6 the Inquiry? 7 A. I did. 8 Q. Could we have GMC-00219 up on the screen, please. Is 9 that your witness statement, Mr Omo? 10 A. Yes, it is. 11 Q. And could we go to the last page, please. Does your 12 signature appear on that page of the statement? 13 A. Yes, it does. 14 Q. And is the statement dated 20 August 2026? 15 A. It is. 16 Q. As far as you're concerned, Mr Massey, are the contents 17 of your statement true? 18 A. Yes, they are. 19 Q. And Mr Omo, are the contents of your statement true? 20 A. Yes, they are. 21 Q. Could I just explain, for the benefit of people 22 listening, the procedure by which we came to have two 23 statements and to have two witnesses this morning. 24 An original Rule 8 request was issued on behalf of the 25 Inquiry and a statement produced in the usual fashion by Page 3
1 A. Yes, we can. Thank you. 2 Q. First of all, Mr Massey, you are Charles Massey? 3 A. Yes. 4 Q. And Mr Omo, you are Anthony Omo? 5 A. Yes, I am. 6 Q. Mr Massey, I understand you are the chief executive and 7 registrar of the General Medical Council; is that 8 correct? 9 A. It is, yes. 10 Q. And Mr Omo, you are the director of fitness to practise 11 at the General Medical Council; is that correct? 12 A. That's correct. 13 Q. Mr Massey, I understand that you provided a witness 14 statement to the Inquiry in response to a Rule 8 request 15 sent to the GMC; is that correct? 16 A. Yes, it is. 17 Q. Could we have GMC-00218 on the screen, please. Can you 18 see that, Mr Massey? Is that coming up with you? 19 A. Yes, I can. I'll just pin it to my screen. Yes, I can. 20 Q. Is that your witness statement? 21 A. It is, yes. 22 Q. Could we go to page 26, please. Just down at the 23 bottom. No, further on. Can we go to page 56. Does 24 your signature, Mr Massey, appear on that page under 25 where it says "CAT C"? Page 2	1 Mr Massey. The General Medical Council indicated that 2 they considered that it may be of benefit to the Inquiry 3 if Mr Omo also appeared alongside Mr Massey today, in 4 particular, given his specific experience and 5 responsibility in relation to the General Medical 6 Council's fitness to practise function. Therefore, his 7 statement was produced which explains his role and 8 explains the way in which his statement came about. 9 Although the vast majority or substantive content is 10 contained within Mr Massey's statement. 11 So if I could just start off. I have spoken with 12 both of the witnesses, sir, this morning. Just to 13 indicate, both of them speak on behalf of the General 14 Medical Council and they're going to indicate -- 15 Mr Massey, I think, will answer most of the questions 16 but when we get to territory where it's thought that 17 Mr Omo may have something to add, Mr Massey will just 18 simply suggest that and we'll get responses from them as 19 appropriate. 20 THE CHAIR: Okay, thank you. 21 MR DAWSON: Mr Massey, I've said already, you're the chief 22 executive and registrar of the General Medical Council; 23 is that correct? 24 A. That is, yes. 25 Q. And I understand that you've held this role since Page 4

1 1 September 2016, is that right? 2 A. Yes. 3 Q. We understand that prior to starting your role with the 4 GMC, you were one of the directors general in the 5 Department of Health with responsibility for workforce 6 acute care and system and professional regulation; is 7 that correct? 8 A. Yes, as it pertains to England. 9 Q. Yes. What are the key responsibilities, first of all, 10 as the chief executive of the GMC? 11 A. So as chief executive I'm responsible for leading the 12 organisation as a whole, so I have oversight of 13 everything that we do and hold accountability for it. 14 Q. And the role of registrar which you also hold, is that 15 a distinct role? 16 A. It is. It is essentially a role in relation to the 17 maintaining of the register, and in terms of the 18 registrar decisions that, by law, we make when we're 19 making decisions about both registering doctors and 20 physician associates, and anaesthesia associates. And 21 indeed, taking action in relation to their licence. 22 Q. Thank you. Can you tell us what the medical register 23 is? 24 A. So the medical register is something that is prescribed 25 in legislation and essentially we have three registers Page 5	1 A. That's correct. 2 Q. Could you tell us what that particular role involves? 3 A. So that role involves me as a member of the senior team 4 at the GMC supporting our GMC office in Scotland with 5 stakeholder management which is meeting with key 6 officials across Scottish Government and supporting the 7 chief exec and chair in their meetings with various 8 officials and relevant senior leaders. 9 Q. There is an aspect of Mr Massey's statement that you, 10 Mr Omo, might be best placed in this regard to help us 11 with. Mr Massey says at, one point in the statement, 12 that the GMC is accountable both to the Westminster and 13 the Scottish Parliaments. An aspect of the devolution 14 settlement which has come up in the setting up of this 15 Inquiry is that health regulation, which I think covers 16 the GMC, falls within the reserve competence of the 17 Westminster Parliament; is that right? 18 A. That's correct. 19 Q. And so in what activities and in what regards are you 20 accountable to the Scottish Parliament? 21 A. So we regulate, in addition to doctors, PAs and AAs and 22 because it is a new -- or new professions, that falls 23 within the Scottish Parliament's purview. 24 Q. I see. And presumably part of the role which you have 25 in Scotland relates to providing advice and input on Page 7
1 at the moment, we have our register which doctors come 2 on to when they qualify. In UK, that's from graduation 3 from medical school. There are different rules which 4 I'm happy to cover off in relation to doctors coming 5 from overseas. We also have a specialist register which 6 is for doctors who are able to practise as consultants 7 and we have a general practitioner register, so that's 8 the doctors working as GPs. 9 Q. Thank you. And Mr Omo, you are the director of fitness 10 to practise at the GMC; is that correct? 11 MR OMO: That's correct. 12 Q. And have you held that position since 2013? 13 A. I have. 14 Q. I understand you are also a solicitor of England and 15 Wales; is that right? 16 A. That's right. 17 Q. And also in 2015 you were appointed as general counsel 18 to the GMC; is that correct? 19 A. That's correct. 20 Q. Which effectively involved giving legal advice to the 21 GMC; is that right? 22 A. That's right. 23 Q. I understand, also of significance to us, in 2020 you 24 became the senior management team sponsor for the work 25 of the GMC in Scotland, is that right? Page 6	1 matters to do with the running of the health service 2 where doctors and the regulation of doctors may play 3 a part. So the topic, if you like, is reserved to the 4 Westminster Parliament but questions and operational 5 matters relating to doctors will, no doubt, come up 6 within the health service in Scotland; is that fair? 7 A. That's fair. 8 Q. Yes, one of the things also that I think it might be 9 perceived -- I don't know whether this is your 10 experience, Mr Omo -- is that the GMC, given the fact 11 that it sits within the legislative competence of 12 Westminster Parliament, is perhaps deemed to be remote 13 from Scotland but your responsibilities cover Scotland 14 as well, don't they? 15 A. They do, and as part of that we have a fully functioning 16 office in Scotland. 17 Q. Where's that office based? 18 A. Edinburgh, at The Tun. 19 Q. And doctors in Scotland are regulated in exactly the 20 same way as doctors in the rest of the UK by the General 21 Medical Council; is that correct? 22 A. That's correct. 23 Q. Thank you. 24 If I could just move on to some of the evidence that 25 you've given -- helpfully given to us, Mr Massey, about Page 8

1 the role of the General Medical Council. If we could 2 go, please, to paragraph 3.1, of Mr Massey's statement. 3 You set out here for us, Mr Massey, the main roles of 4 the GMC and you say: 5 "The GMC is the independent regulator of doctors, 6 physician associates (PAs) and anaesthesia 7 associates ... in the UK. We work with registrants, 8 their employers, their educators, and others to: 9 "... set the standards of patient care and 10 professional behaviours registrants need to meet; 11 "... make sure registrants get the education and 12 training they need to deliver good, safe patient care; 13 "... check who is eligible to work as a doctor, PA 14 or AA in the UK, maintain a register recording this and 15 details relating to their registration (such as whether 16 they hold specialist registration), and check they 17 continue to meet the professional standards we set 18 throughout their careers ..." 19 The organisation also: 20 "... give[s] guidance and advice to help registrants 21 understand what is expected of them; and ... 22 "... investigate[s] where there are concerns that 23 patient safety, or the public's confidence in doctors, 24 may be at risk, and take action if needed." 25 You say, at paragraph 3.2: Page 9	1 for what we do, but we're not accountable to the 2 specific department of Health and Social Care in England 3 or equivalents in Scotland, Wales and Northern Ireland. 4 Q. We heard some evidence last week from the Patient Safety 5 Commissioner for Scotland whose statutory arrangements 6 were similar to that in that she had accountability to 7 the parliament rather than to the Scottish Government. 8 And she also, as you have described, appeared in front 9 of committees to exercise aspects of that 10 accountability. Can you explain why, in particular, 11 it's important that that independence be maintained and 12 what the GMC does to try to safeguard it? 13 A. So I think it's important because -- sorry, I'm kind of 14 straying into slightly hypothetical territory, but it's 15 probably easier if I give an example to kind of 16 illustrate the point. 17 Q. That's fine. 18 A. So if a government wanted, for example, to say: we need 19 to have many more doctors in practice and we want to 20 kind of force our regulator to change the standards that 21 they would maintain in terms of being able to admit 22 those doctors on to the register, the fact that we're 23 independent means that we're not prone to that risk. 24 But the independence doesn't mean that we're not able to 25 be held to account and indeed, we have -- which isn't in Page 11
1 "The GMC is independent of government and the 2 professions it regulates, and accountable to the UK and 3 Scottish Parliaments. Our powers are given to us 4 through the Medical Act 1983 ... and the Anaesthesia 5 Associates and Physician Associates Order 2024 ... 6 "Our role and functions are well-established, having 7 been the regulator of doctors in the UK since 1858. We 8 have expanded on our education, registration and 9 revalidation professional standards and fitness to 10 practise functions ..." 11 And you cover that later in your statement. You 12 mentioned there, Mr Massey, that the GMC is independent 13 of government and the NHS. Why is that an important 14 feature of its function? 15 MR MASSEY: So I think it is important in terms of us being 16 able to make decisions in terms of the registration of 17 doctors, PAs and AAs that is both, in fact and in 18 perception, free of any potential political influence or 19 interference. So for example, maintaining the standard 20 we expect of doctors to be able to practise medicine 21 safely across the UK. 22 We are accountable to parliaments, so essentially it 23 means that we're accountable -- so I attended a hearing 24 in front of the Health and Social Care Committee in 25 Westminster earlier on this year to take accountability Page 10	1 the statement, we are overseen by the Professional 2 Standards Authority which essentially provides judgments 3 about whether or not we're meeting all of the good 4 standards of regulation. So the accountability, both 5 through them and indeed to parliaments in Scotland and 6 in Westminster. 7 Q. Thank you. One of the features of the GMC's role that 8 you've mentioned -- and we've heard a little bit about 9 already because we've heard evidence from the medical 10 director of what was NHS Education for Scotland but is 11 now part of Public Services Delivery Scotland -- relates 12 to your role, as you set out in your statement, in 13 education and training which doctors and PAs and AAs 14 need to deliver good, safe patient care. 15 Can you explain, broadly speaking, the sorts of 16 activities that the GMC gets involved in to try to 17 maintain those standards? 18 A. Yes. So we have always had responsibility for standards 19 set in undergraduate education but I think the things 20 that you're referring to are really the change of our 21 role from 2010 where we became responsible for 22 postgraduate medical education and training and that's 23 the oversight of doctors working within health systems 24 across the UK. And from then, we became responsible for 25 quality assuring NHS Education for Scotland, now Public Page 12

1 Services Delivery Scotland, who in turn were responsible 2 for the quantity management of training in all health 3 boards including NHS Tayside. From that point, we are 4 also responsible for approving postgraduate specialty 5 curricular, so these are curricular that are typically 6 defined by Royal Colleges but which we then approve and 7 we set out some of our expectations for what those 8 curricular need to contain, for example in relation to 9 the generic professional skills that we expect all 10 doctors to have in terms of things like communication, 11 leadership, engagement with patients. 12 In terms of the activities, in addition to the 13 approval of those postgraduate curricular, we also 14 oversee the quality assurance of medical schools and 15 postgraduate training organisations and we look at our 16 data, so we collect data every year from all trainees 17 and we ask all trainers to complete that as well and 18 where we have concerns about postgraduate training 19 environments we can put them into monitoring and indeed 20 we can put them into something we describe as "enhanced 21 monitoring" which essentially requires those 22 organisations to develop a plan to address any 23 shortcomings that we might have identified through the 24 combination of our data and our qualitative insight into 25 how they're doing their work. Page 13	1 organisations, a key to that is trying to gather 2 intelligence to inform where there might be a concern 3 that you could do something about; is that correct? 4 A. Yes, I think that's absolutely correct and that 5 intelligence is both quantitative, in terms of the data 6 we collect through our national training survey every 7 year, and it's also qualitative which is through the 8 combination of our insight, our work with what used to 9 be NHS Education for Scotland, now Public Services 10 Delivery Scotland, but also through a number of other 11 information sharing arrangements we have with other 12 organisations in each of the countries where we work 13 across the UK. 14 Q. We heard some evidence about there being an information 15 sharing network in Scotland which I think the GMC is 16 involved in, including other organisations such as what 17 was NHS Education for Scotland and Healthcare 18 Improvement Scotland. Am I right in thinking the GMC is 19 part of that? 20 A. Yes. So in Scotland there are two important groups, so 21 there is the Sharing Health and Care Intelligence 22 Network, and that was established to bring together 23 intelligence on thematic emerging risks. The idea 24 there -- and we pushed very strongly for the creation of 25 that network -- was that by pooling our intelligence and Page 15
1 Q. Okay, thank you. So a few components there I just want 2 to pick up on. You mentioned the possibility -- one of 3 the functions being to monitor establishments that are 4 providing postgraduate medical education and that 5 being -- your monitoring of that being a means by which 6 you could pick up on concerns. What variety of concerns 7 could be picked up through that? Would there be 8 concerns about the quality of the organisation or 9 concerns about the individuals involved in delivering 10 the education who are doctors themselves? What sorts of 11 concerns could arise through that route? 12 A. All of the above. So we will look at what trainees tell 13 us about the quality of the supervision they're 14 receiving. We will also look at whether or not those 15 trainees are working within effective clinical 16 governance environments. We will look at other issues 17 in terms of whether or not there is bullying or 18 behaviours that are not inclusive, and so we'll take 19 action, both in terms of those issues relating to 20 clinical concerns, and behavioural concerns that affect 21 quality of the environment in which those doctors in 22 training are working. 23 Q. So is it fair to say -- this is perhaps a broader 24 question -- that given your various investigative and 25 regulatory responsibilities for individuals and Page 14	1 our data we might get better and earlier understanding 2 of where things were going wrong and then be able to 3 take action to avoid any patient harm arising. There is 4 also the Scottish Professional Regulators Group which 5 brings together professional regulators, so not just the 6 GMC but also the Nursing and Midwifery Council, 7 Healthcare Professions Council and all of the other 8 professional regulators that operate in Scotland. 9 Q. Thank you. Just on the education side of things 10 specifically, to stick with that. I think as 11 I understand it -- please correct me if I have got this 12 wrong -- but that the way in which the standards of 13 postgraduate medical education are maintained, I think 14 you've set this out already and this is consistent with 15 what we understand, but effectively you've talked about 16 there being curricular that are developed for those 17 purposes. They are, I think, developed by the Royal 18 Colleges, effectively overseen by the GMC who sign them 19 off, but their implication, if you like, in the teaching 20 environment is overseen by now Public Services Delivery 21 Scotland; have I got that right? 22 A. Yes, you've got that absolutely right. 23 Q. Thank you very much. You also in your paragraph 3 that 24 I read out a moment ago give some information about the 25 register which you've mentioned already. One aspect of Page 16

1 the register that I wanted to ask you to explain for us 2 is specialist registration. What does that mean? 3 A. So since 1997 when the legislation changed we maintain 4 a specialist register which essentially contains details 5 of doctors whose level of training enables them to work 6 in consultant roles across the NHS in all four countries 7 in the UK. 8 Q. And in order to be able to get on to that specialist 9 register, my understanding from your statement is there 10 may be different pathways or routes to arrive at it. 11 I wonder if you could explain how one gets to the stage 12 where one is granted specialist registration? 13 A. So for doctors who have graduated in the UK, they will, 14 when they've graduated, go into something called the 15 foundation programme that will last two years. And 16 those doctors, either immediately after that or perhaps 17 a year or two later, will go into specialist training 18 and that is the training that is defined through the 19 curricular that I described a few moments ago. And when 20 they complete that training, they will have a CCT, 21 a certificate of completion of training, and that will 22 enable us to then recognise that completion in terms of 23 their admission to the specialist register. 24 The rules are different in terms of doctors not in 25 formal training. Typically doctors, though not Page 17	1 time, signal a bit of a move from -- in the past before 2 then, the GMC had tended to provide guidance about what 3 misconduct looked like. But instead of talking about 4 all of the things that might give rise to disciplinary 5 procedures, we aimed instead to set out a more positive 6 statement of the standard that patients should expect. 7 So Good Medical Practice was published in 1995 for the 8 first time and it's been updated a number of times since 9 then. 10 And what we've also tended to provide over the years 11 is supplementary ethical guidance for doctors, for 12 example in relation to consent or confidentiality or 13 raising concerns. It's probably worth adding that Good 14 Medical Practice is a document that sets out high-level 15 protocol for doctors rather than a prescriptive code and 16 that's because we expect doctors to apply Good Medical 17 Practice using their professional judgment in the 18 context of their NHS and private work. 19 Q. Thank you. We'll probably come back to Good Medical 20 Practice in due course, but an aspect of it that's of 21 interest to this Inquiry is what you just told us about 22 the date of its introduction. The period that we are 23 looking at starts at the beginning of when Mr Eljamel's 24 employment with NHS Tayside is, in fact, in 1995. 25 I think you mentioned that that represented something of Page 19
1 exclusively, doctors who have qualified overseas. So 2 for those doctors who are not going through formal 3 training, they are able to apply to join a specialist 4 register, but they will then need to demonstrate through 5 a portfolio of paperwork that they meet all of the 6 skills and have all the competencies and knowledge that 7 we require that is equivalent to those doctors going 8 through that formal training route. And we will then 9 assess those applications which can often run into 10 hundreds if not thousands of pages of paperwork. We 11 will usually use Royal College assessors to be able to 12 define whether or not the portfolio contains all of the 13 requirements that we would have for doctors coming on to 14 the specialist register. And if that assessment 15 suggests that those doctors do meet all of those skills, 16 knowledge and competencies, we will admit them to the 17 specialist register. 18 Q. Thank you very much. The next area on your list is the 19 provision of guidance and advice delivered to help 20 doctors understand what's expected of them and the 21 standards they require to maintain. Can you broadly 22 describe to us how the GMC goes about doing that? 23 A. So the core piece of guidance we provide for doctors is 24 something that we call "Good Medical Practice". That 25 was first published in 1995 and it did actually, at the Page 18	1 a change in the regulation of medical culture, but 2 perhaps in the culture of doctors generally, a move away 3 from the rules being about: don't do these things 4 because you'll be disciplined if you do. And more 5 towards: do, do these things. Would that be a fair 6 summary as to the mood of the time? 7 A. Yes, it didn't mean that we changed the bar or threshold 8 in terms of defining what misconduct might give rise to 9 investigations about doctors but what we were trying to 10 do was just flip on its head the idea that the GMC 11 should be trying to support doctors to practice safely 12 to support good patient care rather than simply setting 13 out those things that are likely to get doctors into 14 trouble with us. 15 Q. So the rules remain the same; is that correct? 16 A. The rules remain the same but the way in which we 17 expressed those in the guidance changed. But it was 18 an important change because it signalled other changes 19 we've had over the years which is about how the GMC can 20 be more proactive in providing support to doctors to be 21 good doctors rather than simply waiting for something to 22 go wrong and reacting as a result. 23 Q. Thank you. You also use the expression -- when 24 describing the guidance, you used the phrase, "What 25 patients should expect". Is that the way that the Page 20

1 guidance, at least since 1995, has worked, ie its 2 predicated upon that being the standard that doctors 3 should aspire to? 4 A. Yes, because it covers things like the importance of 5 making care of patients a doctor's first concern. It 6 talks about what it means to provide good care and 7 working within competence. So yes, it is exactly that. 8 Q. Thank you. Perhaps, for Mr Omo now, although you'll 9 keep me right as to whether these are the right 10 questions. Other key function of the GMC, Mr Omo, 11 I think is to carry out an investigative role where 12 concerns about a doctor have been raised; is that right? 13 MR OMO: That's right. 14 Q. Is that an area you call "fitness to practise"? 15 A. It is. 16 Q. Can you give us broadly -- we may get into details in 17 due course, but can you explain broadly what the process 18 might be from the point at which concerns might be 19 raised, right through the gamut of what the GMC might do 20 about it, at a high level? 21 A. Okay, sure. So, we -- anyone can make a complaint at 22 the GMC and when we receive a complaint, we assess it at 23 what we call "triage". So we triage a complaint to 24 check whether it meets the threshold for investigation 25 by the GMC. If it does not, we close the complaint. In Page 21	1 a hearing. If it's referred to a hearing, that then 2 takes place with the Medical Practitioners Tribunal 3 service who will put on a hearing at some point. And we 4 will present the case, the doctor will defend and they 5 will make a decision. 6 The tribunal can, again, decide that there is 7 nothing in the complaint or in the case and close it. 8 They can decide that the fitness to practise is not 9 impaired and issue a warning, but if they decide that 10 fitness to practise is impaired and we've proved that, 11 then they can either impose conditions, a suspension, or 12 erase the doctor, whichever of those sanctions is 13 appropriate. 14 Throughout the life of the case, from triage all the 15 way through the tribunal, we can at any time and do 16 consider whether or not an interim order of 17 restrictions, so stopping the doctor from practising or 18 limiting their practice is necessary and that is kept 19 under review through the life of the case. Again, if we 20 think one is necessary, we have to send that to the 21 Interim Orders Tribunal which is also run by the Medical 22 Practitioners Tribunal Service and they will decide 23 whether or not to impose an interim order of 24 restrictions. If they do, then that order needs to be 25 reviewed every six months. Page 23
1 those complaints where we think there's something for 2 the employer, we feed that back to the employer. If it 3 concerns other regulators, we pass that on to other 4 regulators to take action. If we promote it to 5 an investigation, we then deploy a number of tools 6 including obtaining witness statements, documentation 7 and expert report. In cases where it's relevant, we can 8 do a performance assessment or a health assessment or we 9 can ask for an English language assessment. And we will 10 assess those and gather that evidence. 11 We are required to disclose that to the doctor, get 12 their response and then that is put to our senior 13 decision-makers, one medical and one lay, who we call 14 case examiners who make a decision. And they have to 15 apply a test which is whether or not the information 16 that we have suggests that there is a risk that needs to 17 be -- effectively cannot be managed locally and needs to 18 be referred to a tribunal. So is there a realistic 19 prospect of proving that the doctor's fitness to 20 practise is impaired to a degree warranting action on 21 registration. 22 The case examiners have a number of options. They 23 can close the complaint if they feel that there is 24 nothing there. They can issue a warning. They can 25 agree undertakings with the doctor, or they can refer to Page 22	1 Q. Thank you. The passage in Mr Massey's statement 2 relating to this aspect of the GMC's work suggests that 3 the investigations can take place where there is a risk 4 to do with patient safety, but also that there's a risk 5 that the public's confidence in doctors may be 6 undermined. In relation to that second part, how does 7 the GMC go about assessing whether there might be a risk 8 of public confidence in doctors? 9 A. So it's not dissimilar to whether or not patient safety. 10 So it usually concerns actions in private life, for 11 example convictions or cautions for serious offences, or 12 misconduct which takes place outside of clinical 13 practice, like sexual misconduct or sexual violence, 14 other forms of violence or dishonesty. So in those 15 types of cases where it may not affect patients 16 directly, we have to assess the trust and confidence in 17 doctors would be damaged if we did not take some action. 18 Q. Thank you. This may be a question which one or other or 19 both of you can answer. Is it right to say, given that 20 this Inquiry has a particularly systemic remit, is it 21 correct to say that the GMC is not responsible for the 22 regulation of health boards? 23 MR MASSEY: I can pick that up. Yes, it is correct to say 24 that. So we don't oversee the appointment of doctors, 25 we're not responsible for the day-to-day management of Page 24

6 (Pages 21 to 24)

1 local appraisal systems, or for local clinical 2 governance systems and we're not responsible for 3 complaints and feedback systems. So our role is one 4 step removed, if you like, in terms of setting the 5 professional standards. And also making sure that there 6 are the arrangements for doctors to be revalidated every 7 five years, which we may want to come to later on. 8 Q. Indeed. 9 A. To confirm that they remain fit to practise. That isn't 10 to say we don't take an interest in those other issues. 11 So one thing that has changed in recent years has been 12 that we have taken much more interest in the quality and 13 robustness of local clinical governance systems because 14 we believe that clinical governance systems that are in 15 good shape are more likely to create an environment in 16 which doctors are going to provide safe patient care. 17 Q. Thank you. That's helpful. So in circumstances, for 18 example, where perhaps an investigation were being 19 undertaken into the practice of an individual doctor, 20 which gave rise to those sorts of wider clinical 21 governance systemic type concerns, that wouldn't be for 22 you to regulate, but would action be taken in those 23 circumstances to try to do something about that? 24 Because ultimately if you did do something about that, 25 that might be something that would assist the doctor and Page 25	1 been received in this particular case as being one that 2 was for an individual review of Mr Eljamel's practice 3 but that it was also requested that if any systemic or 4 clinical governance issues happened to be shaken out of 5 that as a result of that investigation, that the board 6 would be happy to hear about those as well. Is that 7 kind of, broadly, what it is that the GMC is also doing, 8 focusing on the individual but with an eye, although 9 perhaps not a proper regulatory responsibility, to the 10 possibility that systems sitting behind the individual 11 may play a part in the issues which have arisen? 12 A. Yes, so when we are looking at individual doctors it's 13 really important that we understand the context in which 14 they're working and that will become part of the suite 15 of evidence that our case examiners look to in terms of 16 making decisions about whether or not to refer a doctor 17 to a tribunal. But it is also true that there will be 18 issues that arise through our investigation of doctors 19 that will raise those wider systemic questions of 20 clinical governance. And it's because of that that we 21 have a series of arrangements internally where, through 22 a combination of our data from fitness to practise but 23 also the work that we do in terms of education and 24 training that I described earlier, that we're able to 25 put all of that intelligence together and have Page 27
1 be able to deliver their best -- their practice to the 2 best of their ability? 3 A. Yes, in short. So at the beginning of the period that 4 you're looking at in 2012, we established our employer 5 liaison advisors and those are a group of colleagues 6 within the GMC who work very directly with 7 responsibility officers who are typically medical 8 directors of health trusts and health boards and that is 9 not only to talk with those individuals about individual 10 doctors that may be in difficulty or may be where there 11 have been complaints, but also to have those 12 conversations with the medical director or responsible 13 officer about the quality of those clinical governance 14 environments and to provide support to the responsible 15 officers in terms of making sure that they are as good 16 as they should be. 17 Q. We heard some evidence from a professor speaking on 18 behalf of the Royal College of Surgeons of England last 19 week in connection with an invited review which was 20 undertaken by that body into Mr Eljamel's practice. He 21 described that there were two types of reviews, broadly, 22 that one could ask the Royal College of Surgeons of 23 England to undertake; one was an individual review and 24 one was a more systemic review of the systems sitting 25 behind it. And he described the instruction which had Page 26	1 conversations where we may have more thematic concerns 2 about health boards or health trusts. And that's 3 ultimately brought together in something called our 4 Patient Safety Intelligence Forum which I personally 5 chair within the GMC. 6 Q. Okay. If one were looking at an investigation into 7 doctors practice in England and they were thrown up 8 serious considerations of a clinical governance nature 9 relating to the systems which form the context in which 10 that doctor were working, which required a regulator to 11 look at it, what body would you go to, to inform them 12 about that? 13 A. So in England, if our intelligence gathered through 14 whichever process, raised systemic concerns about 15 a provider, in an English context a health trust, we 16 would typically raise that with the Care Quality 17 Commission who are responsible for systems regulation in 18 England. 19 Q. Thank you. And if a similar issue, the exact same 20 scenario in Scotland arose, what body would you go to 21 then? 22 A. Well, we would engage with Healthcare Improvement 23 Scotland. Although I think it's worth adding that the 24 role of Healthcare Improvement Scotland is not directly 25 mimicking the role of the Care Quality Commission in Page 28

1 England. Healthcare Improvement Scotland has 2 a responsibility that's embedded in its title around 3 improvement whereas the Care Quality Commission in 4 England has historically within much more focused about 5 reaching regulatory judgments about whether things are 6 awry or not. 7 Q. Thank you for that. Could we have a look, please, at 8 Mr Massey's statement paragraph 4.2. You make the very 9 point that you've just made in your oral evidence, 10 Mr Massey, in this paragraph relating to the importance 11 of the context in which doctors are practising, but one 12 particular aspect which pops up on numerous occasions 13 throughout your statement that I'd like to just have you 14 comment on is the concept that it's important that there 15 be early identification and management of risks to 16 patients which you say here means that you work 17 collaboratively with system partners, sharing 18 information where appropriate. 19 There are really two aspects to that that I'd like 20 to tease out a bit more information from you which is 21 what is done -- and what is meant by "early 22 identification" and what is done to try to identify 23 concerns early? And also what is meant by "appropriate 24 sharing of information" in that context? 25 A. So it's hard to be definitive about what does "early" Page 29	1 survey earlier. That's something we do on an annual 2 basis and that will give us, every year, site-level data 3 what doctors in training are telling us about the 4 quality of their education, their supervision, the 5 behaviours that they are subject to. And again, I think 6 that gives us an earlier sense of what we can do about 7 it. 8 In terms of the kind of question about appropriate 9 sharing of information, one of the kind of tests for 10 appropriateness is what we are or are not able to share 11 in terms of data across educational boundaries and we 12 now have, in a way that we probably didn't a decade ago, 13 a number of data sharing agreements. I think we've got 14 over 160 data sharing agreements with different 15 organisations. We've got a number of memoranda of 16 understanding. We've got many joint working protocols. 17 And the idea of all of those agreements and protocols 18 and memoranda of understanding is that we want to create 19 an environment where, when we get together with other 20 system partners and other professional regulators, that 21 we're able to have proper conversations about what we're 22 seeing in terms of risk that's arising in the 23 environments that we're all individually responsible 24 for. And the kind of hypothesis is that by 25 triangulating the data between us, we may have better Page 31
1 mean. Certainly, one of the most important sources of 2 information for us will always be through our direct 3 engagement and relationship with employers and I believe 4 that now we have a much more substantial and close 5 engagement with employers than we would have done at the 6 time that Mr Eljamel was in practice. So as an example, 7 in fact, I might make this point about actually what 8 should have or could have happened at the time 9 Mr Eljamel was in practice too, but we would certainly 10 expect concerns of the nature that existed at Tayside to 11 have been flagged to us at a much earlier point in time. 12 Certainly, if a health board or a health trust was 13 thinking about initiating a review from a Royal College, 14 as happened at Tayside, I would be very surprised if 15 there weren't conversations with our employer liaison 16 advisors before that review was commissioned and for 17 conversations to take place with our employer liaison 18 advisors about the content and conduct of any such 19 review. 20 And so that is something that I think is part of 21 what I mean by "early". We want to have a relationship 22 with employers where concerns can be flagged with us at 23 the earliest possible stage. But of course we also have 24 early in terms of what we're being told through more of 25 quantitative work, so I described the national training Page 30	1 insight what's going on and be better able to then take 2 action. Whether that action would be for the GMC or 3 whether it would be for Healthcare Improvement Scotland 4 or for Public Services Delivery Scotland would obviously 5 depend on the nature of the risk that we define. So 6 it's not something that I can define in very precise 7 detail but hopefully that gives you enough flavour of 8 how we think about it. 9 Q. With regard to what might be appropriate, is information 10 shared in that way through these agreements amongst 11 these organisations or between organisations in 12 a confidential fashion? 13 A. Yes, it is and it tends to be shared probably more on 14 the thematic, systemic issues than it would be around 15 particular individual doctors. So if we were looking at 16 an individual doctor or the Nursing and Midwifery 17 Council was looking at an individual nurse or midwife, 18 that would tend to be something where what be 19 appropriate would be the wider issues at the surface in 20 that investigation about the quality, for example of 21 clinical governance environment for those healthcare 22 professionals to be working in, rather than the 23 specifics of the exact complaint and the investigations 24 that we were undertaking in relation to that individual 25 doctor. Page 32

1 Q. But as far as information sharing with you about 2 individual doctors, the early sharing principle 3 presumably also applies because are you not best placed 4 to work out whether the information shared meets any 5 sort of threshold that raises a concern with you? 6 You're the body that's best placed to make that 7 decision, aren't you? 8 A. Yes, it does and that is where, I think, the 9 fundamentally important relationship we have is with 10 individual employers and that's why in 2012 we set up 11 our employer liaison advisor team. 12 Q. Yes, I think one of the things you tell us at a later 13 stage in the report where you describe in some detail, 14 in response to a direct question, the role of the 15 employer liaison advisor is that one of the things that, 16 say, a responsible officer could ask an employer liaison 17 advisor about is that very threshold question. They 18 might have a concern about something going on with 19 an individual doctor, they might not quite be sure this 20 is something we really need to be worried about, but the 21 employer liaison adviser is really an expert in knowing 22 whether that is an alarm or it is not an alarm; is that 23 right? 24 A. Yes, so that's exactly how we see it. And the employer 25 liaison advisor will not just be talking to the Page 33	1 we're not required to wait for a referral to come in. 2 But typically, the way in which the ELAs will talk to 3 the responsible officers will be if they believe that it 4 has tipped over that threshold, they will normally ask 5 the employer to make a referral because that then 6 requires the employer to pull together all of that 7 information in a formal way that makes it much easier 8 for our colleagues and the triage function, as we 9 described earlier, to make their assessment about 10 whether that is a case that should be promoted for 11 investigation. But Anthony, correct me if I have got 12 any of that wrong. 13 MR OMO: No, I think that's right. And in cases where the 14 employer and the ELA may disagree, the ELA can bring the 15 case in, as Charlie describes. 16 THE CHAIR: Right, that's helpful. I had a suspicion that 17 that might be the position but you've helpfully 18 clarified that, thank you. 19 MR DAWSON: Thank you, sir. Mr Massey, in various places in 20 the statement you describe, as I've said, this -- 21 because there are various different manifestations of it 22 within the system, this move towards, at a certain 23 point, the GMC becoming much more of a body that's to do 24 with engaging, effectively I think, to try to prevent 25 things happening or prevent things getting worse, rather Page 35
1 responsible officer about: does it move into the 2 threshold where we might have a fitness to practise case 3 to progress, but it also will involve that employer 4 liaison advisor providing advice to the responsible 5 officer about how they might handle that issue locally. 6 So we want to make sure that we are -- we have early 7 sight of those things that should be coming on to our 8 books in terms of investigations we might progress, but 9 we also want to support the employer in handling issues 10 that need to be and should be addressed locally. 11 Q. Okay. 12 THE CHAIR: Sorry, Mr Dawson. Can I come in on one point of 13 detail. And forgive me, but I occasionally ask the sort 14 of questions that you might regard as simplistic but 15 that's my privilege to do so. So this is possibly one 16 of them. But if, in the scenario that you're 17 describing, an ELA comes across a situation relative to 18 an individual doctor which might reach a certain 19 threshold for the GMC to have a concern, in order to 20 progress that in any formal sense, would you require 21 a complaint to have to be made to you or can you, off 22 your own bat if you like, initiate an investigation as 23 a result of that sort of contact and connection? 24 MR MASSEY: So Anthony may correct me if I get this wrong, 25 but we can initiate an investigation off our own bat, Page 34	1 than coming in at the end with a cure; is that correct? 2 MR MASSEY: Yes. So -- and I think an important spur for 3 that was the introduction of revalidation at the end of 4 2012. And revalidation is essentially a process through 5 which we require doctors to demonstrate that they are up 6 to date and fit to practise and that requires 7 a recommendation to be made to us every five years by 8 the responsible officer that the doctors that they have 9 oversight for are fit to practise. And it's on the back 10 of that that we set up our employer liaison advisor 11 teams across the UK, but I think it was probably also 12 fair to say that that time -- and this is something that 13 very much has typified my time as chief executive as 14 well -- is that we have wanted to become a more upstream 15 regulator. And what we mean by that is to be better at 16 supporting doctors to being good doctors, not waiting 17 for harm to arise and really trying to get ahead of the 18 curve in terms of preventing problems from arising. 19 I think it would be fair to describe the -- kind of 20 the rules within the GMC before 2012 as being in 21 a slightly more reactive place, where we waited for 22 referrals to come to us and would then apply all of the 23 tests that Anthony and I have described in terms of 24 determining whether or not there was a kind of fitness 25 to practise case to pursue against an individual doctor. Page 36

1 Q. And as I understand it, please correct me if I have got 2 this wrong, but the development that you're describing, 3 a sort of philosophical but also operational development 4 from one type of a regulation to another, I think 5 logically is connected with wanting to know about any 6 issues or concerns about a doctor as early as possible 7 in order to try to facilitate you with that mission 8 which is really more about trying to notice when the 9 train is slightly going off the tracks and not simply 10 getting involved when there's been a crash? 11 A. Yes, that's exactly right and it's both been through 12 a function of very significantly increasing the resource 13 that we place in that engagement with employers locally, 14 but it's also been driven through quite a significant 15 expansion of our data analytic capability because we 16 want to make sure that we're using our data as best we 17 can to provide understanding of risk as well. And of 18 course, that data is often one of the most important 19 things in terms of the sharing with other regulators 20 that we talked about a little bit earlier. 21 Q. Thank you. To try to put these concepts into a more 22 practical environment, you mentioned a moment ago 23 I think that that culture, that operational attitude is 24 certainly prevalent in the period after 2012 when the 25 medical revalidation requirements came in, I think in Page 37	1 a "never" event? 2 A. Yes, I am. 3 Q. Could you tell us what your understanding of it is? 4 A. So a never event is something where something happens in 5 clinical practice that really shouldn't happen, but 6 sadly does happen across NHS services across the UK. It 7 typically involves significant clinical error and often, 8 sadly, serious harm to patients. 9 Q. Okay. If a never event occurs, would you expect the GMC 10 to be told about it? 11 A. So I think we probably would. Whether or not it would 12 actually lead to a fitness to practise case is, I think, 13 perhaps more a kind of a nuanced question. Because when 14 we assess fitness to practise cases doctors may have 15 made serious clinical mistakes but one of the things we 16 are obliged by law to assess is the doctor's prospective 17 practice. So where doctors make mistakes -- and doctors 18 do make mistakes, sometimes serious, sometimes less 19 so -- what we expect are for doctors to be very candid 20 about that. We have duties of candour but we also 21 expect them to learn from it and address their practice 22 as a result. And those questions around insight and 23 remediation will then be of relevance when our case 24 examiners will make decisions about whether and how we 25 want to progress our investigation against any Page 39
1 December that year, but I think you also alluded to the 2 possibility that -- in relation to the Eljamel matters, 3 that you might even say that more should have happened 4 in the period in which we're looking. Are we actually 5 looking at when things started, as far as you understand 6 it, to go awry, are we actually looking at quite 7 an interesting transitional period between 2011 when we 8 know that complaints started to arise, 2012, and then 9 the Invited Review Mechanism of 2013. I think what 10 you're saying is there was a cultural change going on at 11 that time, is that fair? 12 A. Yes, so I mean cutting to the chase, the first time that 13 the health board raised the question of Mr Eljamel's 14 practice with us was on 10 December 2013. That was just 15 as the Royal College of Surgeons review was being 16 completed and that obviously led to the referral with 17 the Royal College of Surgeons report that we received 18 in January 2014. I think now we would certainly expect 19 to have had more engagement at an earlier point from the 20 employer. But even then, even though the regime that 21 I describe was in relatively early days, even then 22 I think we would have hoped for more engagement at 23 an earlier stage from Tayside than was, in fact, the 24 case. 25 Q. Thank you. Are you familiar with the concept of Page 38	1 individual doctor. 2 Q. Okay. When a never event has occurred and been 3 complained about it, does it then follow that the GMC 4 should know about it? 5 A. I think it probably would, but I would just defer to 6 Anthony on that one, if I may. 7 MR OMO: So I think our expectation would be that that 8 should be a regular part of the discussion between the 9 ELA and the responsible officer because it shows 10 something has gone wrong and what we would want 11 assurance around is that the responsible officer is on 12 top of that and dealing with it and has -- can provide 13 assurance that it isn't a systemic or an individual 14 issue that does need GMC or other attention. 15 Q. Yes, I think, to be clear, I'm not asking you whether, 16 if a never event happens should a doctor's name be 17 erased from the register, I think it would be far more 18 complicated than that. But I think your answer, Mr Omo, 19 makes it clear that your position is -- your answer to 20 my question is in fact "yes", because it contemplates 21 there being a discussion between the responsible officer 22 and the ELA, the ELA effectively being a representative 23 of the GMC in the local area. So there would have to 24 have been contact for such a conversation to have taken 25 place, is that right? Page 40

1 A. Yes. Yes. 2 Q. Thank you. Is it possible for you, based on the 3 information that you have available to you, Mr Massey, 4 to tell me, even under the regime that pertained at the 5 time which I think is certainly different from the 6 regime that pertains now, based on your understanding of 7 the sequence of events, when it is that you think the 8 GMC should have been informed by NHS Tayside about 9 issues relating to Mr Eljamel? I can fill in some of 10 the details of what we think was known when, if that's 11 helpful to you. You may have gleaned that from the 12 paperwork already? 13 MR MASSEY: Yes. So, I have gleaned a lot of it but 14 obviously our own paperwork doesn't contain things that 15 perhaps we might have been told or should have been 16 told. So there is kind of a degree to which there are 17 some kind of unknown unknowns to me. But certainly, we 18 know that in June 2013 Tayside felt that the concerns 19 that had been raised about Mr Eljamel's practice were 20 sufficiently serious to invite the Royal College of 21 Surgeons in to do that review and for them to place 22 supervision requirements around Mr Eljamel's practice 23 from that point. 24 I would expect, even then, for -- at an earlier 25 stage in that process, so if that decision is made Page 41	1 directly; that would be correct, Anthony? 2 MR OMO: That's correct. 3 Q. The sequence of events leading up to the Invited Review 4 Mechanism we know a little more about from evidence that 5 we've heard from witnesses in the last couple of weeks. 6 For example, we know that the history included three 7 complaints against Mr Eljamel being made in 2011, 8 including an allegation of wrong-site surgery. Would 9 that be something that you would expect, at the time, 10 should have been brought to the GMC's attention? 11 MR MASSEY: So without knowing the detail of those three 12 complaints that were raised in 2011, it's hard for me to 13 give you a kind of binary answer to that. We also know 14 there were four complaints raised in relation to 15 Mr Eljamel in 2012 and then there was a flurry of 16 complaints in the first part of 2013. 17 Q. That's correct. 18 A. Certainly, at some stage during all of that, even then, 19 there would have been a sense, I would imagine, from 20 Tayside that there was a level of seriousness in the 21 complaints, particularly when they relate to wrong-site 22 surgery, that would have merited a conversation with my 23 fitness to practise team. 24 Q. Thank you. And I asked you about never events a moment 25 ago and specifically asked you when a never event occurs Page 43
1 in June it must have been some months before that that 2 Tayside were thinking very seriously about the concerns 3 that had been raised. I would expect even then for that 4 to be a conversation that our employer liaison advisor 5 would have been privy to. It is worth saying that our 6 first employer liaison advisor in Scotland was appointed 7 in the early part of 2013, so they won't have 8 necessarily been able to develop the personal 9 relationship with all of the responsible officers across 10 Scotland at that time in the way that they would, for 11 example, now. 12 But certainly I would have expected that engagement 13 to have been at a level of detail at least six months 14 before the health board raised those concerns formally 15 with us about Mr Eljamel. 16 Q. Thank you. Just on the practicalities of matters, 17 given -- I think it's a Mr Paxton was the ELA? 18 A. That's right, Willy Paxton. 19 Q. We've seen the name in some correspondence. Before 20 Mr Paxton took up office in 2013 what would the 21 mechanism have been for NHS Tayside to contact the GMC 22 if they wished to do so? 23 A. So Anthony may want to add, but in the time before we 24 had employer liaison advisors we would have expected 25 employers to contact our fitness to practise directorate Page 42	1 should the GMC know about it and if a never event occurs 2 and there's a complaint, should the GMC know about it. 3 Obviously those are different situations because if 4 there's a complaint then the health board knows about 5 it. If I could focus on the first of those two 6 scenarios a little bit more. If a never event occurs, 7 as you've defined it, should the mechanisms in the 8 hospital be such that the information comes to the 9 attention of the appropriate authorities within the 10 health board? 11 A. Within the health board, yes, I do think the health 12 boards should have the arrangement for, making sure they 13 understand that when it arises, yes. 14 Q. The reason I ask you that -- I know your organisation is 15 not responsible for the internal management of the 16 health board, but it's important, I think, given the 17 evidence you've pointed there are such mechanisms 18 because effectively the GMC depends on there being such 19 mechanisms because when things go wrong, let's say in 20 an operating theatre, there are a small number of people 21 who know about it and if that information is not 22 appropriately escalated to someone who can phone up your 23 director of fitness to practise or the office, then the 24 system will breakdown, won't it? 25 A. Yes. Yes, that's correct. Page 44

1 Q. And it's important that events like that come to the 2 GMC's attention, not necessarily so that fitness to 3 practise proceedings should be instigated, but there 4 should be, what I think you described, as a conversation 5 about where things should go from there? 6 A. Yes, and obviously that is much more straightforward to 7 achieve where, in the world that we exist in now, where 8 we have a relationship with every single responsible 9 officer across the UK and where we've invested very 10 significantly in terms of that network and employer 11 liaison advisors so that we have exactly those 12 conversations with employers. Of course before 2012, we 13 didn't have that in the same way, so our organisational 14 stance would have been to be more reactive and more 15 reliant on employers defining for themselves when they 16 would be escalating those concerns to us. 17 Q. But as you told us, Mr Massey, irrespective of the 18 changes to the environments, the responsible officers, 19 the employer liaison people, the rules always remained 20 the same, didn't they? 21 A. Yes. 22 Q. So the GMC's interest in making sure that the rules were 23 adhered to always remained the same, didn't it? 24 A. Yes. Yes, that is correct. 25 Q. Could I just ask you -- you've given us a lot of very Page 45	1 that would have been doctors but that could now also 2 include physician associates and anaesthesia associates, 3 and we also have six lay members of council. 4 And that is essentially our governing board, so we 5 have council meetings regularly through the year and 6 that is the board through which we make decisions about 7 the strategic direction of the organisation, but it's 8 also how we account for our performance in terms of our 9 day-to-day work, including fitness to practise. 10 Q. And the sort of day-to-day operations, the executive 11 side, that's run by you, is that right? 12 A. It is. 13 MR DAWSON: Thank you. Sir, that would be a convenient 14 moment for a break. 15 THE CHAIR: Gentlemen, we'll take a short break, about 16 15 minutes, please, and gather again after that. As 17 I'm sure you both appreciate, we've reached a stage of 18 a certain formality and for the sake of keeping matters 19 regular, we do ask that you don't discuss your evidence 20 during the break and we'll see you back here in 21 15 minutes' time, thank you. 22 (11.12 am) 23 (A short break) 24 (11.29 am) 25 THE CHAIR: Right, ready to resume, I think. Page 47
1 helpful information, a lot of detail about the 2 structures within the GMC and how they all work and 3 indeed, lists of various people who held various 4 positions at different times. You've provided us 5 a document with information about people who held 6 important positions within the GMC between the years 7 2013 and 2015. I assume you've done that because that's 8 a specific period in which we have a particular interest 9 in this Inquiry. Do such records exist for the period, 10 going further back to our sort of start date, if you 11 like, which is 1995, or at least for some of that time? 12 A. I don't believe they do. I remember reading, in one of 13 the pieces of evidence, that we didn't have information 14 before 2013. 15 Q. Understood. 16 A. But if we do, we can certainly come back and clarify 17 that with you. 18 Q. Understood, thank you. In the information you give us 19 about the operation of the GMC, you mention a body 20 called "the council" and I wondered if you could explain 21 to us what that body does? 22 A. So our council is our governing body and it is up to 23 12 members of council and we typically have six 24 registered members, so those are people who are 25 registered to practice under the GMC. Historically, Page 46	1 MR DAWSON: Yes, sir. Can you both see and hear me? 2 MR MASSEY: Yes, we can, and hopefully you can see and hear 3 us. 4 MR DAWSON: Thank you very much indeed. Mr Massey, you've 5 given the impression this is a topic you're keen to talk 6 about, so I'm getting to get on to medical revalidation. 7 Now, in paragraph 6.2, please, of your report, can we 8 have that up. You say there: 9 "Over time, the GMC's approach to regulatory 10 collaboration and engagement within the wider health 11 landscape has evolved to reflect both changes in 12 healthcare delivery and patient safety. Historically, 13 the GMC's work focused primarily on the regulation of 14 individual doctors, with limited formal interaction with 15 healthcare organisations or other system regulators. 16 The introduction of revalidation in 2012, which I have 17 commented on further at paragraph 11.1, signalled 18 a shift from a more reactive approach to regulation to 19 establishing a two-way flow of information between us 20 and employers." 21 Could you -- I think you've said something about 22 this already, Mr Massey, could you give us just a sort 23 of broad picture as to what the revalidation regime is 24 designed to achieve and the main practical components of 25 its operation? Page 48

1 A. Sure. So revalidation was introduced, as the statement 2 sets out, in December 2012. From that point in time 3 every licensed doctor who practices medicine must 4 revalidate with us as a condition of maintaining their 5 licence. And what that means in practice is that 6 doctors need to collect some supporting information 7 which they should be discussing at annual appraisals -- 8 the appraisal process is still owned and administered 9 and managed by their employer -- and every five years 10 the outputs from those appraisals and that supporting 11 information are required to be reviewed by the 12 responsible officer and they will then make 13 a revalidation recommendation to the GMC. And we 14 provide a suite of guidance to responsible officers on 15 our expectations of them in undertaking their end of 16 that process. 17 Q. Would it be wrong for a doctor to consider revalidation 18 to be something they only need to worry about every 19 five years? 20 A. Yes, I believe it would. Essentially the approach of 21 revalidation is -- the principle is that doctors should 22 maintain their practice, that they should be up to date 23 and fit to practise and they should be taking account of 24 concerns raised by colleagues or patients on a kind of 25 an ongoing basis. The five-year point in time is simply Page 49	1 mechanisms to try and improve the way in which employers 2 locally took responsibility for overseeing doctors' 3 practice and to connect that with our licensing regime 4 by making that a requirement for doctors to continue to 5 have a licence with the GMC. 6 Q. Thank you. You mention in the statement in various 7 places that effectively, the statutory mechanism behind 8 the GMC is the Medical Act 1983; is that correct? 9 A. Yes, that's right. 10 Q. And the background to the requirement for the General 11 Medical Council to have regulations, including, amongst 12 other things, provisions for revalidation is, I think, 13 section 29A of that Act; is that correct? Mr Omo may be 14 able to help there? 15 MR OMO: It is. 16 Q. Thank you. My understanding is that Harold Shipman was 17 convicted 31 January 2000 and that the section 29A of 18 the Act was introduced, becoming effective on 19 17 December 2022 by the Medical Act 1983 amendment order 20 2002. So effectively the requirement for the General 21 Medical Council to have regulations and have a system of 22 this nature was there ten years before it actually came 23 in. Is there any kind of sort of understanding -- there 24 may have been lots of things required to happen in that 25 period why, given as you've described it, there was Page 51
1 the mechanism through which we get that assurance from 2 the responsible officer that that is happening. But it 3 is not something that we expect to be a once-and-done 4 every five years and then forgotten about for four years 5 and 363 days. 6 Q. Because, as we said, the rules apply all the time, not 7 just when the GMC is looking, is that right? 8 A. Correct. 9 Q. Can you explain to us what -- you've mentioned the 10 importance of revalidation in a number of different 11 contexts, including the way in which the GMC has gone 12 about its work. Can you explain what it was that 13 prompted the change towards there needing to be 14 a medical revalidation system within the broader system 15 of medical registration and appraisal? 16 A. So it was before my time so I may not necessarily get 17 all of this right. But there had been concerns raised 18 by various public inquiries over the years, including in 19 relation to Harold Shipman, about the degree to which 20 the GMC had sufficient oversight of doctors' practice 21 and the degree to which they were maintaining their 22 practice. It was also a period when the proportion of 23 doctors that actually had an annual appraisal was not 24 nearly near the 100% mark that we would expect. So 25 essentially revalidation was part of a suite of Page 50	1 I think at the sort of turn of the millennium, 2 a pressing need identified at a political level for more 3 to be done in this area, why it took so long for the 4 system to kick in, in the way that you've described that 5 it did? 6 MR MASSEY: I might have to ask Anthony to -- I'm afraid, 7 I couldn't give you all of that history myself. Anthony 8 might be better placed. 9 MR OMO: I can't give you the full history myself, it's not 10 within my purview, but what I understand was it did take 11 the UK Parliament that length of time to get the 12 legislation through, but in the meantime a lot of 13 preparatory work was done. But I think we can get you 14 a better explanation in writing. 15 Q. It's particularly of interest that, because of the need 16 for the system arising very much in the period that 17 we're looking at and the significance, as you've already 18 described, of the outcome which came ten years later. 19 So that's something, if the GMC has a particular 20 perspective on that, that would be very interested to 21 hear about because it's obviously a very important part 22 of its function. 23 MR MASSEY: And just linked to that -- and I think the other 24 bit, we'll come back to you with it, but I think a lot 25 of this hinges on the responsible officer regulations Page 52

1 which I believe didn't come into effect until very 2 shortly before we were able to introduce the system of 3 revalidation because of course one of the things the 4 revalidation depends on is a network of responsible 5 officers who have that formal responsibility in law in 6 terms of their local governance and oversight of doctors 7 within their purview. But we'll come back to you with 8 chapter and verse on that. 9 Q. Thank you. 10 THE CHAIR: Mr Dawson, I'm sure we've covered this and if 11 nobody can remember, it doesn't matter, we can check it. 12 But I have in mind a date for when the responsible 13 officer regulations came in. Do you have that? 14 MR DAWSON: I think the regulations may have been 1999, but 15 my understanding was that the officers effectively come 16 in as part of this -- around the same sort of period. 17 THE CHAIR: Yes, that was my understanding. Sorry, we can 18 check it. 19 MR DAWSON: Yes, absolutely. The responsible officer, as 20 you say Mr Massey, is a very important part of this. 21 You mention, in the passage that we've looked at in the 22 statement, that this was a move -- you mention it being 23 a shift away from a more reactive approach to 24 regulation, "to establishing a two-way flow of 25 information between us and employers" and I think what Page 53	1 A. Anthony may supplement what I'm about to say but 2 essentially we've been lobbying for a form of 3 underpinning legislation for some years because a lot of 4 way in which we go about our job is defined in quite 5 prescriptive detail by legislation and we believe that 6 we can be a more effective and modern regulator if we 7 have more discretion in terms of how we make decisions 8 about cases that we promote for investigation and how we 9 conclude that, including the potential for us to 10 conclude cases without always having to go through 11 a Medical Practitioner Tribunal Service for the more 12 serious sanctions against doctors' licences. 13 We've also lobbied for change around things that we 14 may come on to discuss this morning, so the five-year 15 rule, which we employed in a few cases in relation to 16 concerns raised about Mr Eljamel, has been, we would 17 argue, quite constraining in terms of our ability to 18 look at cases. Obviously we always need to have regard 19 to the degree to which our evidence requirements will be 20 met with more historic cases of failures in patient care 21 or other concerns but we believe that's been overly 22 constraining in terms of our ability to look at older 23 concerns about doctors. And one of the things that the 24 updated legislation will do will be to remove that 25 five-year rule that we've had to work with in the past. Page 55
1 you're telling us there is that the responsible officer 2 was a very important part of the healthcare systems part 3 of that conversation? 4 MR MASSEY: Yes, that's correct. 5 Q. Could I ask you, please, about -- you've touched already 6 on some of the guidance material. Just before we do 7 that actually, there's one aspect of this I wanted to 8 ask you about, paragraph 7.11, please. You are talking 9 here about -- you're responding to some questions about 10 the extent to which you were involved -- the GMC might 11 be involved in certain areas of interest to the Inquiry, 12 and you say, at 7.11: 13 "The legal framework governing regulation of doctors 14 is currently being reformed, as part of a commitment to 15 modernise the outdated legislation underpinning the 16 GMC's regulation through a process of introducing 17 amendments to the Act in the form of a new GMC Order, 18 which will be consulted upon by the Department of Health 19 and Social Care and require approval by the UK and 20 Scottish Parliaments." 21 You mention that I think as well in a more specific 22 context. Are you aware, Mr Massey, or indeed Mr Omo, of 23 the sort of main thrust behind that? What are the 24 aspects of the system which there are political 25 movements afoot to try to change? Page 54	1 So we believe that the reforms overall will be 2 a really positive development and will enable to us 3 deliver better more effective regulation. But Anthony, 4 you may want to add to some of that. 5 MR OMO: No, I think that covers it. It's updating what is 6 quite an outdated model of regulation which is quite 7 prescriptive and set out in primary legislation and 8 secondary legislation. 9 Q. Just for the sake of completeness, possibly from either 10 of you, what is the five-year rule? 11 MR MASSEY: So the five-year rule is a rule that essentially 12 provides guidance to our case examiners about how they 13 can look at concerns that arose more than five years 14 previously. And at the time when complaints around 15 Mr Eljamel were being made, it required -- in order for 16 that five-year rule to be waived, in other words for us 17 to be able to promote those cases for investigation, it 18 required us not only to define that those issues were 19 within the public interest but also that there were 20 exceptional circumstances that merited that case being 21 promoted to an investigation. 22 That exceptional circumstances rule we removed, 23 I think, in 2017 or was able to be removed under 24 legislation in 2017, but it still exists in legislation. 25 And that's why we've lobbied for its removal entirely Page 56

1 because we believe that we should be looking at those 2 cases and assessing them on their own merits, 3 notwithstanding those evidential constraints that might 4 exist with more historic cases. 5 Q. Interesting. What's your thinking behind that? Why 6 would it be appropriate for you to have greater -- 7 a degree of freedom, I think is what you're talking 8 about, to be able to look at more historic cases? 9 A. So the challenge is where you have, as in this case, 10 multiple concerns raised against a doctor, the five-year 11 rule will be employed in our triage processes. So this 12 is to determine whether or not a case gets promoted for 13 investigation. If cases don't get promoted for 14 investigation through that triage process, they are not 15 made available to our case examiners who may then make 16 decisions about any existing, ongoing or future 17 investigations against the doctor. 18 So if you look at Mr Eljamel's case, there were, 19 I believe, four, we described them as enquiries, made to 20 us which did not progress through decisions made through 21 the five-year rule and whilst I can't say with any 22 certainty how we would have assessed those if they 23 arrived with us now, the triage decision at the time did 24 refer to the exceptional circumstances test being a key 25 reason why some of those cases weren't promoted for Page 57	1 exceptional circumstances test or the public interest 2 test? Because on one view -- I wonder whether this, in 3 fact, may be the reason why they didn't progress -- 4 because Mr Eljamel was no longer in practice in the UK, 5 it might not be deemed to meet the public interest test 6 in theory at least? 7 A. So the decision-making at triage -- and these are in the 8 evidence packs. 9 Q. Yes. Yes. 10 A. I think in -- two of those specifically referenced those 11 cases not satisfying the exceptional circumstances test, 12 and that being the kind of the primary reason not to 13 progress those. Other cases were assessed and were 14 closed because the decision-maker at the time judged 15 them to be at the lower end on gravity, and one or two 16 of them also referenced the fact that there were 17 existing proceedings and that they felt that there 18 wasn't enough in the enquiry that would add to the open 19 investigation that was already underway in relation to 20 Mr Eljamel. 21 But one thing I note is that two of those cases 22 related to probity concerns, about -- allegations about 23 whether surgery had or had not been performed and 24 I mention that, and you may want to probe this later, 25 because probity is a really important issue for us in Page 59
1 investigation. 2 And that matters because that will then inhibit the 3 ability of our case examiners to join that information 4 with other information, if for example, they're trying 5 to establish a pattern of behaviour in relation to 6 individual doctors. 7 Q. Just out of interest, as I understood it, you're saying 8 there would be a public interest test that would remain 9 but that the exceptional circumstances aspect would be 10 removed such that the bar would perhaps slightly change; 11 is that the -- 12 A. No, so the exceptional circumstance test has already 13 been removed, that was removed in 2017 and that gave us 14 more discretion to investigate those older cases. 15 Q. Yes. 16 A. But the legislation that's coming will remove the 17 five-year rule in its entirety. 18 Q. I see. 19 A. And that will then mean that we can assess those older 20 cases on their merits against the investigation 21 thresholds and the passage of time will only be relevant 22 insofar as it would impact on the evidence available and 23 the fairness of proceedings. 24 Q. I see. I was just wondering were those cases that you 25 mentioned not progressed through as a result of the Page 58	1 assessing fitness to practise concerns about doctors. 2 Of course, so is the clinical care provided too. But 3 that question of probity and honesty is so fundamental 4 to the relationship between a doctor and a patient that 5 that's something that we do take a particular interest 6 perhaps arguably more so now than we might have done at 7 the time. 8 Q. I think that's why you told us earlier that the 9 standards and guidance focus on -- and indeed aspects of 10 the curriculum I think you told us focus on technical 11 aspects but what one might describe as non-technical but 12 equally important aspects of a doctor's practice, is 13 that right? 14 A. Yes, so that's -- so again, this postdates the period 15 that the Inquiry is looking at, but we -- I think it was 16 2016 or 2017 published our generic professional 17 capabilities document that set out in some detail those 18 generic skills that we expect from doctors as they 19 progressed through their formal postgraduate training 20 because those questions about how to communicate 21 effectively with patients, with colleagues, those issues 22 around raising concerns, dealing with confidentiality, 23 understanding consents and candour are all absolutely 24 critical, we would argue in terms of doctors practising 25 safely. Page 60

1 Q. But to be clear, probity was always part of the rules, 2 wasn't it? 3 A. Yes. Yes, it was. 4 Q. And communicating effectively with patients so as to 5 promote their interest was always part of the rules? 6 A. Yes, they were always part of the rules, but we place 7 greater emphasis on them and were more specific about 8 our expectations in those documents, particularly as 9 they pertained to the training that we wanted 10 postgraduate doctors to be undertaking. 11 Q. Thank you. On the subject of guidance, you mention, at 12 page 11 of your statement, something we've come across 13 before which is Good Medical Practice. I think you've 14 told us already that that sets out a number of 15 principles rather than being specific to certain 16 situations. Is that a fair assessment? 17 A. Yes. So it is something that is designed to be a set of 18 high-level principles rather than a prescriptive code. 19 It covers kind of six areas which I can very briefly 20 outline, so -- and I mentioned two of these earlier. So 21 taking care of patients is the first concern of doctors. 22 Secondly, providing good care and working within 23 competence. Thirdly, working in partnership with 24 patients and supporting them in making informed 25 decisions. Fourth, treating colleagues with respect and Page 61	1 Q. You mention, at paragraph 7.31, that there was before -- 2 we've talked about the significance for us of the 3 arrival of Good Medical Practice in 1995. You tell us, 4 at paragraph 7.31 that there was something that existed 5 of a documentary nature before that called the "Blue 6 Book". Could you tell us a little bit about that? 7 A. So this is significantly before my time but essentially, 8 the Blue Book described what conduct would be likely to 9 give rise to disciplinary proceedings and GMC referrals. 10 So essentially described, from a rather kind of 11 deficit-laden perspective, about the things that would 12 get you into trouble with the GMC as a doctor. So it 13 was defining misconduct rather than, as Good Medical 14 Practice does, to define our expectations of good 15 practice. 16 Q. Thank you. Could I ask you please about something you 17 mention at paragraph 6.13 of your report. 18 A. Yes. 19 Q. If we could just get that up on our screen, thank you. 20 This is something specific. It's in the section where 21 you're talking to us about NHS Tayside but in the 22 particular context of your obligation with regard to 23 medical education. You say: 24 "In 2014, the GMC undertook visits to 12 Local 25 Education Providers (LEPs) across the UK, comprising six Page 63
1 creating compassionate and supportive environments. 2 Fifth, acting with integrity and honesty when things go 3 wrong. And finally, protecting and promoting the health 4 of patients and the public. 5 So it is very much around those generic skills. It 6 doesn't cover the clinical skills which are -- which are 7 covered within separate guidance typically produced by 8 Royal Colleges and as part of those kind of postgraduate 9 training requirements that I described earlier. 10 Q. Does the Good Medical Practice contain ethical rules? 11 A. Yes, it does around all of those things, but we also 12 supplement Good Medical Practice with additional ethical 13 guidance. So we have specific guidance in addition on 14 consent, confidentiality, raising concerns, leadership 15 and management and a few other things as well. 16 Q. If a doctor conducts him or herself in a way which 17 breaches the rules, is that conduct unethical? 18 A. So it depends on the nature of the conduct but 19 essentially, if a doctor's behaviour breaches those 20 rules, yes, that would be in breach of our ethical 21 standards. 22 Q. There might be exceptions, for example emergency or 23 something like that, but in general terms is that the 24 position, Mr Massey? 25 A. Yes, yes that's right. Page 62	1 obstetrics and gynaecology sites and six surgical sites, 2 to examine issues relating to bullying and undermining. 3 One of the surgical sites visited was Ninewells Hospital 4 within NHS Tayside. Following those visits, feedback 5 was provided and a report was produced." 6 Does the documentation relating to that visit still 7 exist? 8 A. I believe so and I can't recall directly but I think if 9 it does, it will be part of the evidence pack. 10 Q. Okay, it's just we don't appear to have given it any 11 numbers there. So it looks perhaps we don't have it. 12 A. Okay, well perhaps you can leave that with us and if we 13 have it, we will make sure that it is shared with you. 14 Q. Thank you. Do you know why it is that in 2014 that 15 visit to NHS Tayside and Ninewells Hospital in 16 particular took place? 17 A. So as far as I understand it -- and obviously this is me 18 looking back through historical documentation -- it 19 followed results in the national training survey that 20 I described earlier which raised concerns by -- I can't 21 tell you exactly what those concerns related to, in 22 terms of surgery at Ninewells. But I do know 23 that -- well, I am told that when that report was 24 produced, there were no concerns raised about surgery in 25 that final report. Page 64

1 Q. Right, but the concerns related specifically to bullying 2 and undermining? 3 A. As I understand it, yes. 4 Q. Okay, thank you. You've told us already some 5 interesting general information about the GMC medical 6 register. I'd like to ask you a few more questions 7 about that, in particular, in relation to the 8 information that you were able to find in relation to 9 Mr Eljamel himself. You tell us, at paragraph 7.24, 10 could we have that up, please. You talk here about 11 specialist registration being introduced in 1997: 12 "Prior to this, doctors' specialist qualifications 13 could be recognised on the medical register, but there 14 was no separate specialist register. In Mr Eljamel's 15 case, his specialist qualification was recognised by the 16 GMC in 1996 and he was subsequently transferred onto the 17 specialist register when it was established in 1997." 18 So, in essence, I think with him what happened was 19 he had got the specialist qualification and then, 20 shortly thereafter, the GMC changed the system as to how 21 specialist qualification was registered; is that right? 22 A. Yes, so he applied in 1994 for a particular designation 23 that demonstrated that he'd completed his training in 24 surgery which, in essence, is exactly the same test that 25 would be applied for a doctor coming on to the Page 65	1 that correct? 2 A. Yes. 3 Q. And prior to 2007, my understanding is that registration 4 was either full or limited, is that right? 5 A. Yes, that is correct. 6 Q. And we'll jump ahead to Mr Eljamel's situation in 7 a minute, but as far as he's concerned we should be 8 focused, I think, more on the limited registration, as 9 that's what he had initially; is that correct? 10 A. Yes, so it was limited registration that he was granted 11 on 1 June 1986. 12 Q. Great, and you tell us, at paragraph 7.22, just on our 13 screen: 14 "In order to grant limited registration, the GMC had 15 to be satisfied that the doctor held an acceptable 16 primary medical qualification, had acquired the 17 necessary post-qualification experience, possessed the 18 required knowledge and skill, had sufficient knowledge 19 of English, was of good character, and had been selected 20 for suitable employment. During the relevant period, 21 applicants for limited registration were assessed 22 through documentary evidence, declarations and, where 23 required, the Professional and Linguistic Assessments 24 Board ... test. Limited registration could only be 25 granted for employment approved by the GMC and where Page 67
1 specialist register after 1997 and we then had a string 2 of correspondence with I think it was the Irish Surgical 3 Postgraduate Training Committee at the Royal College of 4 Surgeons in Ireland in October 1994. And we asked them 5 for the sealed list that demonstrated Mr Eljamel's 6 eligibility for having that T & S annotation added. And 7 he was awarded that annotation in January of '96 and 8 then, when the specialist register came into being 9 in 1997 he, along with other doctors with those 10 particular designations, was automatically transferred 11 on to the specialist register. 12 Q. And is the specialist registration granted in respect of 13 a particular medical discipline, is that how it works? 14 A. So -- so, for any doctor to -- so, any doctor in any 15 discipline, whether that's surgery or being a general 16 physician or radiologist, they need to be on the 17 specialist register if they're going to operate and 18 perform as a consultant in that specialism. 19 Q. Yes, so the specialism, as far as he was concerned, was 20 what? 21 A. Was neurosurgery. 22 Q. Thank you. If we look a bit further back, you tell us 23 in your statement that the registration framework of the 24 GMC, as it is now, came about in October 2007 and that 25 there are four main forms of registration. Broadly, is Page 66	1 appropriate supervision arrangements were in place. 2 In practice this generally related to recognised NHS 3 training grade posts or equivalent employment. The GMC 4 relied primarily on approvals and inspections undertaken 5 by other competent bodies, including the Royal Colleges, 6 rather than directly inspecting posts itself." 7 So, this is the route then by which -- is it a route 8 which would normally have been used by doctors who had 9 their original qualifications abroad? 10 A. Yes, that's right and -- 11 Q. Sorry, is the purpose of this method of registration 12 trying to find someone who has a certain foreign 13 qualification and go through a process by which their 14 ability to be judged against a peer who has come through 15 the British system, if I can put it that way, is 16 equalised, so they get to the point where they're at the 17 same level as someone had has come through the more 18 familiar British system; is that broadly correct? 19 A. So that is my understanding and it's quite hard -- this 20 is some decades before my arrival here and it's been 21 an interesting kind of history lesson going through some 22 of this in terms of how we approached registration 23 issues in the past. But broadly speaking, the UK has 24 always been a place where doctors who qualified overseas 25 have wanted to practice and the way in which the GMC has Page 68

1 enabled those doctors to demonstrate that they have the 2 level of skills, knowledge and competence they require 3 as changed over the years. At the time in question, 4 limited registration appears to have been the main 5 mechanism through which doctors from overseas would have 6 come into practice, with a level of supervision placed 7 around their practice in those first few years. 8 Q. Okay. And the various aspects that require to be 9 satisfied include primary medical qualification. Does 10 that mean an undergraduate degree or something of that 11 nature? 12 A. Yes, it does, it means a medical degree. 13 Q. Yes: 14 "... acquired the necessary post-qualification 15 experience, possessed the required knowledge and skill, 16 had sufficient knowledge of English, was of good 17 character and had been selected for suitable 18 employment." 19 Do you know -- do you happen to know from any of the 20 records, as we understand that you're helping us by 21 looking back at what happened long before you became 22 involved with the GMC, Mr Massey, how someone being of 23 good character would be assessed? 24 A. So I can't give you chapter and verse on that. I do 25 know that, in relation to Mr Eljamel, we relied very Page 69	1 negatives, but not necessarily having to prove any 2 positives, is that broadly it? 3 A. That's my understanding. 4 Q. Thank you that's helpful. Just on 7.23 while we're 5 there, just to explain what you've managed to find of 6 the process. You say there: 7 "Limited registration was ordinarily granted for 8 a maximum aggregate period of five years, subject to 9 certain transitional exceptions preserved under earlier 10 legislation. Doctors granted limited registration 11 received a certificate recording the scope and duration 12 of their registration and the employment for which it 13 had been granted." 14 Is the theory of the maximum aggregate period that 15 you get a certain amount of time in which to demonstrate 16 that you are up to the requisite standard for full 17 registration, but you can't take more than five years to 18 get to that standard; is that how that works? 19 A. I'm afraid I couldn't, with any confidence, set out a 20 rationale for that five years. 21 Q. Okay. And my understanding from the documentation, the 22 passages there, as far as linguistic ability is 23 concerned, there was a test which could be sat, but 24 I think in Mr Eljamel's case he didn't require to sit 25 it, is that right? Page 71
1 heavily on the sponsorship by the Royal College of 2 Physicians and Surgeons of Glasgow in terms of enabling 3 him to be granted limited registration in coming on to 4 our register. 5 Q. So in essence -- because one of the other requirements 6 is that one has been selected for suitable employment. 7 Is this one of these situations where certain of the 8 components are deduced from the fact that other 9 components have been met? So if you've got suitable 10 employment, would it be assumed that you're probably of 11 good character or else you wouldn't have got suitable 12 employment? 13 A. I'm not sure that that would have been the test and I am 14 speculating now, but I think in terms of the granting of 15 limited registration, the good character would be 16 whether or not there were any pre-existing evidence of 17 problems with that doctor's practice or in other parts 18 of their life, for example through any criminal 19 convictions. The subsequent good character, in terms of 20 them being granted full registration, and indeed 21 Mr Eljamel was granted full registration in 1990, would 22 have then been based on the kind of the four years that 23 he had been in that supervised practice and the fact 24 that no issues will have arisen from that practice. 25 Q. I see. So it's sort of looking at it from there were no Page 70	1 A. I believe that is correct. 2 Q. Yes, thank you. So for things like linguistic ability 3 there was a test, an objective measure, but in relation 4 to other things it seems that there was a reliance on 5 other bodies confirming that ticks should go in the box, 6 if I could put it that way? 7 A. Yes, and that is bit different from how it works now, so 8 we tend to do more of that ourselves rather than relying 9 on third parties. But at the time I believe that both 10 his granting of limited registration, the granting of 11 full registration, and the T & S annotation that 12 essentially led to him being moved on to the specialist 13 register came through that confirmation from other third 14 parties. 15 Q. Because we've seen, not necessarily in relation to the 16 GMC but in relation to other bodies, where there were 17 steps which required verification or steps which 18 required certain qualities or attributes or technical 19 skills to be verified, there does appear to be something 20 of a system, broadly speaking, again, not necessarily 21 related to the GMC, where if a doctor can get another 22 doctor or perhaps a senior doctor to write a letter 23 saying they're fantastic, everybody just assumes that 24 that must be true. Is it important, in order that 25 standards and rules are meaningful, that the bodies who Page 72

1 are charged with regulating them check the information 2 for themselves in situations such as this? 3 A. Yes, I think it is and that's exactly what we do now. 4 So our kind of -- our approach to verification is that 5 we do all of that for ourselves. For example, one of 6 the most critical elements is checking the primary 7 medical qualification and any subsequent qualifications 8 and being able to do that. At the time I don't think 9 the same processes and systems existed that enabled us 10 to do it in the way that we can now, which is through 11 some quite complicated IS systems that we've been able 12 to develop over the years. And I think in the period 13 that we're talking about, there was more reliance on the 14 sponsors and the sponsorship for taking responsibility 15 for the supervision of doctors coming into practice. 16 Q. Thank you. You provide some further information at 17 paragraph 21.2 if we can have a look that the please 18 relating to Mr Eljamel himself just to get the details 19 out there. You say this is as a result of your 20 historical research for us which is extremely helpful: 21 "We determined that Mr Eljamel met our requirements 22 for limited registration, and he was granted this on 23 1 August 1986 under section 22 of the original form of 24 the Medical Act 1983 ... Limited registration, which 25 was abolished in 2009, allowed trainee doctors to Page 73	1 sort of thing, route? 2 A. So if you compare the two, it would be the same as 3 getting full registration as most UK graduates would get 4 on completion of their first year of foundation 5 training. So what we have now is provisional 6 registration when UK doctors graduate from medical 7 school and the first year of the foundation programme 8 they remain provisionally registered and usually at the 9 end of the foundation year, they will then move on to 10 full registration. And that would be the equivalent of 11 what Mr Eljamel was granted in 1990. 12 Q. Yes, and I think you may have mentioned this, or perhaps 13 another witness, is that first year, the FY1 year, as we 14 would call it now? 15 A. Yes, that's right. 16 Q. Yes, and the full registration gained at the end of 17 that, does that effectively mean you are a doctor and 18 you're entitled to work to some extent on your own; is 19 that right? 20 A. Yes, that's correct. 21 Q. Excellent, thank you. It then goes on to say: 22 "Mr Eljamel was granted full registration on 23 20 February 1990, and his application and related 24 correspondence are set out in [documents you've 25 provided]. In the same way that full registration Page 75
1 practise in specified posts under restrictions and 2 supervision, and was often time limited. Mr Eljamel was 3 not required to sit the Professional and Linguistic 4 Assessments Board test to demonstrate his knowledge and 5 skills under section 22(1) of the Act, which 6 international medical graduates were, and still are, 7 ordinarily required to complete to demonstrate they have 8 sufficient knowledge and English language skills 9 required to meet requirements for GMC registration. 10 This was due to the fact he was sponsored for limited 11 registration by the Royal College of Physicians and 12 Surgeons of Glasgow and was therefore granted an 13 exemption under section 23(5) of the Act. Mr Eljamel 14 completed four periods of limited registration under 15 supervision of an appropriate consultant between 16 1 August 1986 and 20 February 1990. Documentation 17 relating to his limited registration is set out at [and 18 you've provided some documents, as well as] 'Guidance on 19 limited registration' ... [which] was in place at the 20 time. 21 So once he gets to the point of 20 February 1990 he 22 gets full registration. Can you tell me what that is 23 equivalent of if you're going through the other route, 24 if you like, not limited registration but the normal, 25 having graduated through a UK university and all that Page 74	1 operates now ... full registration entitled a doctor to 2 practise in the UK without supervision or restriction, 3 having met our requirements for qualification and 4 training. The decision to grant full registration was 5 made based on the factors considered on the decision 6 form [which you've provided] (including having been 7 qualified for at least four years and having at least 8 12 months' substantive registrar experience in the NHS). 9 The decision was also in line with requirements at the 10 time for moving from limited to full registration, which 11 are set out in the first two paragraphs of the 1989 12 Committee minutes ..." 13 Which you've also helpfully provided. You then go 14 on to say that: 15 "Mr Eljamel was recognised as a consultant 16 neurosurgeon on 12 January 1996." 17 And we've already been through the process by which 18 he got on to the more modern form of the specialist 19 register. 20 Just on one point of detail, the 12 months of 21 substantive registrar experience, what would that 22 comprise? 23 A. So that is a -- kind of a more senior decision-maker 24 within the particular setting that's relevant to them at 25 that time. So I couldn't tell you exactly what that Page 76

1 registrar post was that he had. Of course, the 2 terminology has changed over the years from registrar 3 into other roles, but it would have been a more senior 4 clinical role. 5 Q. Thank you. So just to be clear, if one were going 6 through the UK route, to full registration one would 7 have a medical degree and work for a year and then, if 8 everything went to plan, you would be fully registered; 9 is that right? 10 A. Yes. 11 Q. Whereas the limited registration route which, as we 12 understand it, was for doctors coming from abroad, 13 imposed much more onerous conditions, going over 14 a period of up to five years where a doctor would work 15 under supervision and ultimately have to complete 16 12 months of substantive senior training doctor 17 experience as a registrar. The purpose of that 18 presumably being to make sure that that doctor, trained 19 in a different environment, was meeting the UK and the 20 GMC standards. Is that a fair assessment? 21 A. Yes, I think that's a fair summary. 22 Q. Because one of the aspects of this Inquiry and medicine, 23 perhaps more generally, is people sometimes have 24 concerns where they're treated by doctors who come and 25 have been trained in their initial training, or perhaps Page 77	1 A. So that's PLAB tests did exist at the time Mr Eljamel 2 came into practice but I think the sponsorship route was 3 perhaps more frequently used. I don't have the numbers 4 to demonstrate that; that's my speculation. We did 5 actually subsequently tighten up that sponsorship 6 pathway to add further requirements and indeed, we have 7 more requirements where doctors do come through that 8 sponsorship pathway now. There aren't a huge number of 9 them. 10 So for example, we require doctors now coming 11 through that route to have demonstrated that they've 12 practised for at least three of the previous five years, 13 we require declarations of fitness to practise and 14 confirmations of good standing, which will typically be 15 requests for information from the medical regulator in 16 the country where they've been previously practising to 17 assure us that there aren't issues in terms of their 18 practice that we need to be aware of. 19 Q. Is there any aspect of any of those systems which 20 involves asking patients whether they think the doctor 21 is competent? 22 A. Not specifically. Though obviously if there had been 23 concerns arising in relation to patient care, that would 24 be reflected and is reflected sometimes in terms of 25 those declarations of fitness to practise and that Page 79
1 even beyond that, in different systems. People may well 2 often have faith in the GMC system and the UK system but 3 that there are perceptions that people trained in 4 different systems may not meet the same standards. Is 5 this system designed to try it make sure that ultimately 6 a doctor going through training will reach the same 7 minimum level of competence no matter which route they 8 go through? 9 A. So I believe that is why what you've just described is 10 designed in that way at the time. Of course, that isn't 11 the mechanism that we have now. So now, if a doctor who 12 qualified overseas is coming to the UK, the vast 13 majority of those will be required to sit that 14 professional linguistic assessment board process which 15 contains both a written exam and then, in our Manchester 16 offices, running through a kind of clinical assessment 17 circuit where they have a number of stations where we 18 have simulated real-life situations that they would need 19 to apply their clinical judgment to and then -- and only 20 if they then pass both parts of that PLAB test as we 21 call it, would we be able to grant the registration. 22 Q. Are those tests further examples of the GMC taking more 23 control over making sure the standards be met itself, as 24 opposed to perhaps relying on others informing them that 25 the standards have been met? Page 78	1 confirmation of good standing. And obviously we would 2 need to be -- looking at the individual details of that 3 if that was disclosed to us or if we found that in terms 4 of our own searches for information. 5 Q. I think also we've heard some evidence in a slightly 6 different sphere that there may be some patient input 7 into the revalidation process which of course is 8 a separate system. We've heard some information, for 9 example, about patient questionnaires being required as 10 part of the documentation that a doctor provides at the 11 five-year review. Is that something -- is that right? 12 A. So revalidation does require, as part of the supporting 13 information, feedback from patients and reflections from 14 the doctor about that feedback from patients. And so, 15 yes, that is an important part of the revalidation 16 process. 17 Q. And do you know what the requirement is of -- is it 18 questionnaires that are used? It's possible I was 19 speaking to someone about a more historic system? 20 A. In my understanding we're not prescriptive about exactly 21 how doctors acquire that because it will be very, very 22 different. I mean, if I perhaps use an extreme example, 23 the feedback that a general practitioner might get might 24 be very different from that a pathologist might get in 25 terms of their ability to extract feedback from Page 80

1 patients. So we allow doctors, with their responsible 2 officer, to make judgments about how they provide that 3 information. But ultimately it is part of the 4 responsible officer's job to make sure that the doctor 5 is doing that in a proper way. 6 Q. Thank you. I'd like to change into a slightly different 7 area, Mr Omo's area, and ask more specific questions. 8 You've helpfully, Mr Omo, already talked to us about the 9 general system of fitness to practise and the process 10 that's followed including the triaging and the various 11 potential outcomes that one might have in a fitness to 12 practise investigation. Could I just ask about certain 13 specific aspects of the helpful analysis that's been 14 provided in Mr Massey's statement. At paragraph 7.42, 15 please. 16 I think you said this already as part of your 17 general summary, Mr Omo but it says there that anyone 18 can raise a concern with the GMC; is that right? 19 MR OMO: That's correct. 20 Q. How is the information about the mechanisms by which, 21 say a patient, could raise a concern promulgated? 22 A. So we have a website which is the main way. If you 23 search "how to make a complaint" it pops up and then 24 you're guided through on the website. We also work 25 with, certainly in England, PALS and local systems to Page 81	1 "d) adverse physical or mental health; 2 "e) not having the necessary knowledge of English; 3 or ... 4 "f) a determination (essentially, a decision) by 5 a regulatory body either in the UK or overseas to the 6 effect that fitness to practise as a member of the 7 profession is impaired." 8 So this is the regime which is prescribed by the 9 statute, is that right? 10 A. That is correct. 11 Q. And so obviously, ultimately these are matters which the 12 investigation, if followed through, would look to try to 13 see whether they had been established. But given that 14 these are the standards, these standards are also 15 applied in relation to the triage process at the 16 beginning, is that right? 17 A. That is correct. 18 Q. Because if there were no prospect, for example of any of 19 these being met, then it would be impossible for the 20 investigation to have any purpose? 21 A. Yes. 22 Q. There are some aspects of this which are quite clear as 23 to what they're talking about but some which might be 24 deemed to be a bit more amenable to subjective 25 interpretation. So for example, how might the phrase Page 83
1 ensure that patients are aware of the GMC. 2 Q. The statutory regime, I think Mr Massey tells us in the 3 statement requires, under section 35C(2) of the Act, 4 that concerns which have been raised by a patient or 5 through any other mechanism would only be investigated 6 if it falls within one of the grounds for taking 7 regulatory action. And we can find those at 8 paragraph 7.47 of Mr Massey's report. If we could just 9 go down to that, thank you. Just at the bottom of the 10 page. It says that the investigations will openly 11 happen if the concern calls under one of the following 12 grounds for taking regulatory action: 13 "a) misconduct (examples include but are not limited 14 to sexual assault; violence; improper sexual or 15 emotional relationships; serious clinical concerns; 16 knowingly practising without a licence; unlawful 17 discrimination; dishonesty; and gross negligence or 18 recklessness; 19 "b) deficient professional performance (this could 20 consist of acts and/or omissions and includes failing to 21 act appropriately or being unable to provide care to the 22 standard expected); 23 "c) a criminal conviction or caution in the British 24 Isles (or elsewhere for an offence which would be a 25 criminal offence if committed in England or Wales); Page 82	1 "serious clinical concerns" be interpreted? 2 A. So I think we interpret "serious clinical concerns" as 3 any serious error that has led to patient harm or could 4 have led to patient harm or a series of failings which 5 could have put patients at risk. 6 Q. So it's actual harm or what one sees sometimes called 7 a "near miss", something that could have caused harm but 8 didn't in the particular circumstances? 9 A. Yes, particularly if we combined with other evidence to 10 suggest that there is no insight and therefore no 11 remediation, so the risk remains. 12 Q. Yes. What about dishonesty? 13 A. I think that's in accordance with the ordinary term, 14 effectively lying, changing records, fraud, the other 15 types of dishonesty. 16 Q. Would it include being dishonest with patients? 17 A. Yes, it would include being dishonest with patients. 18 Q. Would it include putting false entries on CVs when 19 applying for important medical jobs? 20 A. Yes, it would include that. 21 Q. Would it include not being fully candid with one's 22 colleagues when things have gone wrong? 23 A. Yes, it would. 24 Q. Thank you. You mention, or Mr Massey mentions at 25 paragraph 7.50, he makes reference to there needing to Page 84

1 be consideration taken at the triage stage of what he 2 calls the: 3 "... relevant burden of proof, taking into account 4 our statutory objective to protect the public." 5 What is the relevant burden of proof? 6 A. So the burden of proof rests with the GMC to prove the 7 case and we operate the civil burden. 8 Q. Right, so it would be whether the evidence that's 9 available to you would show that there is a prospect of 10 showing that on a balance of possibilities the ultimate 11 test will be met? 12 A. Yes. 13 Q. Thank you. You mentioned a moment ago the word 14 "insight". Is that an important feature of the way in 15 which the GMC conducts its fitness to practise 16 investigations? 17 A. It is. Because we are looking at -- well, if I start 18 from the beginning. We accept that some doctors will 19 make mistakes, good doctors will make mistakes and so 20 risks exist in medicine. So what we tend to look at is 21 whether or not the doctor has insight and has taken 22 steps to remediate, such that those risks are mitigated 23 or eliminated. 24 Q. And insight is to do with the doctor's attitude towards 25 what may have happened, is that right? Page 85	1 A. That's correct. 2 Q. And presumably that, in principle, amongst the others 3 that we've been discussing, are all part of both the 4 initial triage and ultimately the case examiners' 5 decisions on the cases themselves? 6 A. They are, although less relevant at the triage stage. 7 The triage stage is quite a low test, essentially trying 8 to identify whether or not this is a matter that the GMC 9 can and should investigate. It is part of the next part 10 of it. 11 Q. Mr Massey tells us that's called the "realistic 12 prospect" test. 13 A. Yes. 14 Q. So you consider that to be a low bar at that stage? 15 A. No. So the realistic prospect test is the case 16 examiner's test. That's when we decide to promote 17 a concern for investigation and that comes at the end of 18 the investigation. The triage threshold is simply 19 whether it raises a question about the doctor's fitness 20 to practise, which may be answered by insight 21 remediation and the context we gather. 22 Q. Okay. You mentioned -- Mr Massey mentions, at 23 paragraph 7.51, that: 24 "If the case examiners decide that the realistic 25 prospect test is not met, they may decide that it is Page 87
1 A. Yes, so it's probably what you've just referred to in 2 terms of we expect the doctor then to be open about 3 what's happened, reflect on it, discuss with peers and 4 colleagues and then be clear about what remediation 5 steps have been taken to prevent or mitigate such risks 6 in future. 7 Q. You may have just answered that with your last two 8 words, but is that a feature of what Mr Massey described 9 earlier as essentially the function of this process 10 being a prospective one; it's about trying to work out 11 whether a doctor who may have done something bad in the 12 past should continue to be able to offer medical 13 services in the future? 14 A. Yes, it is. We are -- essentially, the incident that 15 brings a doctor to our attention causes us to focus on 16 whether that doctor poses an ongoing current risk for 17 future patients because we can't do much about what has 18 happened but we can make sure that they don't go on to 19 do future harm. 20 Q. I think, at a different part of the statement, Mr Massey 21 makes what I think is an important observation about the 22 GMC's interpretation of its statutory function, that 23 it's not about punishment for past acts but about the 24 regulation of the future provision of medical services; 25 is that correct? Page 86	1 appropriate to issue the doctor with a warning. The 2 purpose of issuing a warning is to provide a formal 3 response to indicate that the doctor's behaviour or 4 performance represents a significant departure from the 5 professional standards and should not be repeated." 6 Is it not inherent in that that there would have had 7 to have been a finding, or a realistic prospect of 8 finding there had been a significant departure from 9 professional standards, meaning that the case should 10 progress at that stage? 11 A. So that's correct in part. The other bit of it is 12 whether or not we have the evidence to prove it or 13 whether we will get the evidence to prove it. So even 14 if it meets the seriousness threshold, so it has been 15 a breach and it is serious, we may not have the 16 evidence. 17 Q. Thank you. In the next paragraph, Mr Massey says: 18 "The case examiners may conclude that there is a 19 realistic prospect of establishing that the doctor's 20 fitness to practise is impaired. This means that, if 21 established, the facts would demonstrate that the doctor 22 poses a current and ongoing risk to public protection 23 requiring restrictive action in response. In these 24 instances, the case examiners will consider proposing 25 undertakings or refer the case to a Medical Page 88

22 (Pages 85 to 88)

1 Practitioners Tribunal (MPT) hearing." 2 So just on the test first of all, it is an important 3 part of this that there needs be a current and ongoing 4 risk to public protection, is that right? 5 A. That's right. 6 Q. Again, is that a feature of the prospective nature of 7 the exercise that's being carried out? 8 A. It is. 9 Q. What is meant by "public protection"? 10 A. Public protection is part of our statutory objective, so 11 it includes protection of members of the public, 12 patients and others but also includes protection of 13 public confidence and upholding standards. 14 Q. Does that mean the UK public or the public in the whole 15 world? 16 A. It's primarily referring to UK public as we are a UK 17 body and the decisions we make in terms of our 18 registrants do not bar or preclude other countries 19 making different decisions. 20 Q. Because it does seem to be an aspect of the GMC's 21 work -- you go on later to talk about the importance of 22 marking aspects of an individual doctor's practice for 23 other regulators in other countries -- that there is 24 an important element and we've already discussed with 25 Mr Massey the fact that doctors have, for many, Page 89	1 and understanding that where doctors move from one 2 country to another, what you've done can be relied upon 3 in other countries and what they've done can be relied 4 upon here; is that right? 5 A. That's correct. 6 Q. Thank you. And you mention there -- it's a sort of -- 7 I think it's a sort of procedural aspect. You talk 8 about the possibility that the case examiners would 9 consider proposing "undertakings" at that stage in the 10 process. What does that mean and is that different from 11 conditions? 12 A. Yes, it is. So we can propose undertakings which the 13 doctor would have to agree with. In substance, they can 14 be the same as conditions but the difference is that we 15 can't impose undertakings, only a tribunal can impose 16 conditions. 17 Q. Right, so an undertaking would be a situation in which, 18 at this initial stage before a tribunal, someone -- 19 there might be an agreement whereby someone would agree, 20 for example, not to carry out a certain medical practice 21 or something and that that be an agreement, but the 22 matter would not then proceed -- if the matter did 23 proceed and such a similar sanction were imposed, those 24 would be conditions; is that right? 25 A. Correct. Page 91
1 many years, come to Britain to work and indeed, many 2 British doctors now -- or at least now go abroad to 3 work. So is it important when that test is exercised 4 that it may not necessarily be restricted to a doctor 5 working in Britain but there may be a risk to the public 6 in the wider sense? 7 A. Yes, that's correct. 8 Q. It's, I suppose, a feature of what I think from medicine 9 may not even be that much of a feature of the modern 10 world, but it is realistic feature of medicine, I think, 11 that when one is a doctor, one can largely go anywhere 12 to be able to be a doctor. So therefore is it important 13 that regulators like the GMC understand that and 14 therefore understand that public protection is not just 15 about the UK, it's about wherever the doctor may go and 16 practice with his licence to do so? 17 A. Yes, I think that's correct and that's why, if we take 18 action, we would look at -- well, if we decide to remove 19 a doctor from the register, for example, we are saying 20 that we don't think that doctor is fit to work with 21 patients and that's any patient anywhere in the world. 22 But that doesn't preclude other countries from making 23 their own decisions. 24 Q. Indeed, yes, because there has to be, one would imagine, 25 because you're a UK regulator, a degree of reciprocity Page 90	1 Q. Thank you. In what circumstances would undertakings 2 normally be thought appropriate? 3 A. We would normally offer undertakings where the doctor 4 had insight and had agreed to do exactly what you've 5 just suggested which is restrict the practice that we 6 were concerned about or undergo some retraining, or in 7 fact in some cases not do that practice any more or not 8 do that bit of their role any more. But it has to have 9 the doctor's insight and therefore we can believe that 10 they're going to do that. 11 Q. I see. So effectively, at this still relatively 12 preliminary stage, you can be satisfied, based on the 13 evidence available to you, that the undertaking being 14 proposed and the insight shown by the doctor will mean 15 that the problem will be adequately addressed? 16 A. Yes. 17 Q. An aspect of the system, which I don't think is 18 commented upon as far as I could make out in the helpful 19 statements, but does seem to be relevant to us, I think 20 it relates to the concept of insight. Are there rules 21 in place for doctors to self-report to the GMC? 22 A. Yes, it's a requirement of Good Medical Practice. 23 Q. So in essence -- I had a conversation earlier with 24 Mr Massey about the circumstances in which concerns may 25 come to light and the need for systems within health Page 92

1 boards to be able to escalate those concerns to the 2 relevant person, nowadays the responsible officer, so 3 that the requisite contact could be made with the GMC. 4 In fact, doctors where things have gone wrong and they 5 think there may be a problem with the way in which they 6 are conducting their medical practice, don't actually 7 need to engage with any of that system at all. They're 8 actually obliged to engage with it themselves; is that 9 right? 10 A. Yes, correct. 11 Q. Because one thing you can say is that, in my scenario 12 that I gave earlier if one is in an operating theatre 13 and something goes wrong and there's only a limited 14 number of people, one person you can be sure who knows 15 about it is the surgeon because he was standing in the 16 operating theatre himself? 17 A. Yes. 18 Q. And if something went wrong that was sufficiently 19 serious, the doctor would have to report that to the GMC 20 him or herself, correct? 21 A. We would expect that duty of candour, yes. 22 Q. Yes. It's all an important feature, that, as 23 I understand it, of the whole system because you expect 24 doctors to have probity, to be candid, to think first 25 about patient safety. All of those things would Page 93	1 lay and a legally qualified person for each tribunal. 2 Q. Okay, and the importance of that feature of the two 3 functions being separate, was that something that was 4 just coming in around June 2011 or is that what the 5 shadow form means? 6 A. That's what the shadow form means. 7 Q. Yes, yes. So why was it deemed important, as a result 8 of the Shipman Inquiry and the subsequent legislation, 9 that those two functions, investigative and 10 adjudicatory, be separated? 11 A. I think from the Shipman Inquiry there was a finding or 12 a sense that having it all under one umbrella meant that 13 decisions were not necessarily taken that were 14 independent, there was too much influence of the 15 investigation over the hearing and tribunal outcomes at 16 the time. And at the time, the General Medical Council 17 essentially had members of council running various 18 committees and there was an attempt to professionalise 19 the service by removing medical input. It was 20 essentially felt that the medical profession was marking 21 its own homework in a lot of spaces and not necessarily 22 getting that right, would be my summary of the Shipman. 23 And so it was intended to move this on to a more 24 familiar footing, like the courts do, where the 25 prosecution and the adjudication are separate and follow Page 95
1 gravitate towards the need for the doctor, who has 2 a concern about his ability to deliver his practice and 3 what he may or may not have done, to report that to the 4 GMC him or herself? 5 A. Yes. 6 Q. Thank you. To go back to the process that we were 7 discussing, the fitness to practise process. You 8 mentioned the tribunal a few times already, the Medical 9 Practitioners Tribunal. Could you just tell us, 10 broadly, what that body comprises of and does? So we 11 have got beyond the triage stage, there's effectively 12 the next stage of the process. And I'm particularly 13 interested in whether you can cast some light on what 14 is, in fact Mr Massey's comment in paragraph 7.53, that 15 the MPTS was "in shadow form" in June 2011? 16 A. Yes. So again, this was part of the Shipman Inquiry. 17 One of the recommendations was to separate out the GMC's 18 investigation and adjudication and that required an act 19 of parliament to do that. So before it did that, the 20 GMC decided to set up and run a tribunal service, within 21 the organisation but separately, until it had the 22 relevant legal powers to do it. So it ran it in shadow 23 form, which essentially meant setting up a committee of 24 council which then was responsible for administering 25 tribunals made up of independent members, the medical, Page 94	1 separate rules. 2 Q. Right, but both arms are still within the GMC; is that 3 correct? 4 A. Yes. So the initial plan was for the Department of 5 Health, England, I think, to set up a separate 6 adjudication body and steps were taken to do that but 7 the legislation never came into effect and subsequent 8 government decided that it wasn't going to go ahead with 9 that, but what they did do is change our legislation to 10 create the MPTS as a statutory committee on statute with 11 a separate reporting requirement to parliament. 12 Q. Was there a similar structural system in place 13 before June 2011 but just without those bodies being 14 established in the way you've said? Was there a process 15 of investigation, was there a process of triage, was 16 there a process of adjudication and a process of sense, 17 if you like? 18 A. Yes, there were processes similar. 19 Q. Yes, so if matters related to what we are looking at had 20 come to the attention of the GMC before that date, then 21 there would have been a process, it just wouldn't have 22 had those particular post-Shipman-esque components that 23 you've described? 24 A. Correct. 25 Q. Thank you. Could I just ask you, please, about Page 96

1 paragraph 7.55. You tell us here about interim orders. 2 You say, in fact at 7.54: 3 "Where the case examiners refer a case to an MPT 4 hearing, further evidence may need to be gathered prior 5 to the hearing. This may include factual and 6 documentary evidence, witness or expert evidence, and 7 evidence of the doctor's past regulatory history." 8 So that's moving on to, as you mentioned earlier, 9 the sort of prima facie basis of a case but then the 10 need actually to prove it with evidence and this is the 11 stage where the evidence is being gathered; is that 12 right? 13 A. That is correct. 14 Q. It goes on to say: 15 "At any stage, we may seek ..." 16 "We" I'm assuming means the GMC: 17 "... may seek an interim order to restrict 18 a doctor's practice while a GMC investigation is 19 ongoing, for example by imposing conditions or 20 a suspension. Interim orders are determined by Interim 21 Order Tribunals ... also run by the MPTS. [Interim 22 Order Tribunals] do not make any findings of fact. The 23 test for imposing an interim order is whether it is 24 necessary for the protection of the public or is 25 otherwise desirable in the interests of the public Page 97	1 available at that time, the interim order tribunal had 2 thought it appropriate to pronounce it, but subsequently 3 the evidence was examined and it was found that in fact 4 no order was necessary, no suspension, no conditions or 5 anything like that needed to be imposed, no erasure, 6 then the interim would be -- the fact that the interim 7 order had been in place would be removed? 8 A. It would. 9 Q. So I -- as I understand it, interim orders were imposed 10 in Mr Eljamel's case, is that right? 11 A. That's correct. 12 Q. And so if one were to look at what exists as the records 13 of his medical registration, would there be nothing 14 there other than the fact that he had been registered 15 and the details you provided as to how his registration 16 had progressed through full practice to specialist 17 registration and that he was erased at a certain point, 18 voluntarily? 19 A. Yes, that's correct. 20 Q. So no information about the fact that there were -- it 21 was deemed to be appropriate for an interim order to be 22 pronounced would appear there? 23 A. No, that would no longer appear on the record. 24 Q. Why is that the case? 25 A. So we introduced a publication and disclosure policy Page 99
1 and/or in the interests of the doctor (for example, 2 where continuing to practise could worsen a doctor's 3 health, such as in instances of acute psychiatric 4 illness)." 5 And you've helpfully given us the guidance for the 6 MPTS tribunals relating to interim order applications. 7 So an interim order might be deemed appropriate in 8 certain circumstances. Do interim orders remain on 9 a doctor's registration or not? 10 A. So when the order is first imposed, it is on the 11 registration and it can be imposed for up to 18 months, 12 reviewed every six months and thereafter it has to be 13 extended by a court. 14 Q. So that's again, a matter of statute that -- 15 A. It is. 16 Q. But does the fact that a doctor has had an interim order 17 imposed on them at some point remain on the register? 18 A. It remains -- I would need to refer -- we have our 19 publication policy, while the case is active, it does 20 remain on it. I think once the case is concluded, then 21 it will come off. 22 Q. So presumably, if a permanent order is imposed or 23 a different order, that would supersede the interim 24 order anyway, but in circumstances where, for example, 25 there had been an interim order based on the information Page 98	1 which guides -- our council has this in place, which 2 guides how long relevant fitness to practise history 3 stays on a doctor's record. And that effectively says 4 that once the case is concluded, that bit of the record 5 comes off. Now, that's the public-facing record. If 6 an employer were to ask us a question of us, then we 7 would obviously answer that. 8 Q. So if an employer were to ask, hypothetically, if 9 Mr Eljamel wanted to get a job in Britain just now, then 10 it would be -- you would give the information about the 11 fact that there had been an interim order in place, or 12 not? 13 A. We would. 14 MR MASSEY: But also it's worth saying that Mr Eljamel would 15 need to have his licence restored which would require us 16 to make that judgment, which obviously -- 17 MR DAWSON: Of course. It may be better just to make it 18 a hypothetical case rather than Mr Eljamel's case. 19 Let's just say if a doctor had had an interim order 20 without a full order or subsequent permanent order 21 imposed, you would not let the public know, is that 22 right, that the interim order had been in place but you 23 would let a prospective employer know? 24 MR OMO: Yes, it wouldn't appear on the face of the doctor's 25 record, but employers would be able to request that Page 100

1 information or request information about the doctor's 2 fitness to practise. 3 THE CHAIR: Can I just pick up on one point because 4 I'm struck by the language that is used in the context 5 of somebody retiring because we've heard the expression 6 used often enough now "voluntary erasure". The latter 7 word implying something dramatic in terms of the 8 register, like effectively the name and details being 9 expunged altogether from public and historic record. Is 10 that what happens or am I reading too much into the word 11 "erasure" than it reasonably can be expected to bear? 12 MR OMO: It is what used to happen and is a feature from 13 when you literally were removed from the register. 14 THE CHAIR: But the historical record -- to pick up the 15 example that you've just been asked about, in which 16 somebody has had interim conditions imposed and 17 subsequently been given, if you will, a clean bill of 18 health at the tribunal, those conditions disappear but 19 if you retire now, does your entire registration history 20 disappear? Are you literally erased from the register 21 or is it now different? 22 MR OMO: So I think if you -- so, the register, because it's 23 different -- done electronically now, will always show 24 whether you've been registered and a bit of the history. 25 I think if you take yourself off the register or retire Page 101	1 need to apply for restoration should you seek to come 2 back, but you cannot do so until five years have elapsed 3 from that date of erasure. 4 Q. And you mentioned a phrase just a moment ago, 5 "disciplinary erasure". What is that sub-species of 6 erasure? 7 A. So it's to distinguish between -- so, voluntary erasure. 8 Many doctors take voluntary erasure because they stop 9 practising, or change in life, or maternity leave, or 10 whatever it may be. And it's perfectly acceptable to 11 say: I'm going to take myself off the register, for any 12 of those reasons. There's no disciplinary fitness to 13 practise case or anything involved in that and no 14 investigation is ongoing. Disciplinary erasure, when 15 I say that, refers to an erasure by a tribunal, where 16 you have been through a disciplinary hearing and they 17 have found your fitness to practise impaired and have 18 found that actually erasure is necessary in that case. 19 Q. And is -- the marking in the record is marked as either 20 a voluntary or a disciplinary erasure depending on the 21 circumstances, those are effectively different outcomes? 22 They're different outcomes, effectively? 23 A. Yes. Yes, different outcomes are marked and if you are 24 removed by a tribunal, that stays on your record 25 effectively for, I think, it's about 30 years. Page 103
1 or erase, it will, depending on whether it's 2 a disciplinary erasure, show that for a period of time. 3 But if you had no disciplinary record at the time, then 4 that entry will disappear as it were. 5 THE CHAIR: Okay, I'll leave that with you. 6 MR DAWSON: Thank you, sir. One final thing before I think 7 we'll have to break for lunch is, you mention at 7.56, 8 and again, this is Mr Massey's statement, that: 9 "If a doctor's fitness to practise is [ultimately] 10 found [by the MPT] to be impaired, a sanction of 11 conditions, suspension or erasure from the register may 12 be imposed." 13 We've touched on all those concepts I think already, 14 but could you just tell us broadly what conditions, 15 suspension or erasure mean? 16 MR OMO: So conditions are restrictions on practice, 17 effectively. So it could restrict or modify the 18 practice or stop a doctor from performing a particular 19 operation or surgery. And so it essentially is 20 a restriction. The suspension means you cannot practice 21 for the period of suspension. Conditions, I should say, 22 can be imposed for up to 3 years. Suspension is for 23 a year, and it means you cannot practice anywhere in the 24 UK certainly for that period. And erasure means that 25 you are removed from the register and therefore would Page 102	1 MR DAWSON: Okay, thank you. Sir, if that would be 2 a convenient moment. I'm going to need to carry on with 3 these witnesses after lunch but, as ever, it may benefit 4 from a bit of a break to work out what I absolutely need 5 to go through. 6 THE CHAIR: Yes, absolutely. Gentlemen, thank you. We'll 7 break for an hour for lunch. If you don't mind, the 8 same formalities in relation to not discussing your 9 evidence apply. If you could be ready to resume in 10 an hour's time it would be appreciated, thank you. 11 (12.44 pm) 12 (The short adjournment) 13 (1.44 pm) 14 THE CHAIR: Ready to resume? 15 MR DAWSON: Yes, thank you, sir. 16 THE CHAIR: Yes, can we have the witnesses back on the 17 screen, please. Gentlemen, good afternoon. If you can 18 see and hear me all right that means you'll be able to 19 see Mr Dawson who will resume his questions now. 20 Mr Dawson. 21 MR DAWSON: Good afternoon. Hopefully you can hear me okay. 22 We were discussing, Mr Omo, shortly before the break the 23 difference between disciplinary and voluntary erasure. 24 And at paragraph 7.58, if we can have that up, please, 25 of Mr Massey's statement. A broad description of the Page 104

1 latter concept is given, where he says: 2 "A doctor may seek removal from the medical register 3 at any time, through a process known as voluntary 4 erasure ([or] VE). While VE is ordinarily a registration 5 decision, if a VE application is made during an ongoing 6 fitness to practise investigation, the decision will be 7 made by two case examiners, unless the case has been 8 referred to an MPT and the hearing has begun, in which 9 case the MPT will consider the VE application. Further 10 detail is set out in the current 'Guidance on making 11 decisions on voluntary erasure applications [which 12 you've provided]. We provide further information about 13 the voluntary erasure process that was in place during 14 the Inquiry's timeline of interest as part of our 15 response to Part E." 16 Which we'll come on to later. Is it -- as far as 17 voluntary erasure is concerned, is voluntary erasure the 18 means by which a doctor would have his registration 19 removed from the register in circumstances where he was 20 retiring? 21 MR MASSEY: Typically, yes. 22 Q. So would that then be -- no doubt there are applications 23 of that nature that come up every so often the GMC 24 wishes to deal with and it would be the norm then -- the 25 majority of the applications would fall into that Page 105	1 would also consider the doctor's health and likely 2 return to practice, including the likelihood of a return 3 to practice outside the UK. 4 Q. So just to be clear, where an application of this nature 5 is made there are two options, as I understand it, 6 either the voluntary erasure application can be granted 7 which has the result of the doctor's name being removed 8 from the register and it being marked as voluntary, is 9 that right; that's the first option? 10 A. Yes. 11 Q. The second option would be to refuse the application 12 because there would be a preference, in some 13 circumstances, for erasure to be sought by other means; 14 is that correct? 15 A. Yes, that's correct. 16 Q. Are there any other options? I mean, one can't, 17 presumably, have the doctor remain on the register 18 forever against their will. Are there any other options 19 that exist? 20 A. No, in terms of a voluntary erasure decision, it's 21 a binary "yes" or "no" decision that's made. 22 Q. And is "no" always in circumstances where the GMC 23 considers it appropriate for there to be a process which 24 may result in disciplinary erasure? Is that the only 25 other alternative? Page 107
1 category; would that be fair? 2 A. Yes, I think that would be absolutely fair. 3 Q. Obviously we'll get on to the circumstances of the 4 voluntary erasure applications in Mr Eljamel's case. 5 But is it fair to say that -- is it the case that those 6 who deal with those applications within the GMC are 7 aware that there are other circumstances in which 8 voluntary erasure can be sought and that one shouldn't 9 simply sort of wave it through in a way that might be 10 appropriate in circumstances where someone is retiring? 11 A. So if there is an open fitness to practise case, the 12 voluntary erasure decision will be referred to our 13 fitness to practise case examiners. 14 Q. And so why is that the case? If there's a live case 15 going on and someone wants to effectively stop being 16 a doctor, why is that dealt with in that way rather than 17 in the way that would be the case if there were no 18 ongoing fitness to practise investigation? 19 A. So if there is an open fitness to practise question, it 20 goes to our fitness to practise colleagues because they 21 need to consider firstly, the public interest and 22 whether the public interest means that the case -- the 23 voluntary erasure should not be granted and the case; 24 examiners' option then would be about whether or not to 25 refer it to a medical practitioner tribunal and they Page 106	1 A. That is the only alternative that I can think of, yes. 2 Q. So you mentioned a moment ago circumstances in which the 3 voluntary erasure may be refused as being ones where, 4 for example -- or typically being a situation where 5 there was an ongoing fitness to practise process and 6 you've explained why that might be a decision that would 7 be taken. What about circumstances in which there would 8 be reason to doubt the validity of the application or 9 material contained within it, based on a history of 10 information that was available to you? So, for example 11 if we look at Mr Eljamel's case, ultimately in 2005 when 12 there -- 2015 when the application came in, it was 13 granted -- and we'll look at the circumstances of 14 that -- and there was no ongoing fitness to practise. 15 So that would be the first scenario, I think, that you 16 pointed out, the more straightforward scenario; is that 17 right? 18 A. Yes, theoretically, of course. There was an open 19 fitness to practise case in his case. 20 Q. Well, I wanted to get to that with you, but in 21 circumstances where you had information available to 22 you, for example, as was the case with Mr Eljamel, there 23 had been -- it had been deemed appropriate to grant 24 an interim order, there had been consideration given to 25 that, as we've discussed already, there were issues Page 108

1 around probity, candour, honesty, which are of course 2 very important. Would any of those factors be factors 3 that could take you from the classic, normal, this is 4 someone retiring situation, and put you in the other 5 type of situation where the application should be 6 refused and the only other alternative avenue can be 7 pursued, ie erasure via a disciplinary route? 8 A. Yes, that is entirely the set of factors that case 9 examiners will be balancing when they make that 10 decision. They will also be reflecting on the degree to 11 which all of the evidential requirements can be proved, 12 if pursuing it through a medical practitioner tribunal 13 process because it's worth remembering even where we 14 decide that we want to seek erasure through a medical 15 practitioner tribunal, that is not a guaranteed outcome 16 because that tribunal will make its own decisions based 17 on our ability to present the evidence. 18 Q. Yes, so in the same way as Mr Omo described that there 19 are various requirements to assess the strength of the 20 case, as one goes through, against the standards and 21 likelihood of success, that's a factor here too because 22 if you think: well, it's pretty unlikely there's going 23 to be a disciplinary erasure, then that would be 24 a factor in deciding to allow the voluntary erasure; is 25 that right? Page 109	1 MR MASSEY: Yes, we can. 2 MR DAWSON: Sorry for the slight delay. The position that 3 we've reached is that I have asked you a question, 4 Mr Massey, and we for various reasons have had to stop 5 the feed meaning that your answer has been cut out, 6 although there's nothing that you said that causes any 7 difficulty at all. So what you've said -- 8 A. Yes, okay, that's helpful because we weren't quite sure 9 what the breach would be. 10 Q. Yes. It is, as you can imagine, is in the area of 11 family circumstances but nothing that you have said is 12 an issue at all, therefore effectively I'll ask you the 13 question again because your answer has been expunged and 14 you are free to answer in the same way if you wish to do 15 so. Is that clear? 16 A. Okay, that's fine. 17 Q. So I was asking you -- what I said was: the particular 18 aspect, just to put it in to sharper context with 19 Mr Eljamel's case, is the suggestion that he was 20 retiring and wasn't going to practice any more. It's 21 possible that that is a proposition which we now know -- 22 that's a proposition which we now know hasn't been the 23 reality but is one that could have been challenged. Its 24 validity could have been challenged by the case 25 examiners based on the fact there was a history here of Page 111
1 A. Yes, and the other factor in the decision-maker's mind 2 will be a voluntary erasure process does have 3 an immediacy in terms of stopping that doctor from 4 practising in the UK and a guaranteed outcome of that in 5 a way that proceeding through a medical practitioner 6 tribunal doesn't provide that same guarantee. 7 Q. Because the particular aspect -- just to put it in to 8 sharper context, the particular aspect that 9 I'm interested in is, to put it in Mr Eljamel's case, 10 the suggestion that he was retiring and wasn't going to 11 practice any more, it's possible that that is 12 a proposition which we now know hasn't been the reality 13 but is one that could have been challenged, its validity 14 could have been challenged by the case examiners based 15 on fact that there was a history here of him not being 16 honest, lacking probity and not being candid with bodies 17 or individuals with whom he ought to have been? 18 (1.55 pm) 19 (A short break) 20 (2.05 pm) 21 THE CHAIR: Right. 22 MR DAWSON: So, if we could just have the witnesses back, 23 I can explain where we've got to. 24 THE CHAIR: Yes, surely. Here they are, in fact. 25 MR DAWSON: Hello gentlemen, can you hear me? Page 110	1 him not being honest, lacking probity and not being 2 candid with bodies or individuals with whom he ought to 3 have been. 4 A. Yes, and indeed, we know that that judgment turned out 5 to have been mistaken. It's probably worth making a few 6 points. Firstly, obviously the case examiners will have 7 been aware of all of those allegations of probity but of 8 course at the point they made the decision, those were 9 still technically unproven. But I think more to the 10 point. They took at face value two things. Firstly, 11 that Mr Eljamel had left practice over a year before, 12 when he had essentially stepped down from practising at 13 Tayside and in his private work. And secondly, that 14 they had in front of them what they will have found 15 quite compelling in terms of his personal family 16 circumstances with the recent death of his son and the 17 difficult diagnosis and prognosis for his wife which 18 meant that he would be providing full-time caring 19 responsibilities. 20 As I said, that turned out to be a mistaken judgment 21 that our case examiners made, but knowing what they did 22 at the time, I think it is understandable why they took 23 that at face value, albeit that was in fact wrong. 24 Q. Okay, so do we -- I think we've covered this already, 25 but I don't think we know, as a matter of fact, that Page 112

1 they did weigh up the circumstances that you've put 2 forward against the allegations of lack of probity. It, 3 as you've said, no doubt will have been part of the 4 paperwork, but do we actually know that they carried out 5 that exercise? 6 A. So we know that in terms of the investigation there was 7 one element of the concerns that had been raised 8 particularly through the Royal College of Surgeons 9 report that we didn't follow up on in the way that 10 I think we would today and that was in relation to 11 allegations around bullying. There were concerns around 12 probity that did form part of the investigation. Those 13 related to allegations that Mr Eljamel had worked 14 privately whilst on-call for NHS work and what is 15 written in some of the evidence is that that was 16 a recurrent problem, had previously been the case. That 17 was quite hard for our case examiners to follow through 18 because we were also told by NHS Tayside that there was 19 no paper trail of that, so that would have been quite 20 difficult for us to pursue evidently. Though I think we 21 perhaps might have pushed harder at that now than we did 22 then. 23 And then there were two issues in relation to 24 wrong-site surgery, with the allegation that Mr Eljamel 25 had been dishonest in what he said to patients. And in Page 113	1 described were part of the cases that had been 2 considered by our experts and those cases and the 3 consideration by experts was evidence that the case 4 examiners looked at in terms of reaching their decision. 5 But that's my inferring, through the evidence that they 6 had from the expert report, rather than the rationale 7 that they expressed explicitly in their decision. 8 Q. Just on one point of detail, just to clarify. You 9 mentioned a moment ago there had been an investigation 10 in relation to evidence that Mr Eljamel had I think you 11 said repeatedly worked privately whilst on-call in his 12 NHS practice and you said that an issue arose with that 13 in that NHS Tayside were not able to provide documentary 14 evidence of that. When would an NHS health board ever 15 have documentary evidence of someone working privately 16 whilst on-call with them? 17 A. So, there was no -- so, there was evidence in terms 18 of -- potentially in terms of theatre logs, also 19 evidence and recordings of the conversations that had 20 taken place. So we were told that it had been 21 a recurring event and that he was reprimanded by the 22 associate medical director in 2012 and we asked them for 23 evidence of any of those conversations or any of the 24 evidence that they had put to Mr Eljamel to that 25 allegation in relation to working privately whilst Page 115
1 one of those, the doctor -- the doctor's evidence was he 2 had apologised and the other one was where he said he 3 had taken that decision in the best interests of the 4 patient. 5 So those probity concerns were there but they 6 weren't so easily proven as we might believe, knowing 7 everything we know now about Mr Eljamel's practice, than 8 was actually in the eyes of the case examiners at the 9 point they made that decision to grant voluntary 10 erasure. 11 Q. Understood. So there was a certain body of information 12 which was available to them. It might not be as much 13 information as they would have got now because it would 14 have been investigated more fully and more information 15 might have been obtained, but my question was 16 specifically whether the probity concerns were taken 17 into account in assessing the veracity of his assertions 18 about his future practising intentions? 19 A. So it's quite hard to answer that because the rationale 20 expressed in the case examiner decision doesn't 21 explicitly cover off the probity and public confidence 22 questions in the way in which I might expect that to be 23 expressed today. My belief is that that will have been 24 part of their considerations given that the two probity 25 concerns in relation to patients that I have just Page 114	1 on-call and we were told that there was no material that 2 Tayside was able to provide to enable us to consider 3 that probity allegation. And that made it very 4 difficult for our case examiners in terms of pursuing 5 that probity concern which, as we were discussing 6 earlier, we need to provide evidence for in order to 7 make that count in terms of any future tribunal process. 8 Q. Would they know, at that stage of the process, whether 9 that matter was disputed by Mr Eljamel? 10 A. I don't know because we haven't got any of the 11 materials. We do know that he was reprimanded because 12 that's what we were told. We do know that it was 13 referenced in the Royal College of Surgeons report. 14 Arguably, we could, or potentially should, have followed 15 up with the authors of the Royal College of Surgeons 16 report to see whether they had any evidence, given that 17 Tayside told us that they had none. But we would expect 18 any health board or health trust to record any such 19 concerns. It is a serious probity question for a doctor 20 to be working privately whilst they're on-call for the 21 NHS and we have taken action on doctors licences where 22 we found that in different cases but we were unable to 23 do so in Mr Eljamel's case because of that evidential 24 vacuum. 25 Q. Thank you for that. One question which I think Page 116

1 underpins a lot of these questions around the 2 decision-making relating to the voluntary erasure is 3 what difference, as far as you understand from a GMC 4 perspective, which is important, would it make in terms 5 of the likelihood of someone being able to practice at 6 another time in the future in another country as to 7 whether someone had had a disciplinary erasure or 8 a voluntary erasure? 9 A. So it's a decision for individual overseas regulators to 10 make in terms of how they take account of decisions on 11 doctors' licences in different jurisdictions. I think 12 it would be fair to say that a doctor who had been 13 erased through a tribunal process would raise more 14 concerns for an overseas regulator than one that had 15 essentially taken the voluntary erasure route. 16 And that is why we do, and did, have quite extensive 17 notification arrangements. As I'm sure you are aware -- 18 and this was a mistake that was made at the GMC -- when 19 the interim order restriction took place on Mr Eljamel's 20 practice, we published that in our monthly decision 21 circular. That would have been freely available to 22 regulators all over the world. What we also do is we 23 notify relevant regulators, which will include 24 regulators in placing doctors' primary medical 25 qualification and there was a human error where a search Page 117	1 wished to make any distinction between the two. 2 But it is, I think, also a matter which is important 3 to consider within the GMC process itself because if the 4 GMC is of the view, well it doesn't really make any 5 difference whether we do voluntary erasure or not 6 because everyone will treat that the same 7 internationally, then that would mean one might approach 8 matters in a certain way. But if it really did make 9 a difference and there was evidence, for example, that 10 a significant number of regulators would make 11 a distinction with regard to someone's ability to 12 practice in another country, that would be a factor 13 which would weigh into the decision-making. Is that 14 a fair assessment at least? 15 A. It is, and indeed it is this case that gave -- that 16 essentially formed more recent guidance that we provide 17 for our case examiners, and what we now say, that we 18 didn't at the time that voluntary erasure was granted to 19 Mr Eljamel, is, and I quote: "Where there is information 20 that indicates the doctor is already working outside the 21 UK or there is evidence that suggests that they are 22 likely to work outside the UK, this will weigh against 23 granting voluntary erasure". 24 Q. Okay. Thank you. There are some documents which 25 I'd like to go through quickly with you relevant to the Page 119
1 was made for Al-Fateh. So Mr Eljamel qualified from the 2 University of Al-Fateh in Libya, and when a member of 3 staff made the search for Al-Fateh, they discovered 4 a place, Al-Fateh, in Saudi Arabia and therefore the 5 Saudi Arabian regulator was notified rather than the 6 Libyan regulator which, as I say, was a mistake which we 7 very much are sorry for. And that mistake was 8 essentially able to be rectified at the point that 9 Mr Eljamel was granted voluntary erasure but 10 unfortunately it was not picked up and again it was the 11 Saudi Arabian regulator that was notified of that 12 voluntary erasure rather than the regulator in Libya. 13 I should say we take our information sharing 14 responsibilities very seriously. We didn't know that 15 we'd made that mistake until much later, I think it was 16 2023, at which point we notified the Libyan regulator 17 but we received no correspondence back from them to 18 acknowledge that or demonstrate that they were aware of 19 us having written to them but it was our best efforts to 20 do so. 21 Q. Okay, thank you. Just on the subject of whether it 22 would make a difference ultimately in that scenario, if 23 there was voluntary or disciplinary erasure. You say 24 correctly, as I understand it, that that's a matter for 25 the foreign regulator to determine, so whether they Page 118	1 process by which we got to that point, the first of 2 which is a document number GMC-00024, please. This 3 I think is a note of a meeting which took place on 4 10 December 2013, is that right? 5 A. Yeah, that's right. Yeah. 6 Q. And this is a meeting between the medical director of 7 NHS Tayside and Mr Paxton, whom you mentioned earlier 8 who was the ELA for Scotland, is that right? 9 A. Correct, yes. 10 Q. At this time, and now I suppose, is there just one ELA 11 for Scotland; is that right? 12 A. Yes, that's right. 13 Q. Okay. Could we go to -- so this is a meeting in which 14 there were discussions which touched upon the situation 15 with Mr Eljamel, is that right? 16 A. That's right, yeah. 17 Q. And is this the first time that the information was 18 shared with the GMC? 19 A. This is the first time that we had any record of 20 Mr Eljamel's name coming up in conversations that we had 21 with NHS Tayside, yes. 22 Q. Thank you. So would it be normal for the first 23 intimation of these concerns be some information to be 24 conveyed at a meeting like this, would it have been 25 normal at that time? Page 120

1 A. Even at that time we would have hoped and expected to 2 have heard earlier engagement about Mr Eljamel. I think 3 I mentioned earlier -- 4 Q. Yes, you did. 5 A. -- we would have expected conversations to have happened 6 when Tayside was considering inviting the Royal College 7 of Surgeons to do their review, it should have been 8 an issue that was certainly put on to our ELA's radar at 9 that point in time. So it was unusual even then. It 10 would be very unusual now. 11 Q. Okay. Could we go to page 6, please. Further down, 12 please. 13 THE CHAIR: Can I just, while we're looking for that, 14 Mr Massey, just clarify. 15 I'm conscious that you said that Mr Paxton only came 16 into his position at the beginning of that year, 2013. 17 Can I take it though that by the middle of that year he 18 would have been sufficiently embedded and the process 19 sufficiently understood within the profession that he 20 would have been in a position to receive the kind of 21 information that you would have expected to be provided 22 but wasn't? 23 MR MASSEY: Yes, I believe so, yes. 24 MR DAWSON: Thank you. This is a part of the note of the 25 meeting where I think there are some discussions about Page 121	1 Q. Thank you. It would have been entirely open for 2 Dr Russell or NHS Tayside to have suspended Mr Eljamel 3 at any earlier stage, completely within their powers to 4 do so; is that right? 5 A. That is right and indeed, they had placed some 6 restrictions on his practice in June, I believe, when 7 they commissioned the Royal College of Surgeons review. 8 Q. Just in case there was any suggestion that one has to 9 speak to the GMC first before one does that ...? 10 A. No, you don't. 11 Q. One doesn't, thank you. 12 A. No, it's entirely -- and indeed, as it should be, 13 employers need to be able to make early decisions about 14 restricting doctors' practice if they believe there is 15 harm that might arise to patients. 16 Q. And it notes there I think, if we just go a little bit 17 back to where we were, it talks about Dr Russell having 18 chaired a significant event analysis and that that, it 19 would appear, gave rise to serious concerns; is that 20 right? 21 A. Indeed, yes. 22 Q. Could we go back to the statement, please, at 13.2. You 23 explain there what happened next. 13.2: 24 "NHS Tayside then made a formal referral to the GMC 25 regarding Mr Eljamel's professional practice on Page 123
1 various ongoing issues and we get to letter C, where it 2 says: 3 "Confidential discussion re local Neurosurgeon. 4 "AR ..." 5 That's Dr Russell: 6 "... had chaired significant event analysis 7 following evidence of wrong level surgery -- serious 8 concerns. AR commissioned external RCS review into 9 performance of local Neurosurgeon. In addition to 10 performance concerns, issues of probity regarding 11 gaining informed consent from patients subject to 12 second, corrective surgical procedures. AR has 13 restricted current practise and will meet surgeon to 14 suspend today ..." 15 Do we understand that that's a conversation about 16 Mr Eljamel? 17 A. Yes. 18 Q. And it says there "10 November", but I think it should 19 say 10 December which is the date of the meeting, is 20 that right? 21 A. I think that is a typo in the note as the meeting took 22 place on 10 December, yeah. 23 Q. Okay, thank you. So Dr Russell is intimating his 24 intention to suspend Mr Eljamel that day? 25 A. That is what the note suggests, yes. Page 122	1 29 January 2014, following the conclusion of the RCS's 2 external review. Their referral included a copy of the 3 RCS report and supporting documentation for us to 4 consider as part of the initial triage process. 5 NHS Tayside's referral form and supporting evidence 6 (including the RCS report) is set out ..." 7 And you have provided that to us. It then goes on 8 to say, 13.3: 9 "Following receipt of this referral, we opened 10 a fitness to practise investigation into Mr Eljamel and 11 referred him to the ... (MPTS) for an Interim Orders 12 Tribunal (IOT) to consider whether an interim order was 13 necessary for the protection of members of the public or 14 otherwise in the public interest. The IOT can impose 15 an interim order that either temporarily suspends a 16 doctor from practising or attach conditions to limit a 17 doctor's practice. The GMC sought the imposition of 18 conditions given the range of issues raised in the RCS's 19 external review report and Mr Eljamel's apparent 20 inability to sustain changes in his practice. An IOT 21 considered the concerns raised about Mr Eljamel and 22 imposed interim conditions on his practice." 23 We've touched on the procedure for the interim 24 orders already but is it always the case that there's 25 consideration of interim orders or is that only in cases Page 124

1 where there is a kind of prima facie basis for thinking 2 that they would be appropriate? 3 A. Well, it would always be a question that we need to 4 consider with any doctor that we're promoting for 5 investigation. In relation to Mr Eljamel, there was 6 such a weight of evidence that I think it was -- 7 I'm inferring here into terms of the paperwork I've seen 8 but there's such a weight of evidence in the Royal 9 College of Surgeons report that I think it was a very 10 rapid decision that we should be making a referral to 11 the interim orders tribunal. 12 Q. When you say there, it's of interest to us, Mr Massey, 13 you must see a lot of these things and Mr Omo as well, 14 in your work. When you say there's such a lot of 15 evidence. Can you give us kind of an impression because 16 it's slightly difficult for many of the people involved 17 who are not involved in the regulation of doctors' 18 practices on as regular a basis as you both are to 19 understand, when one reads the Royal College of Surgeons 20 report, really how bad is that? 21 A. So obviously at that time we hadn't got our expert 22 report, but essentially many of the enquiries we get in, 23 or the referrals we get are single incidences of alleged 24 poor clinical care or poor behaviours. What we had with 25 the Royal College of Surgeons report was a report that Page 125	1 proceedings taken against you ..." 2 Scroll down a bit, please. It says: 3 "You must inform the GMC if you apply for medical 4 employment outside the UK. 5 "You must confine your medical practice to posts 6 within the National Health Service and not undertake any 7 private practice." 8 It says: 9 "You must not carry out any spinal surgery. 10 "You must inform the following parties that your 11 registration is subject to the conditions, listed at (1) 12 to (6), above. 13 " ... Any organisation or person employing or 14 contracting with you to undertake medical work. 15 "... Any locum agency or out-of-hours service[s] ... 16 "... In the case of locum appointments, your 17 immediate line manager ..." 18 And: 19 "... Any prospective employer or contracting body 20 (at the time of application)." 21 Were you able to ascertain, in the investigation 22 that you've conducted for us, why it was that the 23 limitation on Mr Eljamel's ability to carry out surgery 24 was limited to spinal surgery? 25 A. I couldn't answer that question with any certainty. Page 127
1 brought together many cases and raised questions in 2 relation to the clinical care provided to patients, it 3 raised concerns about the consenting of patients, it 4 raised concerns around probity, and honesty of 5 Mr Eljamel and it also raised concerns about 6 Mr Eljamel's behaviour and engagement with colleagues. 7 So it engaged a range of factors on a number of cases 8 that I would deem to be pretty unusual in terms of what 9 constitutes a referral and that's what I'm referring to 10 when talking about the body of evidence. 11 Q. Thank you, that's helpful. Am I right in recalling 12 there was evidence related to 16 cases, is that right? 13 A. Yes. 14 Q. Yes, thank you. Could we have a look at GMC-00202, 15 please. Could we go to page 3, please. This is 16 a letter setting out the decision of the interim order 17 tribunal and it sets out there what the various 18 conditions are that are being imposed for a period of 19 18 months, as follows. There are certain notification 20 requirements relating to: 21 "... any professional appointment you accept [for] 22 registration with the GMC ... 23 "... allow the GMC to exchange information with your 24 employer or ... contracting body ... 25 "... inform the GMC of any formal disciplinary Page 126	1 I don't know, Anthony, if you can? 2 MR OMO: No, I think that's what we thought was the main 3 area of concern at the time, so removing his ability to 4 carry out any spinal surgery seemed to be a response to 5 the risk, but that was what the interim orders tribunal 6 decided. We don't tell them the conditions to impose. 7 Having considered our argument about the need for 8 an order and the doctor's response, they would then 9 decide what they think are the relevant conditions. 10 MR DAWSON: Right. It's just you've told us, in your own 11 assessment of the evidence available, that although of 12 course the focus of the cases that had gone to the Royal 13 College of Surgeons review had been spinal in nature, 14 there were wider concerns, more all-encompassing 15 concerns one might imagine, about Mr Eljamel's practice 16 which would have been relevant to all surgery that he 17 undertook. So obviously you can't tell me what the 18 thinking was of the interim orders tribunal, but what 19 I'm seeking to ascertain is there was a clear basis upon 20 which this order could have been imposed in relation to 21 all surgery; isn't that correct, at least a basis? 22 MR MASSEY: So I think it could have been. But it's also 23 worth bearing in mind whilst there were very serious 24 allegations made at this point in time, they were still 25 allegations on which we needed to form a judgment. And Page 128

1 I think when we seek conditions to be placed on 2 a doctor's practice through an interim orders tribunal, 3 we're conscious that we want to make sure that we're 4 able to achieve something. And for good reasons, the 5 tribunal will apply a relatively high bar in terms of 6 placing restrictions on a doctor's practice when we 7 haven't been able to pursue all of our investigative 8 activities. So I am speculating because I was not there 9 and don't know what the conversations were as part of 10 that tribunal process, but I suspect the judgment was 11 made that, given the nature of the concerns and the 12 nature of Mr Eljamel's practice in spinal surgery, that 13 was the thing that they really wanted to focus on. But 14 that is my speculation rather than based on having 15 a firsthand understanding of that. 16 Q. Okay and it imposes various obligations on Mr Eljamel 17 I think to tell various organisations that might employ 18 him or come into contact with him about that situation. 19 Is that something followed up by the GMC in terms of 20 does he have to provide evidence he has done that, or 21 you just impose that and assume that he has done it? 22 A. Well, we impose that but, of course, we had already, at 23 the point that the referral came in, we sought evidence 24 from all of the employing organisations which, at that 25 time, was BMI Fernbrae as well as NHS Tayside. So Page 129	1 restored and if there are any extant investigations we 2 would need to consider that at that time. 3 Voluntary erasure, likewise, if he was to come back 4 into practice in the UK, we would have wanted to pick up 5 any unfinished business in terms of fitness to practise 6 investigations. But neither of those bite in the way in 7 which we might ideally want them to, in terms of binding 8 any overseas regulators. 9 Q. But you did explain earlier that in the period after 10 someone's registration has been erased, although of 11 course that individual is no longer regulated because 12 they're no longer a doctor by the GMC, the GMC does 13 retain certain interests and obligations pertaining to 14 that now former doctor. So for example, it would 15 promulgate information, as you said, it would respond to 16 queries from foreign agencies about any information you 17 have on your records. So in those circumstances, even 18 although someone has voluntarily erased their name, 19 would it not be possible to have an erasure, but with 20 a condition attached to it that someone would need to 21 get in contact with you if they were wishing to do 22 something somewhere else? 23 The reality of that is because it would be 24 legitimate for someone to apply to be a doctor in 25 another country. It's not as if you simply can't do Page 131
1 BMI Fernbrae were already aware of the ongoing 2 investigation into Mr Eljamel. So, yes. So, that was 3 already something that we had done. 4 Q. And there is the obligation there about needing to 5 inform the GMC if you apply for medical employment 6 outside the UK. Are you aware of Mr Eljamel ever having 7 notified the GMC of any application for employment 8 outside the UK? 9 A. I am not aware of any in this period, no. 10 Q. So there was no evidence of that in your searches? 11 A. No. 12 Q. And does an obligation of that nature remain extant, if 13 you like, when someone has been erased from the 14 register? Are there any obligations about him telling 15 you that he was not going to work again and then is 16 there any obligation on him to tell you later that, in 17 fact, he is going to work? 18 A. So, as we were talking about earlier the voluntary 19 erasure, when that was granted, superseded the interim 20 order conditions that we're talking about here. And 21 this is where voluntary erasure is different from 22 disciplinary erasure that we discussed earlier. So if 23 somebody is erased through the tribunal process, they 24 are not able to practice during five years and after 25 that five years, they can apply to have their licence Page 130	1 that, it, as you say, would be a matter for the foreign 2 regulator. But if everything were being done above 3 board, it would be right, I think, for the GMC to be 4 informed of that and to be given the options to whether 5 they wanted to pass any information about that on to the 6 new regulator. Is that a concept which has ever been 7 contemplated? 8 A. I'm not sure. I defer to Anthony on this one. 9 MR OMO: No, I don't think it has. I don't think it has 10 been and I take the point. I think -- in the same way 11 when doctors come from overseas, I think what our 12 expectation is that the regulator who is thinking of 13 adding them to the register, will carry out this due 14 diligence, in the same way we would ask whether he had 15 been regulated elsewhere and would seek then 16 a certificate of good standing from that regulator or 17 for the doctor by that. 18 So, I think we don't think do it in the way you 19 describe in terms of us requiring the doctor to do it 20 because we have no locus or power to enforce that, 21 should they not do it. But our expectation and many of 22 the regulators we work with have similar systems where, 23 in the doctor's application, they need to say where 24 they've been, what they've done, etc. And they reach 25 out or they can access our website, where they will get Page 132

1 information or reach out and they'll get other 2 information from us directly. 3 Q. Okay. So you've told us that what happened was that the 4 interim orders were part of a medical disciplinary 5 investigation that was going on. One thing that's not 6 immediately clear to us, I think, is how that 7 investigation came to an end and how long it went on 8 for. Is that something you can help us with? 9 MR MASSEY: I can probably have a go and Anthony may want to 10 supplement. So we had a number of concerns raised 11 during this period. So the key referral that drove the 12 investigation was coming out of that meeting on 13 10 December and the formal referral that we received 14 29 January 2014. In terms of the process of the 15 investigation thereafter, we needed to commission our 16 own expert report on those cases covered. And as is 17 normal practice and remains normal practice in the GMC, 18 advice was taken from one of our medical case examiners 19 as well as our investigation officer on which cases we 20 would put to an expert who is a practitioner, in this 21 case an eminent neurosurgeon, who would provide their 22 own verdict in terms of the care provided by Mr Eljamel 23 and indeed the other concerns that were raised. 24 And the expert was asked to opine on eight other 25 cases. So we had the original sixteen from Tayside. Page 133	1 "His second application was lodged 9 June 2015. It 2 was considered by [case examiners] in light of the 3 ongoing fitness to practise investigation and was 4 granted 4 August 2015." 5 And you sent in a copy of the application and the 6 decision. And so it is the case, as I understand it, 7 that in both the first and second applications there was 8 an ongoing fitness to practise investigation, is that 9 right? 10 A. Yes. Yes. 11 Q. So when we discussed this earlier we talked about the 12 fact that there would be two potential routes available. 13 One would be granting the application, the other would 14 be continuing with an ongoing fitness to practise 15 application. But in both cases -- in the first case the 16 decision was that the GMC wished to continue with the 17 ongoing fitness to practise application, or 18 investigation. But in the second, even though one was 19 going on, it was decided not to do that. And is that 20 for the reasons that we've discussed about the weight 21 given to other evidence, about family circumstances and 22 his intentions and the passage of time, the fact he 23 hadn't been working and that sort of consideration? 24 A. So that's part of it. So the first application was 25 refused because our investigations were incomplete. So Page 135
1 Actually, there were kind of nineteen cases that the 2 medical case examiner looked at in determining which 3 ones to ask the expert to look at. And the expert 4 looked at eight of those, five of which related to 5 wrong-site surgery and then there was a further case 6 from BMI Fernbrae that was raised -- that was added at 7 a later period in time. 8 That expert report, from memory, I think was 9 completed in late 2014. In the meantime, there were one 10 or two further complaints that were made including into 11 the early part of 2015. But it was around kind 12 of May/June/July 2015 that the case examiner was looking 13 and putting all of this together and it was during that 14 period that Mr Eljamel submitted his second application 15 for voluntary erasure which was then granted 16 in August 2015. 17 Q. Okay. The position I think, as far as the voluntary 18 erasure application is concerned, is he applied for 19 voluntary erasure twice; is that right? 20 A. That's right. 21 Q. The first I think was lodged 27 March 2014, refused by 22 the GMC on 18 June; is that correct? 23 A. I believe so, yes. 24 Q. It's paragraph 22.10 of the report, if that's helpful. 25 And at 22.11, it says: Page 134	1 we hadn't got -- had the expert report that I just 2 described, and therefore it was much harder, in that 3 first VE application, to have made any assumption or 4 drawn any view about where the investigation might lead. 5 By the time that Mr Eljamel had made the second 6 application for voluntary erasure we had received that 7 expert evidence, we had been able to send a formal 8 allegation -- so Anthony described the process. 9 Earlier, when we complete a report we then send our 10 allegations to a doctor and the doctor then has a chance 11 to respond. And indeed, Mr Eljamel's representatives 12 responded on his behalf, I think on 2 April 2015 which, 13 again, indicated his intention to reapply for voluntary 14 erasure. 15 So by the time that the second voluntary erasure 16 decision was made, those processes were complete. There 17 was, I believe -- and forgive me as I just check my 18 references -- a further complaint that had been made 19 which was still open as an investigation at that point 20 in time and that was a complaint made -- a referral made 21 on 8 May 2015 from BMI Fernbrae relating to another 22 indent of wrong-level surgery carried out in April 2013 23 and that was promoted for investigation. 24 The voluntary erasure decision took account of that 25 but recognised that that was a case that had still not Page 136

1 been concluded at the point that the VE decision was 2 made and -- this is now me reading into the kind of 3 rationale for the decision-maker -- but I suspect some 4 of those family circumstances, personal circumstances, 5 the fact that Mr Eljamel had not been practising for 6 over a year, will have weighed in the case examiner's 7 mind. Albeit, as I said earlier, that those turned out 8 to be mistaken, given what subsequently happened. 9 Q. Was prominence, as you understand the documentation, 10 given in the decision-making in 2015 -- and I suppose in 11 2014 too -- to the importance in terms of the 12 regulation -- the legal regulation underpinning these 13 matters, that what the GMC needs to focus on is the 14 current issues with regard to the doctor's ability to 15 deliver medical services to the public? "Current and 16 ongoing" I think is the expression? 17 A. Yes, so I am slightly reading into the mind and I'm at 18 risk of kind of getting into the realm of speculation. 19 I mean, my sense is that the case examiner at the time 20 judged the factors to be finely balanced, but 21 considering that the doctor had retired, had full-time 22 caring responsibilities and that whilst the expert 23 report that we commissioned found that five of those 24 eight cases, the care provided was seriously below, some 25 of those issues in relation to probity were not easily Page 137	1 Q. You mentioned there -- that's a helpful summary of what 2 you understand was going on. You mentioned the standard 3 which might have been applied was one of certainty. 4 That would be the wrong standard, wouldn't it? 5 A. Yes, sorry, the point I'm trying to make is that the 6 case examiner will be balancing the lack of certainty 7 about an outcome by deciding to refer a case to 8 a medical practitioner tribunal decision, from the 9 certainty that would be provided by granting a voluntary 10 erasure decision in that moment. So that's what I was 11 just trying to compare and contrast. 12 Q. Okay. I'm just keen on trying to probe this is little 13 bit further because my understanding from your 14 impression, which you've helpfully given to us, 15 Mr Massey, about how bad even the Royal College of 16 Surgeons' report looked, you've told us that there were 17 serious concerns in five out of the eight cases looked 18 at by the expert whom you had instructed and that 19 although there were difficulties in proving aspects 20 related to probity, I think you say that there were 21 still concerns in that regard. And of course, the next 22 stage of the process would have been precisely where 23 those could have been proven, by trying to lead evidence 24 that might support them one way or the other. 25 So in these circumstances would it not be the case Page 139
1 proven, partly because of the issues I've already 2 described in terms of the lack of any documentation from 3 Tayside in terms of his private practice, but the 4 probity concerns in relation to dishonesty actually were 5 quite complicated to reach a binary view on. 6 And I imagine the case examiner will have taken 7 a view that, yes, of course we can proceed to a medical 8 practitioner tribunal, but we can't have certainty or 9 necessarily absolute confidence in what the outcome of 10 that would be. And given that, voluntary erasure would 11 have been within the bounds of reasonable decisions that 12 the case examiner can make, bearing in mind that they 13 don't know all the things we all know now about 14 Mr Eljamel's practice and that decision on voluntary 15 erasure would provide an immediate protection, at least 16 to patients in the UK in terms of the prospects for 17 future practice. 18 That, I believe, is what is in their mind, but 19 I have to say I am speculating on that because the 20 rationale set out in the decision, which you've seen as 21 part of the evidence pack, doesn't really unpack the 22 degree to which I might have liked or you might have 23 liked those questions around probity and the 24 consideration of public confidence in the decision that 25 the case examiner made. Page 138	1 that, although perhaps the standard of certainty 2 wouldn't be met, that it was highly likely that 3 a disciplinary erasure would have been imposed given the 4 severity of what evidence there was? 5 A. I can't really speculate as to the level of confidence 6 they would have. I do believe, in relation to those 7 probity questions -- and this is probably an area that 8 is easier for me to speak to -- that if we were in that 9 situation today, I would feel that it would be much more 10 likely that we would have probed those probity concerns 11 to a much greater degree of detail than we did at the 12 time. So although I described the lack of documentary 13 evidence from NHS Tayside, I think we probably could 14 have done more and probably would, today, in terms of 15 engaging with the Royal College of Surgeons about the 16 probity concerns that they raised. 17 I think I said earlier that one of the questions 18 raised by the Royal College of Surgeons' report related 19 to bullying. That wasn't one of the grounds that we 20 explicitly sought evidence for in that investigative 21 process. Again, today I think we would. I can't 22 speculate on what the outcome of that additional probing 23 would have been around those probity allegations and the 24 bullying allegations, but I do believe we would have 25 looked at them much more closely if the situation arose Page 140

1 today. 2 Q. Okay. Given that you've helpfully taken it that far, do 3 you think it's likely a different decision would have 4 been taken today, if I put it in those terms? 5 A. I really couldn't say because that would really depend 6 on the outcome of that further probing. We certainly 7 take those probity concerns very seriously and I think 8 had that further probing been able to uncover a stronger 9 evidential base, then it's entirely conceivable 10 a different decision be reached. But I'm in danger of 11 speculating about decisions that would or might not be 12 made. I can't, with confidence, tell you precisely that 13 a different decision would have been made because 14 I don't know what the outcome of that further probing 15 would have been. 16 Q. There's a temptation towards thinking that the five out 17 of the eight cases in the expert report of serious 18 concern would be sufficient for erasure. Am I getting 19 the wrong end of the stick there? The probity issues 20 may have existed, Mr Massey, but the evidence that was 21 there from the expert employed to provide precisely that 22 independent opinion seems to be serious, does it not? 23 A. It was serious and indeed all cases that we refer to 24 a medical practitioner tribunal are serious. They don't 25 always result in a decision of erasure. They will Page 141	1 decision. So, given what we know now, I would really -- 2 I would really like this to have been a case this would 3 have progressed to a tribunal hearing and to a decision 4 of erasure, but I can't honestly tell you that the 5 decision that a case examiner has made at the time was 6 an incorrect decision, given the information they were 7 aware of at that time and balancing those questions 8 between what was in the expert report, the degree to 9 which we had the evidence that we felt was capable of 10 meeting the standard and the likelihood of a decision 11 that would come out in a medical practitioner tribunal 12 decision. But I don't know, Anthony, if you would want 13 to add to that in any way? 14 MR OMO: The only thing I would add is I think -- well, two 15 things. One is on the tribunal, obviously when we go to 16 the hearing, we would have to prove the case to the 17 standard we talked about earlier. We do not know what 18 the doctor would put as their defence and what the 19 tribunal would then make of that, which is why it is 20 difficult to say with certainty what the outcome would 21 be. We can say what he would like it to be, but I think 22 it's impossible to say what -- without knowing the 23 response of the doctor and how the evidence would then 24 land, what that tribunal would do in terms of finding 25 impairment and then they have to go on and decide is Page 143
1 sometimes result in cases being closed with no further 2 action. They may sometimes result in conditions being 3 imposed and they may sometimes result in a suspension 4 for any period, up to a year on a doctor's licence. So 5 whilst those were very serious findings in the expert 6 report, tempted though I am, I can't speculate that 7 there was only one conceivable outcome that would have 8 occurred had we put that case to a medical practitioner 9 tribunal. 10 Q. So what that means is the test that you used earlier of 11 "certainty" wasn't met, but a test maybe of "highly 12 likely" could be met. Is that fair, or "likely" or -- 13 A. So -- Anthony may want to come in as well. So, there 14 are questions around: do we have evidence that will 15 satisfy a medical practitioner tribunal in reaching 16 a particular decision? So one of the findings from the 17 expert reports -- I believe I'm correct in this and 18 we'll correct it if I am not, this is from memory -- 19 raised questions that the expert had raised whether 20 consenting had been done properly, but our case examiner 21 concluded that there wasn't sufficient evidence to meet 22 our evidential thresholds in terms of being able to 23 prove that particular allegation. 24 So those will have been some of the factors that 25 will have been in the case examiner's mind in making the Page 142	1 there action that they need to take. 2 And they are required to start with the lower 3 sanction and then work their way up, only if they feel 4 that the doctor's medical practice is incompatible is -- 5 what he has done is incompatible medical practice, can 6 they erase. So that's why I think it is difficult to 7 say. 8 I think on voluntary erasure, one of your questions 9 was -- and I think Charlie has said this -- I think if 10 you say what we now know in terms of the scale, the fact 11 that he did go on to practice elsewhere, and the number 12 of concerns, those are factors that will certainly weigh 13 against granting voluntary erasure now. 14 Q. Yes, understood. Can I probe one further aspect. It's 15 a kind of procedural aspect, it may be of some 16 significance to some who are involved in the Inquiry. 17 At paragraph -- could we just look at the statement at 18 22.8.5. You mention -- this is in the section where 19 you're talking about procedural considerations, I think, 20 related to the voluntary erasure application. One 21 aspect here which it says is: 22 "The doctor [is] to provide a statement to cover 23 three months of work from the [organisation] where they 24 had most recently provided medical services, typically 25 in a 'Provision of medical services statement'. This Page 144

1 statement was (and remains) our means of checking 2 whether there were any known fitness to practise issues 3 that we needed to be aware of and take into account in 4 our decision about whether to grant VE." 5 So is the purpose of that -- I think you mentioned 6 earlier that the decision here was made ultimately in 7 2015, Mr Massey, despite the fact that there was 8 an ongoing complaint that hadn't yet been resolved that 9 had come in latterly, but part of what's going on here 10 is trying to work out whether -- when an erasure 11 happens, your jurisdiction comes to an end and you want 12 to make sure that you've investigated everything that 13 would be relevant to the decision-making. Is the 14 purpose of getting this statement to try and work out 15 whether you're aware of all the fitness to practise 16 concerns? Is that broadly what the purpose of this is? 17 A. That is exactly its purpose, yes. 18 Q. And that -- 19 THE CHAIR: Sorry, just to be clear, Mr Dawson. This is one 20 of the procedural requirements at the time that is 21 contained, as I recollect it from the statement, 22 containing guidance that effectively tells an applicant 23 for voluntary erasure what has to be provided before 24 that can be considered, is that right? 25 MR MASSEY: Yes, that is correct. There are three Page 145	1 Q. The second time round in 2015, the statement which would 2 have shown that there had been intimation of the 3 application to NHS Tayside was not provided; is that 4 correct? 5 A. That is correct, yes. 6 Q. And the statement -- does the opportunity to provide the 7 statement, provide an opportunity to employers or other 8 organisations to contribute information? 9 A. So the statement that's required is actually a very 10 simple one which is essentially whether there are 11 fitness to practise concerns, "yes" or "no". It doesn't 12 provide an opportunity for an employer to either support 13 or oppose an application. But it was a procedural 14 mistake that we didn't get that for the second voluntary 15 erasure application, for which I am very sorry. 16 Q. Do we know why that happened? Is it because the form 17 was already there from the first one and they just 18 worked on the basis of that, is that right? 19 A. I honestly don't know. That is quite conceivable that 20 that might have been the case, but I can't tell you that 21 with any certainty. 22 Q. So there's no -- in the paperwork, there's no basis for 23 knowing whether NHS Tayside or other bodies with whom 24 Mr Eljamel had had a medical connection, if I can put it 25 as broadly as that, had been intimated in his Page 147
1 procedural requirements: a formal written application 2 from the doctor; a referral to fitness to practise 3 colleagues, if there's an open case; and there's 4 provision of a statement from employers covering their 5 most recent period of work. 6 THE CHAIR: I just wanted to check. Thank you. 7 MR DAWSON: But the obligation -- with regard to the 8 provision of the statement, the obligation is on the 9 doctor applying to get that statement, is that right? 10 A. That is correct, yes. 11 Q. So what intimation requirements are there with regard to 12 a voluntary erasure application to current or a former 13 employers of the individual or indeed other institutions 14 in connection with which they had some work, for example 15 a university where they might have taught? 16 A. Yes. So the obligation is on the doctor to provide all 17 of the above at the point where they make a voluntary 18 erasure application. And as you will be aware, we did 19 receive that for the first application that Mr Eljamel 20 made. We did not receive it for the second one and we 21 made a mistake of not requiring that at the time. 22 Q. So the position was, I think, that the first time round, 23 information was provided by NHS Tayside in accordance 24 with what was required, is that right? 25 A. Yes, that is correct yes. Page 146	1 application to apply for voluntary erasure in 2015, is 2 that right? 3 A. That's correct. 4 Q. But we do have a form, I think, that was completed by 5 someone from NHS Tayside in connection with the original 6 application, is that right, in 2014? 7 A. That is correct, yes. 8 Q. Okay. You've mentioned that the form is quite brief but 9 given that intimation is made, what obligations exist in 10 those circumstances on medical organisations, or perhaps 11 the responsible officer within a medical organisation, 12 to bring information that's relevant to the GMC to the 13 attention of the investigating case examiners? 14 A. So I haven't got the form in front of me but it's a very 15 simple form which basically requires the employer to say 16 are they aware of any fitness to practise issues, tick 17 "yes" or tick "no" and obviously if they tick "yes", 18 that would then generate a level of enquiry from 19 colleagues in the GMC to make sure they understand the 20 entirety of what that is. 21 Q. So we have a document here which is the form. We could 22 have a look at that, if you like. It's GMC-00104. 23 Page 57, please, if we just go straight to that. 24 A. Yes, it's the UD8 form, I think it is. 25 Q. Yes, that's it, the UD8 form. I think -- correct me if Page 148

1 I'm wrong -- that this is the form that's filled out, 2 I think, by someone from NHS Tayside. And you can 3 see -- if you scroll down a little bit, you can see the 4 box that you've been talking about: 5 "Are you aware of any proceedings, act or omission 6 on the part of the applicant which might render them 7 liable to be referred to the General Medical Council in 8 relation to their conduct, health or performance?" 9 And there it's ticked "yes". Is that right? 10 A. That's correct. 11 Q. And I think, if we scroll down a little bit further, you 12 can see that this is filled out by a Dr Alan Cook of 13 NHS Tayside who, I think -- it says was the medical 14 director of the NHS Tayside operational unit. So it's 15 filled out by a doctor. What I was asking is whether 16 there are obligations on a medical director like that to 17 provide information to the GMC at that stage, given that 18 doctors also have -- Mr Eljamel is seeking erasure but 19 other doctors have obligations to provide information to 20 the GMC about what they know in connection with that; 21 isn't that right? 22 A. Yes. So typically we'll use that form so that if that 23 box is checked "yes", as it is there, that we would then 24 follow up with the doctor who signed the form to make 25 sure that we are aware of the entirety of the fitness to Page 149	1 did not provide a form like this and nobody chased it up 2 to say: well, you haven't provided one of the three 3 essential components, is that right? 4 A. That is correct. That is correct, yes. 5 Q. And although I think you've called it speculation, we 6 think that that may be because there was a form of this 7 nature already on the file, so it looked like there had 8 been intimation already. If there was a form on the 9 file and someone looked at it, would the fact that the 10 box had been ticked "yes", should that not have prompted 11 some further follow-up? 12 MR OMO: May I come in. So I think part of the thinking was 13 that we had an ongoing investigation at this stage. So 14 we were in touch with Tayside in terms of the referral 15 they had made in January and that continued up until the 16 voluntary erasure decision in 2015. So we were in 17 contact with them and therefore our expectation would be 18 that they were providing and had provided relevant 19 information directly to our investigation officers. 20 Q. Is it possible, because there was that ongoing contact, 21 would they have known -- because presumably you're 22 updating them on the progress of the investigation, 23 would they have known that the voluntary erasure 24 application had come in? Because of course that's 25 relevant to the question as to whether the fitness to Page 151
1 practise proceedings that they're referring to. 2 Q. I understand and it's to make sure that you've got the 3 full suite of information, for the reasons that we've 4 discussed, isn't it, that's the whole point of it? 5 A. Exactly. 6 Q. But in this circumstance, we're talking here about 2014, 7 do we know whether that follow-up happened and what 8 information, if any, was provided by Dr Cook or his 9 colleagues? 10 A. I can't tell you what the exact follow-up was. 11 Obviously that was a decision that was made relatively 12 quickly to reject that application because there was 13 an investigation in the relatively early stages at that 14 point in time. That may have meant that there was less 15 detailed follow-up with Dr Cook. I'm afraid, I don't 16 have the evidence to say either way. 17 Q. But we don't have on the file, or the box, or the 18 computer file, wherever you found this, we don't have 19 any material which shows the GMC writing to Dr Cook 20 saying: we see you ticked the "yes" box, do you have any 21 more information? And him sending it back, there's 22 nothing of that nature, is there? 23 A. Not that I'm aware of. 24 Q. Okay, and then, as we said in 2015, I think you've 25 accepted the position was that effectively Mr Eljamel Page 150	1 practise investigation will continue? 2 A. I don't know whether it was one of the things discussed 3 between ELA and RO, their conversations. I can't 4 remember if it was someone one of the things in the 5 note, but it certainly would be one of the discussions 6 I would expect to have been had between an ELA and 7 an RO. 8 Q. Because if those discussions pertain generally to 9 an ongoing investigation, the application for voluntary 10 erasure is certainly pertinent to that because it could 11 bring the investigation to an end, is that right? 12 A. That's right. 13 Q. Thank you. Just one other matter I'd like to bring up 14 with you, probably for Mr Massey. It relates to the way 15 in which -- you've provided us with a very extensive 16 explanation of the way in which you searched for 17 documents, which is very helpful, on your various 18 systems. One aspect of the way in which documents have 19 been produced, which you do you address in the 20 statement, relates to the fact you pre-redacted some 21 information when you provided it to the Inquiry. 22 Now, our broad understanding is that the 23 pre-redaction relates predominantly to your concerns and 24 your understanding of your data protection obligations 25 relating to the possibility that analyses and sheets and Page 152

1 documents you may have given us may have contained the 2 names of other doctors which are nothing to do with the 3 Eljamel investigation; is that correct? 4 A. That's my understanding, yes. 5 Q. And for the sake of clarity, the Inquiry's position in 6 relation to such matters is that organisations require 7 to produce documents to us unredacted but that there is 8 a process through which the Inquiry can discuss and 9 agree redactions of that very nature. We receive 10 enormous amounts of very sensitive information from just 11 about all the organisations we have contact with and we 12 go through an extensive process, as I'm sure you do as 13 well, to make sure that documents names are redacted. 14 One of the reasons that you give for that practice is 15 public confidence in the GMC. Is that right? That's 16 a consideration in that practice, is that right? 17 A. Yes, because obviously if there was a lack of confidence 18 in our ability to maintain the confidentiality of 19 information, we might not receive the information we 20 need to progress things. But, yes that is correct. 21 Q. Could I suggest to you that when engaging with a public 22 inquiry, there is a need to consider the public 23 confidence in the inquiry as well, because -- 24 A. Indeed, indeed. 25 Q. -- for the very same reasons that you redact Page 153	1 superimposed upon it. I raise that question with you 2 because you are the only organisation who has insisted 3 on keeping redactions in, in that way despite the fact 4 we have contact with numerous -- who have very many of 5 these same considerations. So I'm just looking for 6 a "yes" that you would consider that. Because we 7 understand your public confidence requirements and we 8 share them, although in a slightly different context. 9 A. Yes, I'm very happy to take that away and apologies if 10 we've been overly prurient in terms of the way in which 11 we have applied that, but very happy to take that away 12 and pick it up -- 13 Q. It's understood. Could I just address with you one 14 other final aspect. You've explained to us, and in your 15 statement, the details of the voluntary erasure process 16 and also the processes that you have gone through and 17 the erroneous intimation to the Saudi Arabian 18 authorities, which you explain, Mr Massey, you corrected 19 in 2013 by getting in touch with the Libyan authorities. 20 It is, as I understand it, a matter of considerable 21 importance to former patients of Mr Eljamel that every 22 possible step is taken to try to intimate to any 23 relevant authority, any relevant individual to be frank, 24 who has had any control over his practice in Libya, that 25 every step be taken that they understand the history of Page 155
1 information, we do so as well, and we have legal 2 obligations to consider that. What's important, 3 I think, is that we make clear to recipients of 4 information when it's redacted as to why we have 5 redacted it by applying certain categories of redaction 6 which give a broad explanation. In relation to the 7 material that you have provided we have been unable to 8 do that because we have been unable to verify what 9 information exists under the redactions, therefore we 10 can't give a reason for that. 11 In any event that the information under the 12 redactions is what you say it is -- and I accept that 13 that is a very important thing to need to redact -- then 14 we would redact that information. But for the purposes 15 of public confidence in our process, we tend to prefer, 16 in fact insist, upon organisations providing material to 17 us unredacted so we can go through that process. That's 18 so that confidence in our process can be maintained in 19 the same way that it's maintained in yours. 20 Although I'm not going to push you for an answer 21 now, I'm wondering whether you might be willing at least 22 to consider producing that information to us unredacted 23 and going through the process that I have described. In 24 the event that the material is what you say it is, it 25 would be redacted but have our explanation effectively Page 154	1 this matter and indeed, aspects of the details of the 2 GMC's investigation of it although it was curtailed, as 3 we've said. 4 Mr Omo told us earlier that it would -- although it 5 wouldn't be part of a formal record that would be 6 publicised that, for example, there had been interim 7 conditions attached, that might be something that would 8 be shared with an employer at a later date in the UK. 9 Are there any ways in which you can consider the 10 possibility that information could be transmitted beyond 11 the means you have already taken? You've contacted the 12 regulator, as I understand it, but what I'm interested 13 in is whether any further steps, in the circumstances of 14 this case, can be taken. As an example contacting the 15 hospital in which he works? 16 A. Yes, I'm open to take whatever action we think we can. 17 Indeed, we actually do try very hard, generally, to be 18 one of the medical regulators globally that tries to 19 share as much information as we possibly can. Indeed, 20 we talk through IAMRA, which is the International 21 Association of Medical Regulatory Authorities, about 22 precisely that, how we can get better collectively at 23 sharing information about concerns about doctors. 24 I know that's a more general point, but yes, I'm 25 very happy that we take away that very specific question Page 156

1 about is there anything more we can or should do in 2 relation to Libya or indeed any other countries where 3 Mr Eljamel could practise. 4 Q. Thank you, I appreciate that. Also one other aspect of 5 that which I should make clear is that in your evidence 6 in that area you make it clear that the overriding 7 principle to which the GMC adheres is the prevention of 8 public harm. And in that regard I also understand it to 9 be the case that any intimation which could have some 10 effect on limitation or restriction of Mr Eljamel's 11 practice in Libya would have the effect of limiting harm 12 for people in the UK because, as I understand it, it 13 would have an effect on limiting harm on his former 14 patients in Scotland. 15 That is because the ongoing concerns they have about 16 his practice and his -- the possibility he may do harm 17 to others, as I understand, is a very considerable 18 burden which they carry. And if the GMC or any other 19 similar bodies could do anything to minimise that, they 20 would be minimising public harm in this country. Is 21 that understood? 22 A. Yes, that's understood and I share that perspective with 23 families who have been so dreadfully let down by 24 Mr Eljamel. It can be quite hard to get responses from 25 regulatory authorities but that doesn't mean we can't Page 157	1 probity and bullying concerns, but I do know that that, 2 of course, will not provide enormous comfort to those 3 patients and families that have been harmed by 4 Mr Eljamel. 5 MR DAWSON: Thank you. Mr Omo? 6 MR OMO: Nothing to add to that. 7 THE CHAIR: Thank you. Gentlemen, we're not quite finished 8 because at this point we invariably have a short break 9 just to check whether there aren't any questions that 10 other parties want to put through Counsel to the 11 Inquiry. So if you could remain about or near your 12 computer for a few moments longer, we will be ready to 13 proceed again shortly. Thank you. 14 (3.14 pm) 15 (A short break) 16 (3.27 pm) 17 THE CHAIR: Yes. Gentlemen, Mr Dawson may have a further 18 matter to raise. 19 MR DAWSON: Thank you very much. Can you hear me okay, 20 gentlemen? 21 MR MASSEY: Yes, we can. 22 Q. Thank you. Can we go back, please, to GMC-00104. 23 This is the UD8 form we were looking at earlier. 24 Page 57, please. It's just to highlight with you that 25 when we were discussing the -- what had been inserted Page 159
1 consistently try and try all different routes to get in 2 touch. So I do understand that point and we'll take 3 that way. 4 Q. Thank you very much. Mr Massey, Mr Omo, those are my 5 questions. At this stage I ask all of the witnesses and 6 I ask you both if there's anything you'd like to add? 7 MR MASSEY: I don't think so. I guess, just pulling things 8 together if I may, just for a minute. Obviously given 9 what we know now in terms of the volume and gravity of 10 harm caused by Mr Eljamel -- and I realise that the 11 Inquiry will focus to lot on the voluntary erasure 12 decision -- knowing what we know now, this is obviously 13 a case that I'd have liked to have seen concluded 14 through a disciplinary erasure, through a tribunal. And 15 I know that we've made various mistakes and I'd like to 16 apologise to patients and families affected, both in 17 terms of those procedural errors, in terms of the 18 statement from the employer, the points that I have 19 talked about earlier in terms of our notification of 20 wrong overseas regulator and the fact that we failed to 21 correct that when we could and should have done. 22 And I would want to say that if we were looking at 23 a similar case today, I think we would investigate some 24 of the concerns raised with a greater degree of 25 curiosity and rigour, particularly in relation to the Page 158	1 into this document by Dr Cook -- we'd identified the 2 fact that he had ticked "yes", but just to point out 3 that in the bottom box, it says: 4 "If 'yes', please provide details." 5 So he's providing details on: 6 "... any proceedings, act or omission on the part of 7 the applicant which might render them liable to be 8 referred to the General Medical Council ..." 9 What Dr Cook said in response to that, which could 10 cover proceedings, acts or omissions on the part of the 11 applicant, was: 12 "This has been through IOP on February 28, 2014." 13 Is that referring, do you think, to the interim 14 order process? 15 A. Yes, that is, I think, what it is referring to. 16 MR OMO: Yes. 17 MR MASSEY: And of course it was very shortly after that 18 that Mr Eljamel retired from practice at Tayside. 19 Q. Yes, so Dr Cook had the opportunity to provide 20 information about any proceedings, act or omission on 21 the part of the applicant which might render them liable 22 and he's referred, presumably, to those proceedings 23 because those proceedings will contain information of 24 that nature. Does that seem to be what's happening? 25 A. Yes, and because those proceedings related to the, at Page 160

1 that stage, ongoing investigation that was referred to 2 from Tayside only a month previously. 3 Q. Yes, and the information which is discussed at that time 4 but also in 2015 would not be contained -- or the 5 discussion around that and the communication would not 6 be solely contained within this form because I think you 7 said, Mr Omo, earlier that it would be expected that 8 there would be -- the correspondence, if you like, 9 between the local advisor from the GMC and the 10 responsible officer or someone like Dr Cook from that 11 sort of department, is that right? There would be 12 an ongoing dialogue in particular in relation to 13 developments in the investigation? 14 MR OMO: Yes, once we have an open investigation there is 15 usually an ongoing dialogue between the ELA and the 16 responsible officer. 17 Q. I understand it may be the case that we do have some 18 information suggesting that that was happening with the 19 ELA locally and that the possibility of the voluntary 20 erasure was raised. As we said earlier, that would seem 21 logical that that would be the case because that would 22 be connected to the possibility that this investigation, 23 into which Tayside have to make certain contributions, 24 would be coming to an end, a possibility? 25 A. Correct. A possibility, correct. Page 161	1 which may be of relevance to our Inquiry. There was -- 2 one of the investigations, which one can see at page 4, 3 related, I think, to concerns about workload and in 4 particular related to these departments. And if you 5 look, for example on page 5, at paragraph 8, it 6 discusses a number of workload issues here: 7 "These workload issues have been raised by some 8 foundation year one doctors and a meeting with the 9 clinical director was scheduled for shortly after this 10 check. It was positive to hear that foundation doctors 11 were confident that management will be receptive to 12 their feedback, as they have previously been told by 13 management that they don't want to see foundation 14 doctors under too much pressure." 15 And if one scrolls back to the previous page, one 16 can see that the requirement of the GMC was that: 17 "Appropriate cover must be scheduled on the rota to 18 allow foundation year doctors in training to attend 19 teaching sessions. Additionally, teaching time must be 20 protected." 21 Are these sorts of workload types of issues, the 22 sorts of things that GMC deal with regularly? 23 MR MASSEY: Yes, those come up pretty frequently. So, bear 24 in mind that the basis for the visit and the basis for 25 other visits we undertake or other quality assurances we Page 163
1 Q. Thank you. Can I take you to one other document, 2 please. This is GMC-00054, which my colleagues have 3 helpfully found for me. This is the 2014 report which 4 I asked you, Mr Massey, earlier whether we have a copy 5 of it. It hadn't been referenced in the statement but 6 it was probably our fault. But we do, in fact, have 7 a copy of it and my colleagues have helpfully brought it 8 to my attention. We can see there, this is -- just to 9 remind everyone, this was the GMC investigation at 10 Ninewells which was, amongst other investigations, into 11 allegations of bullying. And they had visited what we 12 understood to be the surgical side of Ninewells in 2014. 13 If we go to page 2, please, in the third full paragraph, 14 just above "Summary of application", it explains that: 15 "This check ..." 16 So the one to which this report relates: 17 "... was one of six surgical checks and was 18 undertaken at Ninewells Hospital in trauma and 19 orthopaedics and general surgery. The check comprised 20 meetings with: foundation, core and higher specialty 21 doctors in training, the hospital Senior Management Team 22 (SMT), general surgery and trauma and orthopaedic 23 Consultants and a meeting with representatives from the 24 East Region of the Scotland Deanery." 25 And if I just scroll down to some of the findings Page 162	1 do undertake are results from the National Training 2 Survey and that asks questions around things like rotas 3 and workloads and enables us to segment that by doctors 4 in terms of the stage of their training, which would 5 allow us to extract foundation year doctors from doctors 6 at a more senior level in their training. So this is 7 the sort of thing that comes up relatively frequently, 8 yes. 9 Q. I see. And connected to that, which may have some 10 relevance to our remit as well, on page 6, it says 11 another aspect connected to that was the process for 12 monitoring hours worked. It says, at paragraph 12: 13 "Doctors in training reported examples of feeling 14 unable to record accurate hours of working due to 15 a range of pressures. It was also unclear what was done 16 with this monitoring information once it had been 17 collected. 18 "We heard that doctors in training recorded their 19 working hours on a form and that if they worked beyond 20 the designated hours on the rota they need to get 21 a Consultant to sign it. 22 "We heard that although doctors in training have 23 been told by some Consultants and HR staff that they 24 need to be honest about hours they have worked on the 25 forms they are required to complete. However, some Page 164

1 reported that they subsequently felt pressured to record 2 their hours inaccurately in order for their rotas to 3 appear compliant with the European Working Time 4 Regulation. 5 "We were very concerned ..." 6 Say those writing the report: 7 "... to hear that some doctors in training may be 8 working inappropriate hours and that they have felt 9 pressure to record these hours inaccurately. Doctors in 10 training must be able to record their working hours 11 accurately for the purposes of monitoring. This is to 12 ensure that the hours being worked by doctors in 13 training are; suitable for education and training, safe 14 and legally compliant." 15 Leading to the requirement at the top: 16 "Doctors in training must be enabled to record their 17 working hours accurately for the purposes of 18 monitoring." 19 Again, connected to the evidence you gave a moment 20 ago, is this a feature which one sees that pressure can 21 be applied to effectively misrepresent working hours for 22 compliance purposes, but doctors are actually being 23 expected to work longer hours than they should? 24 A. So I think the question about working hours does come up 25 quite frequently. I haven't seen it so often in Page 165	1 Consultants confirmed that doctors in training do feel 2 able to report instances of undermining and bullying. 3 They often have difficulty in continuing with the 4 escalation of a concern once they ask for permission for 5 more information. This means that the anonymity would 6 be lost. 7 "We heard from all groups that we met that there may 8 be issues with interaction with other departments such 9 as emergency medicine. There was some confusion as to 10 whether the emergency medicine department has admitting 11 rights into other departments without referral to 12 colleagues in those departments, and we heard this can 13 lead to tension. 14 "We also heard that doctors in training feel unable 15 to attend the Emergency Medicine department unless they 16 are explicitly asked to do so by staff in that 17 department. Additionally when they do attend we heard 18 examples of when they were undermined and/or bullied. 19 "We felt that these issues of poor communication, 20 undermining and bullying and lack of clear patient care 21 processes between the emergency medicine department and 22 other departments are likely to present a risk to 23 patient safety. The regional GMC Education Quality Team 24 in conjunction with the Deanery and Hospital will be 25 investigating and dealing with the concerns externally Page 167
1 relation to asking doctors to be dishonest about the 2 hours they've worked but that obviously does raise quite 3 a serious concern, as well as a patient safety concern. 4 So, yes, but that is – there have been some common 5 elements in terms of – how shall I put it, so before 6 the European Working Time Directive there was a view 7 from doctors who perhaps had been around a lot longer 8 about the way in which they had been trained required 9 them to work very, very many hours, beyond what the 10 European Working Time Directive then required and were 11 perhaps not quite as focused on complying with the law 12 as it currently stood at that time. 13 I don't think that is as much of an issue we see now 14 as we might have seen at that point in time. 15 Q. Thank you. And just to take us through the bit that 16 I think we discussed earlier, page 7 of the document, 17 please, about halfway down the page, this is the 18 specific issue which I think was brought up in your 19 report, the undermining and bullying. It says: 20 "Although we heard isolated examples of bullying and 21 undermining from the doctors in training we met with, we 22 found no evidence that there was a culture of 23 undermining and bullying in the general surgery and 24 trauma and orthopaedic units. 25 "The SMT, Clinical Leads, the Deanery and Page 166	1 to these checks." 2 And the recommendation on the previous page is that: 3 "We heard that there appeared to be an endemic issue 4 with bullying and undermining in the relationship 5 between the Emergency Medicine staff members and 6 surgical doctors in training of all grades. This should 7 be explored in conjunction with the Health Board and 8 Deanery." 9 Again, as I think you've mentioned earlier, these 10 are significant issues relating to the way in which 11 doctors interact with each other but also are able to 12 work in accordance with the required standards, is that 13 right? 14 A. Yes and bullying and undermining, sadly, have 15 historically come up all too frequently in terms of 16 questions we've asked of doctors in training. It's 17 an area that we take very seriously and indeed, our 18 national training survey now contains much more in terms 19 of questions around that, that enable us to be much 20 clearer in terms of our evidence base and the action 21 that we might take. 22 It relates to kind of wider culture/leadership 23 questions which also come back to where I started in 24 terms of the evidence, in terms of us taking a more 25 active interest, in terms of clinical governance and Page 168

1 supporting the responsible officer and medical director 2 to create the culture and leadership where doctors feel 3 able to escalate concerns, where they're not feeling 4 bullied and undermined and where they feel that they 5 won't be jeopardising their position in a health board 6 by raising concerns. 7 So all of those things come together in terms of 8 those ambitions I described at the outset, in terms of 9 us becoming a more upstream regulator. 10 MR DAWSON: Thank you very much. Those are my questions. 11 Thank you, gentlemen. 12 THE CHAIR: Well, gentlemen, as will now be apparent, that 13 is the end of this session and it means it's the end of 14 the evidence that we are inviting you to give this 15 afternoon. Before the screen goes blank, it obviously 16 remains for me to express the thanks of the Inquiry and 17 indeed my personal thanks for your attendance today, for 18 the evidence that you have been able to share over what 19 has been quite a long session during the course of the 20 day. But I also do not lose sight of the fact that in 21 preparing for today you have been involved in the 22 generation of witness statements and no doubt intimately 23 involved in the process by which they are supported by 24 many documents to which reference is made in those 25 statements. Page 169	1 Is that right? 2 A. That's correct, yes. 3 Q. And you made some contributions to certain sections but 4 others are responsible for others, is that right? 5 A. Yes. 6 Q. I won't go to it because the statement runs in the name 7 of Dr James Cotton, who is the executive medical 8 director, is that right? 9 A. Correct. 10 Q. He signed the statement, but as far as you're concerned 11 in the relation to the contributions you made to it, are 12 the contents of those contributions true? 13 A. Yes. 14 Q. Thank you. Could you tell me a little about the role of 15 executive nurse director and what the responsibilities 16 you have in that role are? 17 A. So as executive nurse director, I'm the most senior 18 nurse within the organisation. I hold responsibility 19 for professional governance arrangements for nursing, 20 midwifery, allied health professions, which means 21 I'm responsible for ensuring policy standards, practice, 22 care assurance around practice for all of those 23 professions. I also hold executive responsibility for 24 certain things delegated by the chief executive such as 25 patient experience, public protection, those sort of Page 171
1 For that, the Inquiry and I are extremely grateful. 2 You're now free to go, thank you. 3 MR MASSEY: Thank you. 4 MR OMO: Thank you. 5 MR DAWSON: Sir, we have one more witness today so could we 6 have a relatively short break. 7 THE CHAIR: Yes, indeed. Thank you. 8 (3.40 pm) 9 (A short break) 10 (3.53 pm) 11 MR DAWSON: The next witness is Simon Dunn. 12 THE CHAIR: Simon Dunn. Yes, please. 13 MR SIMON DUNN (sworn) 14 Questions by COUNSEL TO THE INQUIRY 15 MR DAWSON: You are Simon Dunn? 16 A. I am, yes. 17 Q. I think you are the Executive Nurse Director of 18 NHS Tayside; is that correct? 19 A. Correct. 20 Q. Is it the case, Mr Dunn, that you made a contribution to 21 a statement -- a witness statement which has been 22 provided on behalf of NHS Tayside to this Inquiry? 23 A. That's correct. 24 Q. And the statement, as I think we've heard with another 25 witness, was contributed to by various different people. Page 170	1 responsibilities. 2 Q. We've heard some evidence already about -- mostly in 3 relation to doctors, as it happens, related to a role 4 called the "responsible officer" for doctors? 5 A. Yes. 6 Q. And our understanding is that the responsible officer 7 holds an important position in relation to the 8 regulation of doctors and liaison with the General 9 Medical Council. Is there a similar system for nursing 10 regulation and is that something you play a role in? 11 A. So there is no responsible officer in the same way that 12 there is for medics which is a statutory role, but there 13 is a responsibility that I hold to liaise with the 14 Nursing and Midwifery Council who regulate nursing 15 midwifery practice, so supporting the organisation to 16 make sure we have the right policies and practice in 17 place. I liaise with the Nursing and Midwifery Council 18 liaison around any individuals who we have concerns 19 about practice who have been referred to them. Because 20 the role of nurses and doctors are different, around 21 their accountability and autonomous practice, that's why 22 the difference around responsible officer for medics and 23 nurses differ slightly. 24 Q. Thank you. So it's a similar sort of system? 25 A. Yes. Page 172

1 Q. But different names, different statutory basis, 2 different bodies, is that right? 3 A. Yes, correct. 4 Q. One of the aspects that I thought you might be able to 5 help us with in relation to the work of the Inquiry -- 6 it's not one of the areas that you have spoken to about 7 NHS Tayside, but in a broad sense given your role, we 8 wonder whether it might be something you can help us 9 with. 10 We saw -- we looked at a report, which you may or 11 may not have seen, relating to Mr Eljamel way was 12 a Royal College of Surgeons Invited Review Mechanism 13 report from 2013. 14 A. Yes. 15 Q. And have you seen the report? 16 A. Yes, I have. 17 Q. I'm not going to go into the details of it, there was 18 just a general part of it I was interested in exploring 19 with you. As part of that review, the review team 20 visited Ninewells Hospital over a period of two days and 21 interviewed a very wide variety of different medical 22 professionals and indeed executives relating to matters 23 pertaining to Mr Eljamel's practice. And it was pointed 24 out, when we went through this with someone from the 25 Royal College of Surgeons, that nurses were involved in Page 173	1 work is there's different theatres functioning with 2 different specialties, orthopaedics, neurosurgery, ENT, 3 different things. So there will be a group of them that 4 will be led by one senior charge nurse and the people 5 and the staff that work in those theatres, they will be 6 responsible for them. 7 Q. And you may know this specifically for Ninewells, but in 8 a general sense as well if not, would the nurses who 9 work -- as you mentioned all these different surgical 10 environments, would nurses work across a wide variety of 11 surgical specialties or would they be dedicated, for 12 example, to the neurosurgery department? 13 A. So they would generally be dedicated because the 14 skill-set that you would need in order to be able to be 15 there supporting surgeons during procedures is, you 16 know, very specific at times, depending on your 17 specialty. At times we will move nurses around based on 18 their competency and ability to work in different 19 theatres. But most nurses who will work in a theatre 20 environment will remain within the specialty of that 21 theatre. 22 Q. That might help with answering my original question 23 which was why they'd want to speak to the nurses because 24 if they're dedicated to the neurosurgery unit, they 25 probably know quite a lot about what's going on there, Page 175
1 that discussion. 2 In those sorts of circumstances, I was interested to 3 understand -- because what the purpose of that was, was 4 to try and understand what was going on in the 5 neurosurgical unit -- could you tell me, broadly 6 speaking first of all, the sort of the different 7 hierarchy of nurses that there might be there, the sort 8 of numbers of nurses and what sort of information nurses 9 have about what goes on in a unit like that? 10 A. So, I mean nurses are the largest workforce within any 11 NHS establishment, so there's obviously more nurses than 12 there is medical staff. If you're looking at it from 13 a theatre environment point of view, so you will have 14 a cohort of nurses who are allocated to that theatre. 15 They will be led by a senior charge nurse, so that's 16 somebody of significant experience and authority who's 17 worked in that environment, who has a lot of experience 18 around that environment and they will lead a number of 19 nurses underneath them within their team. 20 Q. So would it normal -- just on the senior charge nurse, 21 would there be one for that unit, do you think, or would 22 there be a number of senior charge nurses, or is there 23 just one that runs it in a unit of that broad size, 24 which I think you have some familiarity with? 25 A. Yes. So the way you can imagine theatre environments Page 174	1 would that be fair? 2 A. Correct, yes. 3 THE CHAIR: So little or nothing may turn on this, Mr Dunn, 4 but since you were asked about the hierarchy, you're 5 obviously a very, very senior nurse. The senior charge 6 nurse, by the virtue of the name itself, suggests 7 somebody who has a measure of authority and leadership 8 over the nurses that might be working in theatre. Can 9 you go down from the senior charge nurse and just 10 explain to me the grades below that? 11 A. Yes. So a senior charge nurses a band 7 grade, just 12 somebody, as you say, is of seniority to manage a team 13 of people. Normally, you will have charge nurses, so 14 they are band 6s, so they are people who may take charge 15 of a shift, have extra responsibilities and may be in 16 charge of a smaller group of staff. And then you will 17 have staff nurses. So that's band 5, normally. And 18 those are registrants who have come out of practice. 19 They will be healthcare support workers underneath of 20 different grades and bands, but generally that's the 21 hierarchy. Obviously above that, there is significant 22 hierarchy as well, up to my position. 23 THE CHAIR: All right, thank you. 24 MR DAWSON: Another concept we've heard in the surgical 25 field is something called a "scrub nurse". Page 176

1 A. Yes. 2 Q. What's that? 3 A. So a scrub nurse is just a description of a role that 4 happens within the theatre environment. It's the same 5 cohort of nurses, but one of them will be on for scrub 6 for the day. So you've got a sterile nurse and 7 a non-sterile nurse. So the scrub nurse is somebody who 8 is sterile, who is supporting and assisting the surgeon 9 with his operation, handing tools to him, complying with 10 requests from the surgeon. And you will have somebody 11 who is on the floor as well just supporting the running 12 of that theatre. 13 Q. I see, so the scrub nurse is not a single person but 14 a single person performing a certain role one day. And 15 it might be a different person the next day, is that 16 right? 17 A. Correct. 18 Q. Just to be clear, the scrub nurse is someone who is 19 scrubbed up, effectively, therefore meaning that they 20 work within the sterile field of the operation, is that 21 right? 22 A. That's correct, they're sterile. 23 Q. And there will be other nurses working within the 24 theatre environment who are not scrubbed up in that way, 25 performing other tasks that don't require them to be Page 177	1 a patient, they will record that in the clinical 2 records. If there is pieces of equipment that are used 3 that have identification codes on them and they need to 4 record that, then they will be recorded within the 5 records. The nurse will record things like any changes, 6 any monitoring. 7 So they have a role to support and monitor a patient 8 within the theatre environment and they record 9 contemporaneously within the healthcare record. That is 10 separate from a logbook. I'm just trying to explain 11 that the record for the patient is part of their health 12 record that continues and is contemporaneous and moves 13 through the journey with them. 14 So the logbook is a log of who is in and out of the 15 theatre environment. So it's more of a log of the 16 environment than the specific patient episode around 17 their operation, their care, what happened during that 18 operation, etc. 19 Q. So one is -- the logbooks were attached to the theatre. 20 Where the notes are attached to the patient, I suppose? 21 A. That's right, yes. 22 Q. I'm just interested in trying to understand how, in 23 an environment like a neurosurgical unit, where there's 24 a need for people to be scrubbed up and that sort of 25 thing, whether that would mean that the responsibility Page 179
1 sterilised in the same way; is that right? 2 A. Yes, often described as the floor nurse, you know, 3 somebody who is within that theatre environment, 4 supporting the running of the theatre but they're not 5 within the sterile environment. 6 Q. One matter that's come up in connection with the way in 7 which things are ordered and roles that people would 8 have, relates to the keeping of records of what goes on 9 within the theatre? 10 A. Yes. 11 Q. And indeed, the difficulty, if I could put it that way, 12 of the fact that when one is involved in an operation 13 it's very difficult to be writing down what's happening. 14 So we've heard, for example, some evidence about 15 logbooks that are kept in theatre, that would record 16 contemporaneous information about what was going on in 17 the surgery. Would it be the floor nurse that would 18 tend to keep those notes, or would that vary? 19 A. So the clinical records which make up a patient's 20 journey, start from a ward environment, come with the 21 patient into the theatre environment. Anything that 22 happens within that theatre environment is recorded 23 within those clinical records. So that's around 24 anaesthetic, so if nurses are involved in that, for 25 example taking the observations, the blood pressure of Page 178	1 for taking notes of any kind that you've mentioned would 2 perhaps be different, given the fact that there would be 3 limitations on people's ability to take notes because of 4 the fact they're actually participating in a sterile 5 operation. Are there clear lines of responsibility as 6 to which notes are completed by which members of the 7 broad medical team? 8 A. I mean, it's like any clinical environment. You're 9 looking after a patient, whether you're delivering care 10 as a nurse or you're delivering care as a medic or 11 another health practitioner. It's your responsibility 12 to document that care that you have delivered within the 13 health records of the individual. So although there's 14 individuals who may be sterile performing a task, 15 performing an operation, then they will still be the 16 ones responsible for recording what happened, what they 17 did, in the health records after that operation. 18 Q. So the primary responsibility then lies with the person 19 who is delivering the care to record what that care was 20 that they delivered; is that broadly correct? 21 A. That's correct and lots of different people in the 22 theatre environment will be delivering different aspects 23 of that care, whether it be an anaesthetist, whether it 24 be a surgeon, a nurse. So it's them documenting the 25 care that they've delivered. There may be people Page 180

1 taking -- as you say, the floor nurse may be recording 2 pieces of information throughout the operation that are 3 important, that are captured contemporaneously at the 4 time, such as, you know, blood loss or a piece of 5 equipment that's used. 6 Q. Thank you. You say, in your statement, that in addition 7 to the various nursing responsibilities you've set out 8 already as the executive lead nurse, that you are also 9 the joint executive lead for clinical governance in 10 NHS Tayside. And you tell us paragraph 2.12 that this 11 role involves ensuring that NHS Tayside implements 12 a clear clinical governance framework and has a system 13 and processes to assure the clinical governance 14 arrangements up to board clinical governance committee. 15 Is that right? That's a role you have? 16 A. That's correct, yes. 17 Q. Who is that responsibility held jointly with? 18 A. The medical director. 19 Q. Okay. And is that sort of ex officio, that comes with 20 your role, or is that -- 21 A. It does, yes. So it's delegated. The overall 22 accountability sits with the chief executive and the 23 board, but it's delegated to the executive medical and 24 nurse director to make sure that it's contemporary, it's 25 compliant. Page 181	1 board level, the overseeing of clinical governance, have 2 a clear framework, have clear parameters, are understood 3 throughout the organisation, have clear communication 4 lines and channels throughout the organisation. It's 5 our responsibility to ensure that from floor -- so 6 I described that as a staff nurse band 5 working within 7 an environment, right up to myself, that there's 8 an ability to escalate concerns through incident 9 management systems, through professional structures, 10 through the hierarchy that we mentioned earlier. So all 11 of that has to be in place. 12 Q. So are you, along with the medical lead, are jointly 13 responsible for those systems? 14 A. Correct, yes. 15 Q. So there's different aspects of this. So, for example, 16 we talked about systems which relate to revalidation and 17 things like that, but there are also systems which 18 operate within a hospital to try to make sure there is 19 a proper oversight of what's going on and that's a part 20 of the clinical governance system, is that right? 21 A. That's right. So I would describe the revalidation, as 22 you mention, as the professional governance arrangements 23 and clinical governance is broader than that. So, for 24 example, we have a clinical governance framework which 25 sets out the framework and parameters that we would Page 183
1 Q. I was wondering if that perhaps follows logically from 2 what you told us earlier about the medical director's 3 responsibility as responsible officer for doctors and 4 the nursing -- the person in your role, the head nurse 5 being responsible in a slightly different way but for 6 all the nurses. 7 A. Yes. 8 Q. We understand the responsible officer is effectively in 9 charge of clinical governance, but if the two of you 10 come together, effectively you're in charge of clinical 11 governance for the hospital; is that correct? 12 A. Well -- so we cover the whole of -- so, for example, 13 NHS Tayside is not just Ninewells Hospital, it covers 14 three Health and Social Care partnerships, three 15 hospitals, etc. 16 Q. Of course. 17 A. What we are responsible for is all of the healthcare 18 professionals that work within a healthcare system. So 19 for example, as I've said, I cover nurse and midwifery 20 and allied health professions. The medical director 21 covers medics, pharmacists, psychologists. So between 22 us we cover the responsibility of all the health 23 professionals that work within a healthcare environment. 24 So it's our responsibility, from a clinical governance 25 point of view, to make sure that the arrangements at Page 182	1 monitor clinical care and governance arrangements 2 throughout the organisation. 3 Q. Is professional governance then a sort of subset of the 4 larger clinical governance? 5 A. It is a subset because they're so intrinsically 6 connected because of the practice of healthcare 7 professionals to the practice of healthcare, that they 8 are intrinsically linked, yes. 9 Q. I have also seen the phrase "corporate governance". Is 10 that a phrase that you're familiar with and use? 11 A. Yes. 12 Q. What aspect of the system would that apply to? 13 A. So corporate governance governs the arrangements that 14 need to be in place for an organisation to function to 15 ensure that they are compliant with all of the statutory 16 and legislation within place. Most of that is governed 17 by something called the "Blueprint for Good Governance". 18 So all healthcare authorities have to act within the 19 Blueprint for Good Governance, which state things like 20 you need so have a clinical governance committee, for 21 example. So the corporate governance states that you 22 need to have that under a board environment. The 23 responsibilities of clinical governance move to the 24 medical and nurse director to ensure that that's been 25 implemented through the organisation. Page 184

1 Q. You mentioned, I think a moment ago, adverse incident 2 management. 3 A. Yes. 4 Q. Would that be a system which exists within the corporate 5 governance system? 6 A. No, that would be within clinical governance. 7 Q. I see, but it's not part of corporate governance then? 8 A. So corporate governance covers everything. So corporate 9 governance covers that we have the correct clinical 10 governance arrangements in place within the 11 organisation. So the corporate governance is the 12 overarching banner that sits above every governance 13 arrangement within the organisation. 14 Q. You, as I said earlier, have contributed certain parts 15 to the statement. I have tried to endeavour to 16 understand exactly what it is that you've covered. So 17 if I can just go through the bits that you've covered, 18 some of which I'd like to ask you so some more detailed 19 questions about today. My understanding is, broadly 20 speaking, you've provided us with information in 21 response to questions to do with the complaint system, 22 to an extent? 23 A. Yes. 24 Q. In particular, I think what you dealt with was the sort 25 of overarching complaints systems and processes in Page 185	1 pointed out now I can understand where that comes from, 2 is you helped us with policies in relation to adverse 3 incident management, significant event management and 4 significant clinical event analysis; is that correct? 5 A. Correct, yes. 6 Q. Now, can we just, before we get into all the other bits 7 and pieces of that, just understand what the difference 8 is. Are those three different things? I said adverse 9 incident management, significant event management, and 10 significant clinical event analysis? 11 A. So what we were doing was giving you, as part of our 12 Rule 8 submission, the evolution of policies and 13 procedures. And terminologies often have changed over 14 that time. 15 Q. That's helpful. 16 A. A serious adverse event, so a SCEA, which I think is 17 described in some of the evidence that we've submitted, 18 is a type of adverse event that is the most serious of 19 nature. So that's a particular type of event. The 20 other adverse event management policies are more around 21 how we govern and what the processes were in place at 22 different points throughout the time that we gave 23 evidence against. 24 Q. Okay, and I think, as I understand it, you also 25 provided -- we also asked questions about whether there Page 187
1 place, what the policies were and that sort of thing, 2 but you also answered a specific question in relation to 3 how it was that the existence and operation of 4 complaints systems was promulgated amongst patients; is 5 that right? 6 A. Yes. I answered about that, yes. 7 Q. You answered questions about that? 8 A. Yes. 9 Q. However, we also asked questions about complaints 10 relating to Mr Eljamel and I think the executive medical 11 director answered that; is that right? 12 A. I mean, it was a joint effort. So the complaints team, 13 which is our patient experience team, currently sit 14 under my responsibility. So obviously for the 15 historical nature of it, they were pulling records and 16 being able to supply what we needed to as part of our 17 Rule 8 submission. 18 Q. Yes, but the questions relating to the specific 19 complaints were ones that were listed as being 20 Dr Cotton's responsibility in the way the statement was 21 set out? 22 A. Yes, I think it probably was both, to be honest. So 23 I have an awareness of them as well. 24 Q. Understood, that's fine. Other aspect you helped us 25 with, especially given the experience that you've Page 186	1 had been adverse event investigations or serious adverse 2 event investigations relating to aspects of Mr Eljamel's 3 practice and I think you responded to that aspect of 4 things? 5 A. Yes. 6 Q. So you told us: these are the investigations we've been 7 able to find and these are broadly what happened and the 8 outcomes; is that correct? 9 A. Yes. 10 Q. I wonder whether I could have a look with you, please -- 11 you provided a lot of information, as you say, about 12 policies and how they've existed over the years. But 13 you mention, as in the passage I have just gone to 14 there, I think you mentioned it in your explanation as 15 well, the clinical governance committee. Now, could you 16 tell me, first of all, is that a committee -- because as 17 you say, you were trying to help us to look back as well 18 as looking now, to the best you could, is that committee 19 a committee which, as far as you understand it, has 20 always been around within NHS Tayside or was it 21 an innovation that came along at a certain point in 22 time? 23 A. So, it came along at a certain point in time. As you 24 probably recognise from a lot of the information, the 25 construct of NHS Tayside has changed over time as well. Page 188

1 Q. Yes. 2 A. So 1998 there was a mail, so a circular from Scottish 3 Government around clinical governance and that really, 4 across Scotland, was the establishment of clinical 5 governance arrangements within health authorities. So 6 at that point a clinical governance committee was put in 7 place within the organisation. It's changed name and 8 remit and format over the years, but that was the start 9 of it. In 2000, there was a further circular that came 10 which I think we provided evidence for as well which 11 really just clarified that each health board needed to 12 have in place a clinical governance committee and it 13 clarified what the roles and responsibilities were at 14 board level. So overseeing, which was the committee's 15 role; implementation of clinical governance arrangement, 16 which is leaders' roles and clinical leaders within our 17 system; and then practitioners who have to work towards 18 making sure that they are compliant with clinical 19 governance arrangements. 20 Q. Just so I'm clear on this, the role of the committee -- 21 you, for example, have clinical governance 22 responsibilities. You sit on that committee, 23 I'm assuming? 24 A. Yes, myself and the medical director are the lead 25 officers for that committee, but it's a non-executive Page 189	1 A. So Datix is the repository system which NHS Tayside use 2 and many other health boards use to record all of our 3 incidents that happen. So if you work in a ward and 4 an incident happens, somebody falls, then you would 5 record that within this electronic system which allows 6 to us keep a repository of it. Complaints are also 7 logged within Datix, so the patient experience team log 8 all complaints within the Datix system. It also has 9 other functionality around dashboards, etc. 10 THE CHAIR: When you refer to "incidents", Mr Dunn, is that 11 medical incidents? It's not a kind of accident book 12 where somebody trips and slips or does it record all of 13 that? 14 A. Everything. So mainly related to patient incidents, but 15 if there were staff incidents, they would be recorded 16 within there as well. So if a staff member tripped and 17 fell within a ward, then it would be recorded within 18 that system too. So it's a complete repository. 19 MR DAWSON: So, obviously, as you've pointed out already, 20 you are trying to help with something in the past. So 21 there were systems, I think, that existed before Datix 22 came along? 23 A. Yes. 24 Q. Did Datix come along in 2011? 25 A. Came along in 2012/2013. 2012 started the roll out of Page 191
1 member that chairs it. 2 Q. So you're also part of the board and presumably you 3 report in to the board about clinical matters that 4 relate from that, insofar as that's necessary? 5 A. Yes. 6 Q. But that board is effectively -- that committee, sorry, 7 is a committee which is basically overall in charge of 8 the way in which clinical governance is set up and runs 9 throughout NHS Tayside; is that correct? 10 A. It's an overseeing committee to ensure that the set-up 11 of clinical governance, which is implemented through the 12 executive structure, is working, is robust, it has 13 scrutiny. They look for evidence around our 14 arrangements that were compliant with certain standards. 15 We will report external reports etc into that committee. 16 So that's a sub-committee of the board. 17 Q. Okay, A sub-committee of the board. 18 A. Yes. 19 Q. Understood. In relation to the way in which, I think, 20 may apply to complaints and adverse incidents are 21 recorded, you mention in the passages which you have 22 contributed on a number of occasions something called 23 Datix? 24 A. Yes. 25 Q. What is that? Page 190	1 Datix and between 2012 and 2013 it was fully rolled out 2 across the organisation. For incident management, there 3 was a system called AEM prior to that. For complaints, 4 for example, there was a system called CAFT. 5 Q. Right, so AEM, what did that stand for? I've seen that 6 as well. 7 A. Adverse event management. 8 Q. Right. So was that just another system that did the 9 same thing as Datix, in terms of covering the same sorts 10 of information being stored? 11 A. To be clear, I didn't work in the organisation at the 12 time, so I'm not clear exactly how the system worked and 13 whether it was compatible. 14 Q. Yes, but did complaints go in there? 15 A. No, they went into a different system. 16 Q. Was that system called the complaints and advice 17 management system? 18 A. Correct, yes. 19 Q. Okay, so just to be clear there's an adverse event 20 management system where adverse incident information 21 goes in, before 2012 roll-out, is that right? 22 A. Correct, yes. 23 Q. And then, alongside that, there's another system called 24 the complaints and advise management, I think it's CAMS 25 it was known as at the time -- I've seen it referred to Page 192

1 by the acronym -- and that was the complaint system? 2 A. Yes. 3 Q. And is it right to think when Datix came along, it 4 effectively dealt with both of those aspects? Adverse 5 incidents would be recorded there and also complaints 6 would be recorded there, is that right? 7 A. Datix has different modules. So, you know, the 8 NHS Tayside current Datix system has modules which allow 9 us to put complaints and incidents within it, so, yes. 10 Q. Yes, so it can do multiple functions that were 11 previously provided by perhaps multiple systems, is that 12 right? 13 A. Yes. 14 Q. Those other systems, the CAMS system and the AEM system, 15 they were computer systems too, were they? 16 A. Yes, as far as I'm aware. 17 Q. Yes, so they weren't just sort of a name for a cupboard 18 with hard-copy documents in it, they were computer 19 systems, as far as you understand? 20 A. As far as I understand, but actually when I look back at 21 some of the information and I think back to my 22 contemporary practise when I first qualified, incidents, 23 for example, were put onto carbon copies of incident 24 reports which went off to different levels of senior 25 management at the time. So it's unclear to me at what Page 193	1 all of the information that related to the Mr Eljamel in 2 a broad sense. 3 A. Yes. 4 Q. Because there hadn't been such a consolidation in the 5 past and I think they called that "the information log". 6 Are you familiar, at least, with the fact that's what 7 they called it? 8 A. Yes. 9 Q. Does such a thing still exist now? Do we still have 10 that information log? 11 A. Yes, we do, yes. 12 Q. And is that where a lot of the information that you and 13 your colleagues have provided to the Inquiry in 14 connection to the Rule 8 statement came from? 15 A. It's mixed, but if you -- for complaints, for example, 16 what they were able to do, as part of the preparation 17 for due diligence, was to gather the complaints, store 18 them in the information log from the different reviews 19 that had happened, different records that we had for 20 complaints. That didn't take away from our 21 contemporaneous logs that we hold in the patient 22 experience team, we still retain them obviously -- 23 Q. Right, I see. So in 2011, does that mean a copy was put 24 into the information log and a copy was retained within 25 the patient experience team? Is that what you're Page 195
1 point we moved from paper on to an electronic version. 2 Q. You've worked in various other health boards, haven't 3 you, before -- 4 A. I have, yes. 5 Q. So when you're talking about thinking back to the carbon 6 copy days, you're not talking about NHS Tayside 7 specifically, but just your general experience? 8 A. Just general experience, yes. 9 Q. Okay. So when one is looking back to the pre-2011 10 period, based on your experience of working elsewhere 11 and your understanding that these systems existed, could 12 it be the case that maybe there was a kind of hybrid 13 paper/computer system, broadly, in that period? 14 A. Yes, I mean obviously going back -- 15 Q. I mean further back, it would be all paper, yes. 16 A. Yes, yes. 17 Q. Okay. The reason I'm interested in that in particular 18 which pertains to some of the areas that you've helped 19 us with is, at the time of the due diligence report -- 20 are you aware of that, the 2023 due diligence report? 21 A. Yes. 22 Q. Which was undertaken by NHS Tayside, one of the things 23 that happened at that stage, as you'll probably be 24 aware, is that the team that were compiling the report 25 considered it important to try to consolidate together Page 194	1 saying? 2 A. Well, no, sorry. I thought you asked about the 3 preparation for the due diligence report in '23. 4 Q. Yes, but I was asking because of the fact that I wanted 5 to know whether, when the Rule 8 statement was replied 6 to, the place that the information was gathered from 7 would be the information log? It would make sense 8 because -- 9 A. Both, yes. 10 Q. -- in 2023, what the people then involved in the process 11 were trying to do was to pull together everything to do 12 with Eljamel into one place. So it would be logical, 13 would it not, that you would go -- if we were asking you 14 questions about Mr Eljamel, as we were, that you would 15 go there to try and find it? Is that right; is that 16 where you found that information? 17 A. Both. 18 Q. When you say "both", do you mean it was also found in 19 other places? 20 A. No, we also checked our patient experience log, our 21 Datix system. So for complaints, for example, we also 22 went into the archive to check for any records that 23 still retained. Obviously, a lot were destroyed as part 24 of our normal retention. But, yes, we used the log and 25 we used the information that we had and available Page 196

1 source. 2 Q. But what you're telling me is you didn't just rely on 3 the log? 4 A. No. 5 Q. You looked in other places where you thought you might 6 find useful things? 7 A. Yes. 8 Q. But as far as the log is concerned, is the log something 9 kept within a computer system, or is it documents, 10 hard-copy documents, what is it? 11 A. Both. So most of it is around things that may have been 12 in paper copy or things that may be electronic but have 13 been scanned on to an electronic version of it. So it's 14 to try and keep a repository and to make sure that 15 that's contemporary and up-to-date as possible. 16 Q. Understood. One of the things that is of interest in 17 a sort of historical investigation which you've been 18 helping us with, with your Rule 8 statement, is the fact 19 that at the time when the due diligence report was done, 20 there were -- there was limited material still available 21 pertaining to Mr Eljamel. The reason for that that's 22 given in the report is that material from before 2011 23 was destroyed in connection with the abandonment of 24 older systems. Is that your understanding of the 25 position? Page 197	1 A. So I did, I think, note it within my submission. So 2 I'm doing this from memory. I don't recall exactly. 3 I think it was '21, but it was noted within the Rule 8. 4 Q. Okay, but it was destroyed some years later in 5 accordance with the document retention policies. 6 Because AEM finished 2011, documents would be retained 7 for a certain period of time and when you hit a certain 8 date -- I don't know if it's eight years or something 9 like that for certain documents, then eight years later, 10 they would be able to say: well, everything in the AEM 11 system runs out in 2011, so if it's eight years, you get 12 to 2019 or if it's ten years, 2021, and you say: well, 13 we can destroy everything there because that's in 14 accordance with the policy; is that right? 15 A. Yes, it was destroyed as per the retention policy. It 16 was no longer accessible at that point. 17 Q. So -- I won't hold you to it, but it will be in the 18 statement -- if we work on the basis that it was done in 19 2021, that would be a ten-year policy for the latest 20 documents that was being applied; is that right? 21 A. So for complaints, the retention policy would state 22 seven years, as an example. 23 Q. Seven years. So the complaints from, say, 2010 then 24 would have been destroyed in 2017; is that right? 25 A. I'm unclear whether they were destroyed per year. So Page 199
1 A. Yes. So for example the AEM system that you mentioned. 2 Q. Yes, indeed, precisely. So does that mean that it's 3 still the case that we can't access information from 4 before that date or, in the additional searches you've 5 undertaken, have you been able to find information from 6 before that date that's relevant to what we asked you 7 for? 8 A. So what we were unable to look at was anything that was 9 recorded within the AEM system, for example, for adverse 10 events prior to that date because that system no longer 11 existed and was destroyed as part of normal retention. 12 So what we're unclear about is anything that was in that 13 system. Any record that we had which may have been on 14 paper format or may have been stored for another reason 15 somewhere else, that was retained and handed in as part 16 of the repository or collected as part of the 17 repository. 18 Q. So did the AEM system -- was that a system in which 19 adverse incidents were recorded up to 2011, broadly -- 20 roughly? 21 A. Yes, that's correct, yes. 22 Q. And at some point, all of the contents of that system 23 were destroyed? 24 A. Yes. 25 Q. When was that? Page 198	1 for example, the original complaint that comes in at 2 that point often came in, in paper format. So they were 3 stored in the archive and every year, those archives are 4 destroyed. Now things come in, in much more electronic 5 formats and they are automatically filed within the 6 electronic database. So it depends on the method that 7 the complaint came in, as an example. 8 Q. Okay. One of the areas, as we say already, that you 9 helped us with was the adverse event management policy. 10 Could we have a look at a document, please, NHST-01553. 11 Zoom in a bit, please. This, I think, is a copy of one 12 of the documents that you provided in connection with 13 sections you answered which was -- it's a copy, I think, 14 of the adverse event management policy for NHS Tayside; 15 is that right? 16 A. Yes. 17 Q. If we scroll down a bit, we can see a bit about the 18 dates. It tells us, I think, this one was an update 19 to August 2013; is that right? 20 A. Yes. 21 Q. But you can see, from the policy establish date, that it 22 was -- this was a policy that had been in place in 23 different iterations since July 2002. Is that right? 24 A. Yes. 25 Q. Did you look at, in the statement, questions around the Page 200

1 extent to which this policy, which would be sitting over 2 the way in which things should operate with regard to 3 adverse incident management, what systems existed for 4 this policy being disseminated to staff? 5 A. So back in 2013, do you mean? 6 Q. Well, I mean really over the whole period for which this 7 existed because that's a question we asked you? 8 A. So the general dissemination of policies would be that 9 any update to new policies would be shared throughout 10 the organisation. The contemporary way of doing that 11 would be through a Vital Signs to make sure that people 12 are aware. 13 Q. Is that a kind of email? 14 A. It's a kind of communication newsletter. It's currently 15 in email and obviously, prior to that, it was it in 16 paper format available for people. These would be 17 updated through our professional leadership structures. 18 So any policies that would need professionals to be 19 aware of them, it would be their responsibility to 20 ensure that people knew how to use them and were aware 21 of the details within that policy. 22 Q. Did you look into systems around NHS Tayside ensuring 23 that policies like this had been read by the relevant 24 people within the organisation, what systems existed for 25 that? Page 201	1 any incidents within the organisation that would look 2 like that the policy was not fit for purpose or needed 3 updated. Have we had any feedback from anybody within 4 the organisation. That group has peer people around it, 5 so it's people that understand the policy and also 6 people that work across the organisation at different 7 levels. 8 Q. Okay. And the group that you said that was involved in 9 that, just for clarity? 10 A. Clinical policy implementation group and that reports up 11 into the clinical governance committee to endorse all 12 new policies that happen within the organisation, 13 clinical policies. 14 Q. Clinical policies, of which this would be one? 15 A. Yes. 16 Q. Could I just have a little bit of a look at some of the 17 content of this, please. Page 4. It says there: 18 "NHS Tayside recognises and accepts that it has 19 legal and other requirements for managing all incidents 20 and near misses. The organisation seeks to establish 21 a balance of proactive and reactive risk management 22 processes to enable early identification of potential 23 problems thus creating prevention cycles and enhance 24 patient ... safety." 25 So that's the general purpose of this is to try and Page 203
1 A. I don't think there's any system to be able to tell us 2 whether a policy has been read that I'm aware of. 3 Q. There's no such system? 4 A. Not to say that a policy has been read. 5 Q. Okay. Is there any system by which -- which you were 6 able to find in your searches which suggested that -- 7 was there any system in place to try to make sure that 8 people had understood this policy? 9 A. I don't think there is a system that allows us to record 10 information on whether a policy is understood. 11 Q. Does that relate to any policy, or just this policy, 12 what you just said? 13 A. I don't think there's a specific system. It's more that 14 mechanism of communication through the line, clarity 15 around the purpose of a policy, clear understanding of 16 who owns that policy around professional roles and 17 responsibilities within the organisation and then 18 monitoring compliance against the policy. 19 Q. Well, how would you monitor a compliance against the 20 policy then? 21 A. So for example for clinical policies, which this would 22 fall into, we have a clinical policy implementation 23 group. That clinical policy group looks at the 24 robustness of our policies, when they're due for review, 25 how do we know that a policy a working, has there been Page 202	1 look at evidence of things that have happened or there 2 have been near misses, to try to prevent similar things 3 happening in the future, is that right? 4 A. Yes. 5 Q. And there are some definitions which may assist with 6 some of the questions the Chair asked earlier. The 7 definitions, if one scrolls down a bit. It says that: 8 "The term incident refers to an unplanned or 9 unexpected occurrence or event arising during NHS 10 service provision where there is loss of life, harm, 11 injury, loss or damage to persons or property. It can 12 include any event that may give rise to physical, 13 emotional or psychological harm." 14 So insofar as this policy refers to things that 15 people need to do around incidents, that's the 16 definition; is that right? 17 A. In 2013, yes. 18 Q. Yes, do you have any reason to believe the definition 19 was any different to any other time? 20 A. No, I'm just referencing the date of the policy. 21 Q. And I suppose having had a look at this policy, there 22 are aspects of it which I'm sure would be changed over 23 the years, in the sense that it refers to other systems 24 that come in, it has perhaps technological advancements, 25 that sort of thing, new website addresses. But Page 204

1 I'm assuming, in Tayside's favour frankly, that a policy 2 of this nature would include these essential components 3 throughout; would that be fair? 4 A. Yes. 5 Q. It also refers to something that was mentioned at the 6 beginning: 7 "A near miss is any incident that had the potential 8 to cause harm but was prevented, resulting in no harm 9 but could have resulted in harm, loss or damage in other 10 circumstances." 11 And it's important that employees would understand 12 and follow the idea, I think, that we're not just 13 looking at incidents, but circumstances where something 14 may have caused incident because that can teach us 15 lessons too, is that right? 16 A. Yes. 17 Q. Over the page, it says, under "Aims and objectives": 18 "The NHS Tayside Adverse Event Management Framework 19 covers all accidents, incidents, near misses and system 20 failures which, either caused, or could have caused, 21 injury or death to individuals or damage or loss to 22 NHS Tayside property." 23 And says, in paragraph 3: 24 "The primary purpose of our significant event 25 management framework is to improve systems, practice and Page 205	1 Q. It does, however, say: 2 "... in the event of negligence, intended harm and 3 professional mal-practice the reporting framework will 4 convert into a disciplinary procedure ..." 5 So therefore the idea that these things are separate 6 isn't quite right, is it, because if you report 7 something and it turns out to be your fault, it will 8 automatically become a disciplinary process? 9 A. So this is a reporting system of the incident, what it 10 isn't is the investigation of the incident. That's 11 determined by the severity of the incident, the initial 12 investigation into the incident that was reported and 13 then determination of the correct route of that 14 investigation. So I think that's what it's trying to 15 convey. 16 Q. It says, in "NHS Tayside Fair and Just Culture" that -- 17 just reading the second sentence a little further down: 18 "When events occur that cause harm or have the 19 potential to cause harm to patients or staff members or 20 place NHS Tayside at legal, financial or ethical risk, 21 a choice exists: to learn or to blame." 22 Is the policy really about trying to deal with 23 situations which NHS Tayside may be in legal, financial 24 or ethical risk? 25 A. No, the policy is to report any incident or near miss Page 207
1 care and NOT to apportion blame. All staff have 2 a responsibility to report incidents and take 3 appropriate remedial action where relevant. However, in 4 the event of negligence, intended harm and professional 5 mal-practice the reporting framework will convert to 6 a disciplinary procedure where appropriate. It is 7 important to remember that Incident 8 Reporting/Investigation are distinct from disciplinary 9 procedures. The purpose of this is to encourage staff 10 to recognise a 'just' reporting culture as the bedrock 11 for sustained changes in practice to improve patient 12 care and services." 13 So what the policy, I think, is trying to promote is 14 an obligation on staff to report a high number of 15 incidents or near misses because that will result, 16 I think, in a larger pool of information to aid with 17 prevention in the future; is that correct? 18 A. Yes. 19 Q. And it says there -- it's trying to make the point there 20 that there's a separation between the reporting system 21 and the possibility you might be blamed for it. Again, 22 I think the theory behind that is to encourage people to 23 report things without the fear they're going to get into 24 trouble for it. Is that broadly right? 25 A. Correct, yes. Page 206	1 that's happened in a clinical environment or any 2 environment within NHS Tayside so that it's investigated 3 appropriately. A "just culture" is a terminology 4 suggested by Healthcare Improvement Scotland and all 5 adverse event management policies are guided by 6 Healthcare Improvement Scotland's guidance on it and 7 it's to state that when you do the investigation, you do 8 it in a just culture way. So it's about learning, it's 9 about recognising where you can improve practice, it's 10 about recognising if something went wrong how do we 11 learn from it and prevent it from happening in the 12 future. 13 Q. Is that -- what you just said there, what a "just 14 culture" way of doing it means? 15 A. A just culture way is to ensure that it's focused on 16 learning. 17 Q. Okay, it goes on to say: 18 "Within NHS Tayside we are committed to creating a 19 work environment that emphasises learning rather than 20 blame." 21 As you just said. 22 A. Yes. 23 Q. "We want all workplaces across NHS Tayside to be 24 environments where respect and fairness are obvious from 25 the moment staff walk into work. We want staff to feel Page 208

1 safe in putting their hands up to report mistakes, speak 2 up about flaws in our systems and not be party to 3 inappropriate or risk-taking behaviours." 4 It then acknowledges that: 5 "Most errors, whether or not they cause harm, are 6 due to breakdowns in the organisations systems ..." 7 Is that correct? 8 A. I think that's a reflection of recognition that when 9 incidents happen within an organisation often it's 10 a complex thing that's caused the incident to happen. 11 Could be procedural, process. So it's trying to take it 12 away from that all incidents are about individuals. 13 They could be about the environment, the place that you 14 work, the processes that overlay whatever you're doing, 15 the task. 16 Q. But it says here: 17 "Most errors, whether or not they cause harm, are 18 due to breakdowns in the organisations systems." 19 Is that not right then? 20 A. I think that would be a fair assumption. There are 21 systems and processes that support how organisations run 22 and if incidents happen, then we need to look at it in 23 the round. 24 Q. One of the things that is a responsibility here, in 25 accordance with what you've said, is it says, at Page 209	1 list for Significant Clinical Event Analysis ... or is 2 a "never" event, the General Manager or Head of Nursing 3 must be advised immediately and they will escalate to 4 the relevant Executive Director within 1 hour." 5 So what this recognises, I think, is that there is 6 a reporting obligation on everyone, yes; is that right? 7 A. Yes. 8 Q. The second feature is that that obligation falls on the 9 first person to come across an incident or accident, 10 irrespective of what their connection to the domain or 11 the job is; is that the principle? 12 A. Yes. 13 Q. And that there is a premium, I think, put on the speed 14 with which incidents need to be reported. Is that 15 connected to the fact that the quicker one reports 16 something, the more likely it is that something can be 17 done and prevention can be put into place? 18 A. Yes, it's to ensure that something of such significance 19 in an incident is reported to the most senior place in 20 the organisation to assess it. 21 Q. Yes, and that, the relevant -- the reference there to 22 the "General Manager or Head of Nursing", head of 23 nursing is you now, is that right? 24 A. Well, "Head of Nursing" is the terminology for a lead 25 nurse, so it's not necessarily my level. Page 211
1 paragraph 3.1 just a little bit further down: 2 "All staff are accountable for following the 3 procedures defined within this Policy." 4 That's important, yes? 5 A. Yes. 6 Q. And it says at the bottom: 7 "All staff have a professional responsibility to 8 report incidents and near misses and taking appropriate 9 remedial action where relevant. Responsibility for 10 raising an incident report within Datix lies with the 11 first person [or persons] to recognise [or] become 12 involved in the incident or near miss 13 irrespective/regardless of their domain, department or 14 position within the organisation or area in which the 15 incident occurs." 16 Going a bit further down to 4.1, there's a bit more 17 information given about what that means in a time sense. 18 It says, in the middle of paragraph: 19 "The first person to recognise or become involved in 20 the incident, irrespective of domain, department or 21 position within the organisation or areas in which the 22 incident occurs, is responsible for completing the 23 incident reporting form within Datix as soon as possible 24 but within 24 hours of occurrence for all incidents and 25 near misses. However, if the incident features on the Page 210	1 Q. Oh, I see, so it would be the head of that department or 2 something -- 3 A. Yes. 4 Q. I understand. And that the general manager, one sees 5 quite a lot as well. What does that mean? Is that 6 a manager of an area or ...? 7 A. Yes, it's not a contemporary term in NHS Tayside now, 8 but it was the manager that was responsible for surgery, 9 for example, or that specialist. 10 Q. Okay. So they would be the points of contact? Head 11 nurse or general manager for the surgical area or 12 something like that? 13 A. Significant leadership. 14 Q. And it refers there -- in particular, it imposes -- 15 THE CHAIR: Sorry, I didn't hear. 16 A. I'm just saying of significant leadership level. 17 THE CHAIR: Right, thank you. 18 MR DAWSON: And it speaks there about there being very 19 particular time requirements in certain extreme 20 circumstances, is that right? And it refers to 21 "Significant Clinical Event Analysis" or 22 a "'never' event". Now, without going into the details 23 necessarily, those are at the very high end of severity, 24 is that right? So a "never" event would be the top and 25 then there's another level of severity below it and then Page 212

1 there's all other incidents, is that broadly right? 2 A. Broadly, yes. 3 Q. Yes. There are lots of specifics that the report goes 4 into, but could I have a look, just in that regard, 5 please, at page 10, because as the Chair asked earlier, 6 this covers a multitude of different things that can 7 happen in a hospital. For example, it can cover 8 accidents to staff, as you said, it can cover clinical 9 things to do with patients, or -- any occurrence really 10 which has the possibility to cause harm is covered here; 11 yes? 12 A. Yes. 13 Q. On page 10, there's a bit more of a definition given 14 here as to these more serious events. Could I just go 15 back to the previous page, just to cover off something 16 else. Page 9. Sorry to jump around. There is, here, 17 an explanation of different types of reviews because 18 reviews are the way in which the system looks back on 19 what's happened to try to learn lessons; is that 20 correct? 21 A. Yes. 22 Q. And there's something called a "Local Incident Review" 23 at 5.1 and it says that that requires to: 24 "Be held within 7 days of the incident where it is 25 identified as on the list for Significant Clinical Event Page 213	1 out what happened, but because it's not so serious, the 2 design is that it can be resolved at that level, 3 hopefully? 4 A. Yes. 5 Q. Great. And it goes on to give some information about 6 what would be included as these sorts of things, 7 therefore, requiring to be investigated along those 8 timescales. 5.2, over the page, it says: 9 "A Significant Clinical Event Analysis must also be 10 held for the following Never Events ..." 11 And the first one on the list is "Wrong Site 12 Surgery"? 13 A. Correct, yes. 14 Q. So wrong-site surgery, within the policy, is 15 a "never" event? 16 A. Correct. 17 Q. What does "never event" mean? 18 A. It shouldn't happen. It doesn't mean that it never 19 happens, but it means that it shouldn't happen because 20 the mechanisms that support the incident, or the thing 21 that you're doing, so wrong-site surgery, for example, 22 should be so robust and in place that it shouldn't 23 happen. 24 Q. I mean, obviously it must happen because otherwise there 25 wouldn't be an incident to investigate? Page 215
1 Analysis ... or is a "never" event otherwise to take 2 place within [20] days of the occurrence of the event." 3 Now, my understanding of this is that a local 4 incident review would take place in certain 5 circumstances where a threshold were met and that would 6 take place whether the incident was part of the serious 7 clinical -- the significant clinical event or 8 a "never" event or in other circumstances, but in other 9 circumstances, that would be the review. But in the 10 previous two, there would be a further investigation on 11 top of it; is that right? 12 A. So that's not contemporary practice, but that's my 13 understanding of this policy at the time. 14 Q. That's what the position would be at the time. So 15 effectively, for the more serious ones, you would have 16 a local incident review? 17 A. Yes. 18 Q. The theory by that, presumably, you have people who are 19 local to it, who look into it, try to find out what's 20 gone on. But then it needs to be escalated to a higher 21 level because someone at a higher level needs to look at 22 it because it is significant; is that right? 23 A. Yes. 24 Q. Whereas a local incident review has the people local to 25 that incident, department or whatever, trying to work Page 214	1 A. Yes, that's why I say "should", yes. 2 Q. But the idea, I think, is that it is something should 3 never happen -- 4 A. Should never happen. 5 Q. -- therefore it's in the highest grade; is that right? 6 A. Yes. 7 Q. Understood. There's one other aspect I would like to 8 ask you about. You've helpfully provided us with some 9 information in relation to the investigations under 10 these policies in relation to Eljamel patients and 11 you've given us, I think, an indication that there were 12 a number of investigations, some of which were under the 13 adverse incident policy and some of which -- one of 14 which, I think, you've identified as being something 15 which occurred within the significant clinical event 16 analysis policy; is that correct? 17 A. Yes. 18 Q. Thank you. In particular, I would be interested to ask 19 you about -- could we go, please, to paragraph 120.1 of 20 the statement. This is where you were telling us about 21 the information you had about the significant clinical 22 event that you found. 23 A. Yes. 24 Q. So we'll just have a look at that. Scroll up a bit to 25 the question. You were asked: Page 216

1 "Please explain the process which was followed to 2 generate significant clinical event analysis ('SCEA') 3 into any cases involving former patients of Mr Eljamel, 4 including the patient(s) to whom they related and the 5 methodology and reasoning why the relevant cases 6 qualified for such an analysis, whereas other[s] ... did 7 not." 8 And you told us, if we just scroll down: 9 "One case has been identified involving a patient of 10 Mr Eljamel and has been categorised as wrong site 11 surgery. [And as we've seen] this 'qualified' for SCEA 12 because of the categorisation of 'wrong site surgery', 13 as a 'never event' ..." 14 And that was passage we were just looking at, 15 I think: 16 "... further explained below." 17 So you provide the details to us, and indeed, you've 18 provided the actual review, it has a number. It related 19 to a surgery on 18 July 2011. It says: 20 "This was recorded on the AIM system and was 21 triggered after the patient contacted the Chief 22 Executive on 5 December 2012 ..." 23 So this was relating to a surgery which took place 24 in July 2011, but what -- the investigation was 25 triggered only in December 2012, is that right? Page 217	1 Datix system of which noted Professor Eljamel within 2 them. They were all supplied, yes. 3 Q. Yes, and as far as that -- the other investigations are 4 concerned, just to try to fit it in to where it fits in 5 the policy, does that mean they were the local incident 6 investigation system; is that correct? 7 A. It depends. It depends on the level. So usually you're 8 categorising something as "minor", as "moderate" or as 9 "severe". So it's not necessarily separate around 10 "never" events. It's a severity of the incident would 11 fall into that. So "minor", you might not do a local 12 adverse event review, you might just review the incident 13 and close it. "Moderate" you would probably want to do 14 a local adverse event review because it's a more 15 moderate incident. And the most severe, you should do 16 a serious adverse event review which is current 17 practice, or a SCEA back in the policy we're looking at. 18 Q. I see, but those events are sitting within that -- if 19 they are reviewed, are sitting within that lower level 20 of the system that we looked at as opposed to the 21 "never" event or the serious clinical adverse event; is 22 that right? 23 A. So my professional view, having looked at all of the 24 four events that I supplied to you, is one of them 25 should have triggered a SCEA because it was a similar Page 219
1 A. Yes. 2 Q. And this was a "never" event, is that right? 3 A. When it was triggered, yes. 4 Q. Yes. It was a "never" event before that, wasn't it, 5 when it happened? 6 A. So an incident is reported when the incident is known. 7 So I think we've also supplied you with a complaint 8 letter related to the same incident. So this incident 9 wasn't known at the time of the operation, it wasn't 10 until I think just over a year later where it was 11 recognised that wrong-level surgery had taken place. 12 Q. But it was always the case wrong-site surgery should 13 never have happened, isn't that right? 14 A. Correct, yes. 15 Q. So in that sense, it was always a "never" event? 16 A. Yes. It was a "never" event, yes. 17 Q. Thank you. And just to understand, this was the only 18 case that you found that fell -- which had triggered 19 an investigation under that significant clinical event 20 analysis, is that right? 21 A. Yes. 22 Q. Because there were -- I think were there four others you 23 found that were under the adverse incident management 24 policy, is that right? 25 A. There were four other incidents reported within the Page 218	1 situation to this one, so it was a wrong-level surgery. 2 Q. Yes, understood. 3 A. It was noted, again later after the surgical date, in 4 2013 when it was reported, I think September 2013 from 5 memory. So in my eyes, that should have been a SCEA. 6 The other three, I don't think were, no. 7 Q. Right. Could we have a look, please, NHST-00075. This 8 is the due diligence review that I referred to earlier. 9 Part of this review involved looking at a number of 10 cases and looking at the way in which the adverse 11 incident management, serious clinical event management 12 system had dealt with key problem cases under 13 Mr Eljamel's ambit, is that right? 14 A. Yes. 15 Q. So could we have a look, please, at page 18. So this 16 was a sort of run-down of the different cases that 17 existed with some broad information about them and it 18 tells us some information about the way in which the 19 cases came about. Now, there were six cases looked at 20 and four of them were wrong-site surgery; can you see 21 that from "issue"? 22 A. Yes. Yes. 23 Q. And it shows us that for four of the cases, it was 24 a complaint that triggered the review, as you said could 25 happen. And it was -- in two of them, it was Datix. Page 220

1 For the two that are Datix, does that mean it wasn't 2 a complaint so someone logged it in the system, is that 3 how it works? Someone internal to the organisation has 4 logged it; is that what that means? 5 A. So for example, if you look at the second one down, what 6 it would look like to me was that it came in as 7 a complaint on 5 December. When it was noted that the 8 complaint content was something that was a significant 9 incident, that was recorded within Datix. That would be 10 my understanding of it. 11 Q. Yes, I think that's the one we were talking about 12 earlier? 13 A. It was, yes. That's exactly the one. 14 Q. The dates are coincident and it's a wrong-site surgery. 15 A. Yes. 16 Q. And as you explain, the actual date was July 2011? 17 A. '11, yes. 18 Q. But what triggered what you said was the significant 19 clinical event analysis was the complaint that came in 20 December 2012; is that right? 21 A. Yes. 22 Q. What I'm trying to highlight here though is that in 23 these cases, there's a significant gap between the 24 operation date and the complaint or the Datix, in all of 25 them. So for example in the first one, it's Page 221	1 Q. Of course. I understand how the technical system works, 2 but the principle behind the system is trying to make 3 those two dates very close together, as I understand it, 4 such that the investigation happens and that the 5 incident can be addressed as soon as possible after the 6 event, not many years after, is that right? 7 A. If you know there was an event, then it should trigger 8 it as soon as the event is known and normally that would 9 be immediate. 10 Q. But the staff in the hospital are obliged, in terms of 11 the policy, to report the event pretty much as soon as 12 it happens, isn't that right? 13 A. When the event is known, yes. 14 Q. Yes, but if something happens in hospital, it is known. 15 If an operation happens, a wrong-site surgery, someone 16 knows it's happened, don't they? 17 A. Well, it's unclear to me, in relation to these cases. 18 So the one, for example, that we looked at, the SCEA, it 19 wasn't known it was wrong-site surgery at the point the 20 operation happened. It wasn't until later when 21 a patient received a scan that it was recognised, the 22 wrong-level surgery had happened. 23 Q. So, do I understand -- you obviously have significant 24 experience and responsibility in this area. So do 25 I understand your position to be that the system worked Page 223
1 a complaint-triggered one. 2 A. Yes. 3 Q. The event was on 24 January 2007 but it wasn't 4 investigated within the system until 10 June 2014. Is 5 that right? Is that what it says? 6 A. So it looks like a complaint came in on 10 June 2014, 7 yes. 8 Q. Yes, so that triggered the system coming into operation. 9 As you said earlier, the complaint had triggered for the 10 one you looked at; is that right? 11 A. Yes. 12 Q. But is it not significant, when the theories that lie 13 behind the adverse incident management policy are to try 14 to instigate an investigation, local and then more 15 serious if necessary, as soon as possible, and that 16 there is an obligation on all staff to report any 17 incident, no matter how minor, that there are 18 several years between the dates when something happened, 19 something that either did or could have caused harm, 20 that's an incident, and when it was actually being 21 looked at internally? As someone who has responsibility 22 in this area, is that concerning to you? 23 A. The date of the operation and the date the incident are 24 known are two separate dates. So an incident should be 25 reported as soon as the date that the incident is known. Page 222	1 fine because as soon as the complaint was made, the SCEA 2 was triggered? 3 A. As soon as an incident is aware, we should report it and 4 then the severity of that incident is assessed and this 5 one, it would have been a SCEA that should have been 6 triggered, yes. 7 Q. Now, we can go through the details if you like, but in 8 this there is a report to suggest there are, in fact, 9 two serious clinical event analyses. The patients are 10 given letters here, just to anonymise it, I'm assuming, 11 and the ones that are given the letters are patient C, 12 which is the one we looked at, which is the one that you 13 identified, it's the same date, the same patient 14 I think. Is that your understanding? 15 A. Yes. 16 Q. That is what I worked out. And the other one is one of 17 the other patients but there is comment on the way that 18 the system worked for all of these patients. So if we 19 look, for example, at patient A, if we scroll down 20 there's an analysis of patient A and it says, at five 21 lines up from the bottom, in relation to the handling of 22 patient A: 23 "There is no documented evidence of a formal 24 investigation conducted under the adverse events policy 25 and no evidence of an apology from NHS Tayside at the Page 224

1 time that the complaint was received. Subsequently, 2 patient A has received an apology from the Chief 3 Executive and the Chair of NHS Tayside in 2022 and 4 a subsequent detailed review of their surgical procedure 5 by the Executive Medical Director which they received 6 in March 2023." 7 So this was, if we scroll up to the top again, have 8 a look at patient A, a wrong-site surgery. And there 9 was no documented evidence of a formal investigation 10 conducted under the adverse events policy. Is that not 11 a very significant omission? 12 A. Yes. 13 Q. If we look at patient D, again, that's a wrong-site 14 surgery. Again, bottom two lines, it says: 15 "... there is no evidence of a formal adverse event 16 review which should have been triggered in line with the 17 Adverse Events policy." 18 Again, the same outcome really, is that right? 19 A. Yes. 20 Q. Could we have a look at patient E, please. This whole 21 thing here, this is again anonymised. It says: 22 "Patient E was operated on by Professor Eljamel for 23 an intramedullary lesion on 29th April 2013. X-ray 24 marking was used to guide the level of surgery and a 25 radiological procedure was undertaken during the Page 225	1 I'm wrong -- the due diligence report in this context, 2 in the analysis of the way that the systems work, 3 whether they work well, adverse events and also 4 significant clinical event reviews, looked at six cases, 5 is that right, patients A to F? 6 A. Yes. 7 Q. And in selecting those cases, what the authors of the 8 due diligence review were trying to do was, I assume, to 9 look at a sample which would give an indication as to 10 whether the systems worked well or not, is that right? 11 A. Yes. 12 Q. And one sixth of those cases didn't even involve 13 Mr Eljamel; is that correct? 14 A. That's correct. 15 Q. Thank you. 16 MR DAWSON: Sir, those are my questions for Mr Dunn. 17 THE CHAIR: Would you like to invite him to make any 18 observations? 19 MR DAWSON: Yes. Mr Dunn, thank you very much for your 20 evidence. At this point, I offer the witness the 21 opportunity to say whatever it is they would like which 22 they think may be helpful to the Chair of the Inquiry. 23 So I will invite to you do that. 24 A. Thank you. I suppose just to recognise the role I hold 25 as Executive Nurse Director for NHS Tayside, you know, Page 227
1 procedure. However, the spinal tumour was not 2 successfully removed because surgery was performed at 3 the wrong level. This was logged as a 'never event' on 4 12th July 2013 and the SCEA was commissioned following a 5 local incident review that took place on 6 12th August 2013. The SCEA took place some 7 months 7 later on 3rd March 2014. The report from the SCEA was 8 finalised on 2nd June 2014, 14 months after initial 9 surgery and 11 months after the issue was logged as 10 a 'never event'. It is mentioned in the SCEA report 11 that patient E had communicated his concerns but this 12 has not been formally logged as a complaint at any 13 time." 14 Now, patient E's case didn't show up your analysis 15 of the SCEA. Can you tell us why that is? 16 A. So obviously this was produced before my time and 17 I wasn't part of the production of the due diligence 18 report. What we submitted was all cases that we had 19 record of Mr Eljamel being the surgeon. When we did 20 a cross-check with the clinical notes for patient E, it 21 wasn't Mr Eljamel that operated on this individual. So 22 we're unclear why it was included within the due 23 diligence report. I think we noted it in 2.20 of the 24 submission of the Rule 8. 25 Q. So as I understand it -- you'll explain to me if Page 226	1 it is incumbent upon me to make sure that any learning 2 that comes from this Inquiry that we have not recognised 3 before is put in place within NHS Tayside. I recognise 4 the lasting impact that this has had on many patients 5 and I will commit, every day in the role that I hold, to 6 building the confidence back with patients. Thank you. 7 THE CHAIR: Thank you very much for that, Mr Dunn. We're 8 going to have a short break because, as we always do at 9 this stage, we just need to check that there aren't any 10 further questions that parties may wish to raise. So if 11 you could go with Ms Miller in the meantime, we'll be 12 ready to resume again shortly. 13 (5.03 pm) 14 (A short break) 15 (5.15 pm) 16 THE CHAIR: Have a seat, Mr Dunn. 17 MR DAWSON: Just A couple of questions, Mr Dunn. 18 A. Yes. 19 Q. We had a discussion about the role of nurses, the types 20 of nurses that one might see, in particular in 21 a surgical environment. But in a broader sense, to 22 combine two of the areas that we've discussed, do nurses 23 get involved in the investigations connected to adverse 24 event reviews or significant clinical event reviews? 25 A. Yes. Page 228

1 Q. What role might nurses theoretically play in that? 2 A. It would depend on the detail of the adverse event. So 3 they may lead it, they may be the lead investigator 4 within it, they may contribute to it, they may be 5 a witness or an expert as part of the investigation 6 review. They may review the incident when it happens to 7 assess the severity of it. So nurses are working within 8 clinical environments all of the time so they will tend 9 to have quite a significant role to play in incident 10 management. 11 Q. Given what we discussed earlier about the nurses, 12 theoretically, in a neurosurgical unit being dedicated 13 to that, if there were investigations into what had 14 happened, it would presumably be important to involve 15 nurses in that because they are likely to have relevant 16 and important information? 17 A. Yes, correct. 18 Q. In the same way as we saw in the Royal College of 19 Surgeons' report, they went to speak to the nurses and 20 I think we're both in agreement that it was probably 21 a good thing to do because they will probably be able to 22 tell them what was happening? 23 A. Correct, yes. 24 Q. One other aspect is at one stage in your evidence, you 25 refer to Mr Eljamel as "Professor Eljamel". Is that Page 229	1 and the investigations that you undertook in that 2 respect. They're all very much appreciated. You're now 3 free to go, thank you. 4 A. Thank you. 5 (Witness withdrew) 6 THE CHAIR: 10 o'clock? 7 MR DAWSON: Nothing further, sir. 8 THE CHAIR: Thank you. 10 o'clock, everybody. 9 (5.18 pm) 10 (The hearing adjourned until 10.00 am on Friday, 11 18 September 2026) Page 231
1 a name by which he is still commonly known within 2 NHS Tayside? 3 A. No, I just referenced it because I recognised the title 4 that often comes with Mr Eljamel's name, so -- but no. 5 Q. But it wouldn't normally be that when discussions are 6 being had in an executive level or anything like that 7 about anything to do with this, that he's still referred 8 to that? 9 A. No. 10 Q. He would be "Mr Eljamel", I'm assuming? 11 A. Yes. 12 MR DAWSON: Okay, thank you for that. Thank you for your 13 evidence. 14 THE CHAIR: Mr Dunn, that's now the end of your evidence. 15 A. Thank you. 16 THE CHAIR: I'm afraid, we were a little late in starting 17 your evidence, so I'm sorry that you probably found 18 yourself waiting for a certain amount of time. It 19 necessarily follows that we are probably here a little 20 later than you anticipated too, but it, nonetheless, is 21 incumbent upon me to express, on behalf of the Inquiry 22 and indeed on my own behalf, my thanks for your evidence 23 this afternoon, the insights and reflections you have 24 provided but also your contribution to the NHS Tayside 25 statement and the generation of the associated documents Page 230	1 MR CHARLES MASSEY and MR ANTHONY OMO1 (called) 2 MR CHARLES MASSEY (sworn)1 MR ANTHONY OMO (sworn)1 3 Questions by COUNSEL TO THE INQUIRY1 MR SIMON DUNN (sworn)170 4 Questions by COUNSEL TO THE INQUIRY170 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 232

A				
AA 9:14	accepts 203:18	active 98:19	204:24	agreement 91:19
AAs 7:21 10:17	access 132:25	168:25	adverse 83:1 185:1	91:21 229:20
12:13	198:3	activities 7:19	187:2,8,16,18,20	agreements 31:13
abandonment	accessible 199:16	12:16 13:12	188:1,1 190:20	31:14,17 32:10
197:23	accident 191:11	129:8	192:7,19,20	ahead 36:17 67:6
ability 26:2 55:17	211:9	acts 82:20 86:23	193:4 198:9,19	96:8
55:22 58:3 68:14	accidents 205:19	160:10	200:9,14 201:3	aid 206:16
71:22 72:2 80:25	213:8	actual 84:6 217:18	205:18 208:5	AIM 217:20
94:2 109:17	account 11:25	221:16	216:13 218:23	aimed 19:5
119:11 127:23	47:8 49:23 85:3	acute 5:6 98:3	219:12,14,16,21	Aims 205:17
128:3 137:14	114:17 117:10	add 4:17 42:23	220:10 222:13	Al-Fateh 118:1,2,3
153:18 175:18	136:24 145:3	56:4 59:18 79:6	224:24 225:10,15	118:4
180:3 183:8	accountability	143:13,14 158:6	225:17 227:3	Alan 149:12
able 6:6 10:16,20	5:13 10:25 11:6	159:6	228:23 229:2	alarm 33:22,22
11:21,24 16:2	11:10 12:4	added 66:6 134:6	advice 6:20 7:25	albeit 112:23
17:8 18:3,11	172:21 181:22	adding 19:13	9:20 18:19 34:4	137:7
26:1 27:24 31:10	accountable 7:12	28:23 132:13	133:18 192:16	all-encompassing
31:21 32:1 42:8	7:20 10:2,22,23	addition 7:21	advise 192:24	128:14
51:14 53:2 56:17	11:1 210:2	13:12 62:13	advised 211:3	allegation 43:8
56:23 57:8 65:8	accurate 164:14	122:9 181:6	adviser 33:21	113:24 115:25
73:8,11 78:21	accurately 165:11	additional 62:12	advisor 33:11,15	116:3 136:8
86:12 90:12 93:1	165:17	140:22 198:4	33:17,25 34:4	142:23
100:25 104:18	achieve 45:7 48:24	Additionally	36:10 42:4,6	allegations 59:22
115:13 116:2	129:4	163:19 167:17	161:9	112:7 113:2,11
117:5 118:8	acknowledge	address 13:22	advisors 26:5	113:13 128:24,25
123:13 127:21	118:18	39:21 152:19	30:16,18 42:24	136:10 140:23,24
129:4,7 130:24	acknowledges	155:13	45:11	162:11
136:7 141:8	209:4	addressed 34:10	AEM 192:3,5	alleged 125:23
142:22 165:10	acquire 80:21	92:15 223:5	193:14 198:1,9	allied 171:20
167:2 168:11	acquired 67:16	addresses 204:25	198:18 199:6,10	182:20
169:3,18 173:4	69:14	adequately 92:15	affect 14:20 24:15	allocated 174:14
175:14 186:16	acronym 193:1	adhered 45:23	afoot 54:25	allow 81:1 109:24
188:7 195:16	act 10:4 51:8,13,18	adheres 157:7	afraid 52:6 71:19	126:23 163:18
198:5 199:10	51:19 54:17	adjourned 231:10	150:15 230:16	164:5 193:8
202:1,6 229:21	73:24 74:5,13	adjournment	afternoon 104:17	allowed 73:25
abolished 73:25	82:3,21 94:18	104:12	104:21 169:15	allows 191:5 202:9
abroad 68:9 77:12	149:5 160:6,20	adjudication	230:23	alluded 38:1
90:2	184:18	94:18 95:25 96:6	agencies 131:16	alongside 4:3
absolute 138:9	acting 62:2	96:16	agency 127:15	192:23
absolutely 15:4	action 5:21 9:24	adjudicatory	aggregate 71:8,14	alternative 107:25
16:22 53:19	14:19 16:3 22:4	95:10	ago 16:24 17:19	108:1 109:6
60:23 104:4,6	22:20 24:17	administer 1:16	31:12 37:22	altogether 101:9
106:2	25:22 32:2,2	administered 49:8	43:25 85:13	ambit 220:13
accept 85:18	82:7,12 88:23	administering	103:4 108:2	ambitions 169:8
126:21 154:12	90:18 116:21	94:24	115:9 165:20	amenable 83:24
acceptable 67:15	142:2 144:1	admission 17:23	185:1	amendment 51:19
103:10	156:16 168:20	admit 11:21 18:16	agree 22:25 91:13	amendments
accepted 150:25	206:3 210:9	admitting 167:10	91:19 153:9	54:17
	actions 24:10	advancements	agreed 92:4	amount 71:15

230:18 amounts 153:10 anaesthesia 5:20 9:6 10:4 47:2 anaesthetic 178:24 anaesthetist 180:23 analyses 152:25 224:9 analysis 81:13 122:6 123:18 187:4,10 211:1 212:21 214:1 215:9 216:16 217:2,6 218:20 221:19 224:20 226:14 227:2 analytic 37:15 and/or 82:20 98:1 167:18 annotation 66:6,7 72:11 annual 31:1 49:7 50:23 anonymise 224:10 anonymised 225:21 anonymity 167:5 answer 4:15 24:19 40:18,19 43:13 100:7 111:5,13 111:14 114:19 127:25 154:20 answered 86:7 87:20 186:2,6,7 186:11 200:13 answering 175:22 Anthony 1:6,9,20 2:4 34:24 35:11 36:23 40:6 42:23 43:1 52:6,7 55:1 56:3 128:1 132:8 133:9 136:8 142:13 143:12 232:1,2 anticipated 230:20 anybody 203:3 anyway 98:24 apologies 155:9	apologise 158:16 apologised 114:2 apology 224:25 225:2 apparent 124:19 169:12 appear 2:24 3:12 64:10 72:19 99:22,23 100:24 123:19 165:3 appeared 4:3 11:8 168:3 appearing 1:5 appears 69:4 applicant 145:22 149:6 160:7,11 160:21 applicants 67:21 application 75:23 105:5,9 107:4,6 107:11 108:8,12 109:5 127:20 130:7 132:23 134:14,18 135:1 135:5,13,15,17 135:24 136:3,6 144:20 146:1,12 146:18,19 147:3 147:13,15 148:1 148:6 150:12 151:24 152:9 162:14 applications 18:9 98:6 105:11,22 105:25 106:4,6 135:7 applied 65:22,25 83:15 134:18 139:3 155:11 165:21 199:20 applies 33:3 apply 18:3 19:16 22:15 36:22 50:6 78:19 103:1 104:9 127:3 129:5 130:5,25 131:24 148:1 184:12 190:20 applying 84:19	146:9 154:5 appointed 6:17 42:6 appointment 24:24 126:21 appointments 127:16 apportion 206:1 appraisal 25:1 49:8 50:15,23 appraisals 49:7,10 appreciate 47:17 157:4 appreciated 104:10 231:2 approach 48:9,18 49:20 53:23 73:4 119:7 approached 68:22 appropriate 4:19 23:13 29:18,23 31:8 32:9,19 44:9 57:6 68:1 74:15 88:1 92:2 98:7 99:2,21 106:10 107:23 108:23 125:2 163:17 206:3,6 210:8 appropriately 44:22 82:21 208:3 appropriateness 31:10 approval 13:13 54:19 approvals 68:4 approve 13:6 approved 67:25 approving 13:4 April 136:12,22 225:23 AR 122:4,8,12 Arabia 118:4 Arabian 118:5,11 155:17 archive 196:22 200:3 archives 200:3	area 18:18 21:14 40:23 52:3 81:7 81:7 111:10 128:3 140:7 157:6 168:17 210:14 212:6,11 222:22 223:24 areas 54:11 61:19 173:6 194:18 200:8 210:21 228:22 arguably 60:6 116:14 argue 55:17 60:24 argument 128:7 arisen 27:11 70:24 arises 44:13 arising 16:3 31:22 36:18 52:16 79:23 204:9 arms 96:2 arose 28:20 56:13 115:12 140:25 arrangement 44:12 185:13 189:15 arrangements 11:5 15:11 25:6 27:21 68:1 117:17 171:19 181:14 182:25 183:22 184:1,13 185:10 189:5,19 190:14 arrival 63:3 68:20 arrive 17:10 arrived 57:23 ascertain 127:21 128:19 asked 1:14 43:24 43:25 66:4 101:15 111:3 115:22 133:24 162:4 167:16 168:16 176:4 186:9 187:25 196:2 198:6 201:7 204:6 213:5 216:25	asking 40:15 79:20 111:17 149:15 166:1 196:4,13 asks 164:2 aspect 7:9,13 16:25 19:20 24:2 29:12 54:7 58:9 79:19 89:20 91:7 92:17 110:7,8 111:18 144:14,15 144:21 152:18 155:14 157:4 164:11 184:12 186:24 188:3 216:7 229:24 aspects 11:9 29:19 54:24 60:9,11,12 69:8 77:22 81:13 83:22 89:22 139:19 156:1 173:4 180:22 183:15 188:2 193:4 204:22 aspire 21:3 assault 82:14 assertions 114:17 assess 18:9 21:22 22:10 24:16 39:14,16 58:19 109:19 211:20 229:7 assessed 57:22 59:13 67:21 69:23 224:4 assessing 24:7 57:2 60:1 114:17 assessment 18:14 22:8,8,9 35:9 61:16 77:20 78:14,16 119:14 128:11 Assessments 67:23 74:4 assessors 18:11 assist 25:25 204:5 assisting 177:8 associate 115:22 associated 230:25 associates 5:20,20
--	--	---	--	---

9:6,7 10:5,5 47:2 47:2 Association 156:21 assume 46:7 129:21 227:8 assumed 70:10 assumes 72:23 assuming 97:16 189:23 205:1 224:10 230:10 assumption 136:3 209:20 assurance 13:14 40:11,13 50:1 171:22 assurances 163:25 assure 79:17 181:13 assuring 12:25 attach 124:16 attached 131:20 156:7 179:19,20 attempt 95:18 attend 163:18 167:15,17 attendance 169:17 attended 10:23 attention 40:14 43:10 44:9 45:2 86:15 96:20 148:13 162:8 attitude 37:23 85:24 attributes 72:18 August 3:14 73:23 74:16 134:16 135:4 200:19 226:6 authorities 44:9 155:18,19 156:21 157:25 184:18 189:5 authority 12:2 155:23 174:16 176:7 authors 116:15 227:7 automatically	66:10 200:5 207:8 autonomous 172:21 available 41:3 57:15 58:22 85:9 92:13 99:1 108:10,21 114:12 117:21 128:11 135:12 196:25 197:20 201:16 avenue 109:6 avoid 16:3 awarded 66:7 aware 54:22 79:18 82:1 106:7 112:7 117:17 118:18 130:1,6,9 143:7 145:3,15 146:18 148:16 149:5,25 150:23 193:16 194:20,24 201:12 201:19,20 202:2 224:3 awareness 186:23 awry 29:6 38:6 B b 82:19 back 19:19 22:2 36:9 46:10,16 47:20 52:24 53:7 64:18 66:22 69:21 94:6 103:2 104:16 110:22 118:17 123:17,22 131:3 150:21 159:22 163:15 168:23 188:17 193:20,21 194:5 194:9,14,15 201:5 213:15,18 219:17 228:6 background 51:10 bad 86:11 125:20 139:15 balance 85:10 203:21 balanced 137:20 balancing 109:9	139:6 143:7 band 176:11,14,17 183:6 bands 176:20 banner 185:12 bar 20:7 58:10 87:14 89:18 129:5 base 141:9 168:20 based 8:17 41:2,6 70:22 76:5 92:12 98:25 108:9 109:16 110:14 111:25 129:14 175:17 194:10 basically 148:15 190:7 basis 31:2 49:25 97:9 125:1,18 128:19,21 147:18 147:22 163:24,24 173:1 199:18 bat 34:22,25 bear 101:11 163:23 bearing 128:23 138:12 becoming 35:23 51:18 169:9 bedrock 206:10 beginning 19:23 26:3 83:16 85:18 121:16 205:6 begun 105:8 behalf 3:24 4:13 26:18 136:12 170:22 230:21,22 behaviour 58:5 62:19 88:3 126:6 behavioural 14:20 behaviours 9:10 14:18 31:5 125:24 209:3 belief 114:23 believe 25:14 30:3 35:3 46:12 49:20 53:1 55:5,21 56:1 57:1,19 64:8 72:1,9 78:9	92:9 114:6 121:23 123:6,14 134:23 136:17 138:18 140:6,24 142:17 204:18 benefit 3:21 4:2 104:3 best 7:10 26:1,2 33:3,6 37:16 114:3 118:19 188:18 better 16:1 31:25 32:1 36:15 52:8 52:14 56:3 100:17 156:22 beyond 78:1 94:11 156:10 164:19 166:9 bill 101:17 binary 43:13 107:21 138:5 binding 131:7 bit 12:8 19:1 29:20 37:20 44:6 52:24 63:6 66:22 72:7 83:24 88:11 92:8 100:4 101:24 104:4 123:16 127:2 139:13 149:3,11 166:15 200:11,17,17 203:16 204:7 210:1,16,16 213:13 216:24 bite 131:6 bits 185:17 187:6 blame 206:1 207:21 208:20 blamed 206:21 blank 169:15 blood 178:25 181:4 Blue 63:5,8 Blueprint 184:17 184:19 BMI 129:25 130:1 134:6 136:21 board 27:5 30:12 38:13 42:14 44:4	44:10,11,16 47:4 47:6 67:24 74:4 78:14 115:14 116:18 132:3 168:7 169:5 181:14,23 183:1 184:22 189:11,14 190:2,3,6,16,17 boards 13:3 24:22 26:8 28:2 44:12 93:1 191:2 194:2 bodies 68:5 72:5 72:16,25 96:13 110:16 112:2 147:23 157:19 173:2 body 26:20 28:11 28:20 33:6 35:23 46:19,21,22 83:5 89:17 94:10 96:6 114:11 126:10,24 127:19 book 63:6,8 191:11 books 34:8 bottom 2:23 82:9 160:3 210:6 224:21 225:14 boundaries 31:11 bounds 138:11 box 72:5 149:4,23 150:17,20 151:10 160:3 breach 62:20 88:15 111:9 breaches 62:17,19 break 47:14,15,20 47:23 102:7 104:4,7,22 110:19 159:8,15 170:6,9 228:8,14 breakdown 44:24 breakdowns 209:6 209:18 brief 148:8 briefly 61:19 bring 15:22 35:14 148:12 152:11,13 brings 16:5 86:15
--	---	--	--	--

Britain 90:1,5 100:9 British 68:15,18 82:23 90:2 broad 48:23 104:25 152:22 154:6 173:7 174:23 180:7 195:2 220:17 broaden 14:23 50:14 183:23 228:21 broadly 12:15 18:21 21:16,17 26:21 27:7 66:25 68:18,23 71:2 72:20 94:10 102:14 145:16 147:25 174:5 180:20 185:19 188:7 194:13 198:19 206:24 213:1,2 brought 28:3 43:10 126:1 162:7 166:18 building 228:6 bullied 167:18 169:4 bullying 14:17 64:2 65:1 113:11 140:19,24 159:1 162:11 166:19,20 166:23 167:2,20 168:4,14 burden 85:3,5,6,7 157:18 business 131:5	184:17 190:22 192:3,4,16,23 195:5,7 213:22 232:1 calls 82:11 85:2 CAMS 192:24 193:14 candid 39:19 84:21 93:24 110:16 112:2 candour 39:20 60:23 93:21 109:1 capabilities 60:17 capability 37:15 capable 143:9 captured 181:3 carbon 193:23 194:5 care 5:6 9:9,12 10:24 11:2 12:14 15:21 20:12 21:5 21:6 25:16 28:16 28:25 29:3 54:19 55:20 60:2 61:21 61:22 79:23 82:21 125:24 126:2 133:22 137:24 167:20 171:22 179:17 180:9,10,12,19 180:19,23,25 182:14 184:1 206:1,12 careers 9:18 caring 112:18 137:22 carried 89:7 113:4 136:22 carry 21:11 91:20 104:2 127:9,23 128:4 132:13 157:18 case 22:14,22 23:4 23:7,14,19 27:1 27:15 34:2 35:10 35:15 36:25 38:24 39:12,23 56:12,20 57:9,12	57:15,18 58:3 65:15 71:24 85:7 87:4,15,24 88:9 88:18,24,25 91:8 97:3,3,9 98:19,20 99:10,24 100:4 100:18,18 103:13 103:18 105:7,7,9 106:4,5,11,13,14 106:14,17,22,23 108:11,19,19,22 109:8,20 110:9 110:14 111:19,24 112:6,21 113:16 113:17 114:8,20 115:3 116:4,23 119:15,17 123:8 124:24 127:16 133:18,21 134:2 134:5,12 135:2,6 135:15 136:25 137:6,19 138:6 138:12,25 139:6 139:7,25 142:8 142:20,25 143:2 143:5,16 146:3 147:20 148:13 156:14 157:9 158:13,23 161:17 161:21 170:20 194:12 198:3 217:9 218:12,18 226:14 cases 22:7 24:15 35:13 39:14 55:8 55:10,15,18,20 56:17 57:2,4,8,13 57:25 58:14,20 58:24 59:11,13 59:21 87:5 92:7 115:1,2 116:22 124:25 126:1,7 126:12 128:12 133:16,19,25 134:1 135:15 137:24 139:17 141:17,23 142:1 217:3,5 220:10 220:12,16,19,19	220:23 221:23 223:17 226:18 227:4,7,12 cast 94:13 CAT 2:25 categories 154:5 categorisation 217:12 categorised 217:10 categorising 219:8 category 106:1 cause 205:8 207:18,19 209:5 209:17 213:10 caused 84:7 158:10 205:14,20 205:20 209:10 222:19 causes 86:15 111:6 caution 82:23 cautions 24:11 CCT 17:20 certain 1:13 34:18 35:22 47:18 54:11 61:15 68:12 70:7 71:9 71:15 72:18 81:12 91:20 98:8 99:17 114:11 119:8 126:19 131:13 154:5 161:23 171:3,24 177:14 185:14 188:21,23 190:14 199:7,7,9 212:19 214:4 230:18 certainly 30:1,9,12 37:24 38:18 41:5 41:17 42:12 43:18 46:16 81:25 102:24 121:8 141:6 144:12 152:5,10 certainty 57:22 127:25 138:8 139:3,6,9 140:1 142:11 143:20 147:21 certificate 17:21	71:11 132:16 chair 1:3,7,10,13 1:18,21 4:20 7:7 28:5 34:12 35:16 47:15,25 53:10 53:17 101:3,14 102:5 104:6,14 104:16 110:21,24 121:13 145:19 146:6 159:7,17 169:12 170:7,12 176:3,23 191:10 204:6 212:15,17 213:5 225:3 227:17,22 228:7 228:16 230:14,16 231:6,8 chaired 122:6 123:18 chairs 190:1 challenge 57:9 challenged 110:13 110:14 111:23,24 chance 136:10 change 11:20 12:20 20:1,18 38:10 50:13 54:25 55:13 58:10 81:6 96:9 103:9 changed 17:3 20:7 20:17 25:11 65:20 69:3 77:2 187:13 188:25 189:7 204:22 changes 20:18 45:18 48:11 124:20 179:5 206:11 changing 84:14 channels 183:4 chapter 53:8 69:24 character 67:19 69:17,23 70:11 70:15,19 charge 174:15,20 174:22 175:4 176:5,9,11,13,14 176:16 182:9,10
C c 2:25 82:23 122:1 224:11 CAFT 192:4 call 18:24 21:14,23 22:13 75:14 78:21 called 1:9 17:14 28:3 46:20 63:5 84:6 87:11 151:5 172:4 176:25				

190:7 charged 73:1 Charles 1:6,9,17 2:2 232:1,2 Charlie 35:15 144:9 chase 38:12 chased 151:1 check 3:1 9:13,16 21:24 53:11,18 73:1 136:17 146:6 159:9 162:15,19 163:10 196:22 228:9 checked 149:23 196:20 checking 73:6 145:1 checks 162:17 168:1 chief 2:6 4:21 5:10 5:11 7:7 36:13 171:24 181:22 217:21 225:2 choice 207:21 circuit 78:17 circular 117:21 189:2,9 circumstance 58:12 150:6 circumstances 25:17,23 56:20 56:22 57:24 58:9 59:1,11 84:8 92:1,24 98:8,24 103:21 105:19 106:3,7,10 107:13,22 108:2 108:7,13,21 111:11 112:16 113:1 131:17 135:21 137:4,4 139:25 148:10 156:13 174:2 205:10,13 212:20 214:5,8,9 civil 85:7 clarified 35:18 189:11,13	clarify 46:16 115:8 121:14 clarity 153:5 202:14 203:9 classic 109:3 clean 101:17 clear 40:15,19 61:1 77:5 83:22 86:4 107:4 111:15 128:19 133:6 145:19 154:3 157:5,6 167:20 177:18 180:5 181:12 183:2,2,3 189:20 192:11,12,19 202:15 clearer 168:20 clinical 14:15,20 24:12 25:1,13,14 25:20 26:13 27:4 27:20 28:8 32:21 39:5,7,15 60:2 62:6 77:4 78:16 78:19 82:15 84:1 84:2 125:24 126:2 163:9 166:25 168:25 178:19,23 179:1 180:8 181:9,12 181:13,14 182:9 182:10,24 183:1 183:20,23,24 184:1,4,20,23 185:6,9 187:4,10 188:15 189:3,4,6 189:12,15,16,18 189:21 190:3,8 190:11 202:21,22 202:23 203:10,11 203:13,14 208:1 211:1 212:21 213:8,25 214:7,7 215:9 216:15,21 217:2 218:19 219:21 220:11 221:19 224:9 226:20 227:4 228:24 229:8	close 21:25 22:23 23:7 30:4 219:13 223:3 closed 59:14 142:1 closely 140:25 code 19:15 61:18 codes 179:3 cohort 174:14 177:5 coincident 221:14 collaboration 48:10 collaboratively 29:17 colleagues 26:5 35:8 49:24 60:21 61:25 84:22 86:4 106:20 126:6 146:3 148:19 150:9 162:2,7 167:12 195:13 collect 13:16 15:6 49:6 collected 164:17 198:16 collectively 156:22 College 18:11 26:18,22 30:13 38:15,17 41:20 66:3 70:1 74:11 113:8 116:13,15 121:6 123:7 125:9,19,25 128:13 139:15 140:15,18 173:12 173:25 229:18 Colleges 13:6 16:18 62:8 68:5 combination 13:24 15:8 27:22 combine 228:22 combined 84:9 come 6:1 7:14 8:5 19:19 25:7 34:12 35:1 36:22 45:1 46:16 52:24 53:1 53:7,15 55:14 61:12 68:14,17 69:6 77:24 79:7	90:1 92:25 96:20 98:21 103:1 105:16,23 129:18 131:3 132:11 142:13 143:11 145:9 151:12,24 163:23 165:24 168:15,23 169:7 176:18 178:6,20 182:10 191:24 200:4 204:24 211:9 comes 34:17 44:8 87:17 100:5 145:11 164:7 181:19 187:1 200:1 228:2 230:4 comfort 159:2 coming 2:18 6:4 18:13 34:7 36:1 58:16 65:25 70:3 73:15 77:12 78:12 79:10 95:4 120:20 133:12 161:24 222:8 comment 29:14 94:14 224:17 commented 48:17 92:18 commission 28:17 28:25 29:3 133:15 commissioned 30:16 122:8 123:7 137:23 226:4 Commissioner 11:5 commit 228:5 commitment 54:14 committed 82:25 208:18 committee 10:24 66:3 76:12 94:23 96:10 181:14 184:20 188:15,16 188:18,19 189:6	189:12,20,22,25 190:6,7,10,15 203:11 committee's 189:14 committees 11:9 95:18 common 166:4 commonly 230:1 communicate 60:20 communicated 226:11 communicating 61:4 communication 13:10 161:5 167:19 183:3 201:14 202:14 compare 75:2 139:11 compassionate 62:1 compatible 192:13 compelling 112:15 competence 7:16 8:11 21:7 61:23 69:2 78:7 competencies 18:6 18:16 competency 175:18 competent 68:5 79:21 compiling 194:24 complained 40:3 complaint 21:21 21:22,23,25 22:23 23:7 32:23 34:21 44:2,4 81:23 136:18,20 145:8 185:21 193:1 200:1,7 218:7 220:24 221:2,7,8,19,24 222:6,9 224:1 225:1 226:12 complaint-trigg... 222:1
--	---	--	---	--

complaints 22:1 25:3 26:11 38:8 43:7,12,14,16,21 56:14 134:10 185:25 186:4,9 186:12,19 190:20 191:6,8 192:3,14 192:16,24 193:5 193:9 195:15,17 195:20 196:21 199:21,23 complete 13:17 17:20 74:7 77:15 136:9,16 164:25 191:18 completed 38:16 65:23 74:14 134:9 148:4 180:6 completely 123:3 completeness 56:9 completing 210:22 completion 17:21 17:22 75:4 complex 209:10 compliance 165:22 202:18,19 compliant 165:3 165:14 181:25 184:15 189:18 190:14 complicated 40:18 73:11 138:5 complying 166:11 177:9 components 14:1 48:24 70:8,9 96:22 151:3 205:2 comprise 76:22 comprised 162:19 comprises 94:10 comprising 63:25 computer 150:18 159:12 193:15,18 197:9 conceivable 141:9 142:7 147:19 concept 29:14	38:25 92:20 105:1 132:6 176:24 concepts 37:21 102:13 concern 15:2 21:5 33:5,18 34:19 61:21 81:18,21 82:11 87:17 94:2 116:5 128:3 141:18 166:3,3 167:4 concerned 3:16 66:19 67:7 71:23 92:6 105:17 134:18 165:5 171:10 197:8 219:4 concerning 222:22 concerns 9:22 13:18 14:6,6,8,9 14:11,20,20 19:13 21:12,18 22:3 24:10 25:21 28:1,14 29:23 30:10,22 37:6 41:18 42:2,14 45:16 49:24 50:17 55:16,21 55:23 56:13 57:10 59:22 60:1 60:22 62:14 64:20,21,24 65:1 77:24 79:23 82:4 82:15 84:1,2 92:24 93:1 113:7 113:11 114:5,16 114:25 116:19 117:14 120:23 122:8,10 123:19 124:21 126:3,4,5 128:14,15 129:11 133:10,23 138:4 139:17,21 140:10 140:16 141:7 144:12 145:16 147:11 152:23 156:23 157:15 158:24 159:1	163:3 167:25 169:3,6 172:18 183:8 226:11 conclude 55:9,10 88:18 concluded 98:20 100:4 137:1 142:21 158:13 conclusion 124:1 condition 49:4 131:20 conditions 23:11 77:13 91:11,14 91:16,24 97:19 99:4 101:16,18 102:11,14,16,21 124:16,18,22 126:18 127:11 128:6,9 129:1 130:20 142:2 156:7 conduct 30:18 62:17,18 63:8 149:8 conducted 127:22 224:24 225:10 conducting 93:6 conducts 62:16 85:15 confidence 9:23 24:5,8,16 71:19 89:13 114:21 138:9,24 140:5 141:12 153:15,17 153:23 154:15,18 155:7 228:6 confident 163:11 confidential 32:12 122:3 confidentiality 19:12 60:22 62:14 153:18 confine 127:5 confirm 25:9 confirmation 72:13 80:1 confirmations 79:14 confirmed 167:1	confirming 72:5 confusion 167:9 conjunction 167:24 168:7 connect 51:3 connected 37:5 161:22 164:9,11 165:19 184:6 211:15 228:23 connection 26:19 34:23 146:14 147:24 148:5 149:20 178:6 195:14 197:23 200:12 211:10 conscious 121:15 129:3 consent 19:12 62:14 122:11 consenting 126:3 142:20 consents 60:23 consider 23:16 49:17 87:14 88:24 91:9 105:9 106:21 107:1 116:2 119:3 124:4,12 125:4 131:2 153:22 154:2,22 155:6 156:9 considerable 155:20 157:17 consideration 85:1 108:24 115:3 124:25 135:23 138:24 153:16 considerations 28:8 114:24 144:19 155:5 considered 4:2 76:5 115:2 124:21 128:7 135:2 145:24 194:25 considering 121:6 137:21 considers 107:23 consist 82:20	consistent 16:14 consistently 158:1 consolidate 194:25 consolidation 195:4 constitutes 126:9 constraining 55:17 55:22 constraints 57:3 construct 188:25 consultant 17:6 66:18 74:15 76:15 164:21 consultants 6:6 162:23 164:23 167:1 consulted 54:18 contact 34:23 40:24 42:21,25 93:3 129:18 131:21 151:17,20 153:11 155:4 212:10 contacted 156:11 217:21 contacting 156:14 contain 13:8 41:14 62:10 160:23 contained 4:10 108:9 145:21 153:1 161:4,6 containing 145:22 contains 17:4 18:12 78:15 168:18 contemplated 132:7 contemplates 40:20 contemporaneous 178:16 179:12 195:21 contemporaneo... 179:9 181:3 contemporary 181:24 193:22 197:15 201:10 212:7 214:12 content 4:9 30:18
---	--	--	--	---

203:17 221:8 contents 3:16,19 171:12 198:22 context 19:18 27:13 28:9,15 29:11,24 54:22 63:22 87:21 101:4 110:8 111:18 155:8 227:1 contexts 50:11 continue 9:17 51:4 86:12 135:16 152:1 continued 151:15 continues 179:12 continuing 98:2 135:14 167:3 contracting 126:24 127:14,19 contrast 139:11 contribute 147:8 229:4 contributed 170:25 185:14 190:22 contribution 170:20 230:24 contributions 161:23 171:3,11 171:12 control 78:23 155:24 convenient 47:13 104:2 conversation 40:24 42:4 43:22 45:4 54:3 92:23 122:15 conversations 26:12 28:1 30:15 30:17 31:21 45:12 115:19,23 120:20 121:5 129:9 152:3 convert 206:5 207:4 convey 207:15 conveyed 120:24	convicted 51:17 conviction 82:23 convictions 24:11 70:19 Cook 149:12 150:8 150:15,19 160:1 160:9,19 161:10 copies 193:23 copy 124:2 135:5 162:4,7 194:6 195:23,24 197:12 200:11,13 core 18:23 162:20 corporate 184:9 184:13,21 185:4 185:7,8,8,11 correct 2:8,11,12 2:15 3:4 4:23 5:7 6:10,11,18,19 7:1 7:18 8:21,22 15:3,4 16:11 20:15 24:21,23 34:24 35:11 36:1 37:1 43:1,2,17 44:25 45:24 50:8 51:8,13 54:4 67:1,5,9 68:18 72:1 75:20 81:19 83:10,17 86:25 87:1 88:11 90:7 90:17 91:5,25 93:10,20 96:3,24 97:13 99:11,19 107:14,15 120:9 128:21 134:22 142:17,18 145:25 146:10,25 147:4 147:5 148:3,7,25 149:10 151:4,4 153:3,20 158:21 161:25,25 170:18 170:19,23 171:2 171:9 173:3 176:2 177:17,22 180:20,21 181:16 182:11 183:14 185:9 187:4,5 188:8 190:9 192:18,22 198:21	206:17,25 207:13 209:7 213:20 215:13,16 216:16 218:14 219:6 227:13,14 229:17 229:23 corrected 155:18 corrective 122:12 correctly 118:24 correspondence 42:19 66:2 75:24 118:17 161:8 Cotton 171:7 Cotton's 186:20 council 2:7,11 4:1 4:14,22 8:21 9:1 16:6,7 32:17 46:20,22,23 47:3 47:5 51:11,21 94:24 95:16,17 100:1 149:7 160:8 172:9,14 172:17 Council's 4:6 counsel 1:15,22,24 6:17 159:10 170:14 232:3,4 count 116:7 countries 15:12 17:6 89:18,23 90:22 91:3 157:2 country 79:16 91:2 117:6 119:12 131:25 157:20 couple 43:5 228:17 course 19:20 21:17 30:23 37:18 45:12 53:3 60:2 77:1 78:10 80:7 100:17 108:18 109:1 112:8 128:12 129:22 131:11 138:7 139:21 151:24 159:2 160:17 169:19 182:16 223:1 court 98:13	courts 95:24 cover 6:4 8:13 10:11 62:6 114:21 144:22 160:10 163:17 182:12,19,22 213:7,8,15 covered 53:10 62:7 112:24 133:16 185:16,17 213:10 covering 146:4 192:9 covers 7:15 21:4 56:5 61:19 182:13,21 185:8 185:9 205:19 213:6 crash 37:10 create 25:15 31:18 96:10 169:2 creating 62:1 203:23 208:18 creation 15:24 criminal 70:18 82:23,25 critical 60:24 73:6 cross-check 226:20 cultural 38:10 culture 20:1,2 37:23 166:22 169:2 206:10 207:16 208:3,8 208:14,15 culture/leadership 168:22 cupboard 193:17 cure 36:1 curiosity 158:25 current 86:16 88:22 89:3 105:10 122:13 137:14,15 146:12 193:8 219:16 currently 54:14 166:12 186:13 201:14 curricular 13:5,5	13:8,13 16:16 17:19 curriculum 60:10 curtailed 156:2 curve 36:18 cut 111:5 cutting 38:12 CVs 84:18 cycles 203:23 D d 83:1 225:13 damage 204:11 205:9,21 damaged 24:17 danger 141:10 dashboards 191:9 data 13:16,16,24 15:5 16:1 27:22 31:2,11,13,14,25 37:15,16,18 152:24 database 200:6 date 19:22 36:6 46:10 49:22 53:12 96:20 103:3 122:19 156:8 198:4,6,10 199:8 200:21 204:20 220:3 221:16,24 222:23 222:23,25 224:13 dated 3:14 dates 200:18 221:14 222:18,24 223:3 Datix 190:23 191:1,7,8,21,24 192:1,9 193:3,7,8 196:21 210:10,23 219:1 220:25 221:1,9,24 Dawson 1:3,4,22 1:25 4:21 34:12 35:19 47:13 48:1 48:4 53:10,14,19 100:17 102:6 104:1,15,19,20 104:21 110:22,25 111:2 121:24
---	--	--	--	---

128:10 145:19 146:7 159:5,17 159:19 169:10 170:5,11,15 176:24 191:19 212:18 227:16,19 228:17 230:12 231:7 day 122:24 169:20 177:6,14,15 228:5 day-to-day 24:25 47:9,10 days 38:21 50:5 173:20 194:6 213:24 214:2 deal 105:24 106:6 163:22 207:22 dealing 40:12 60:22 167:25 dealt 106:16 185:24 193:4 220:12 Deanery 162:24 166:25 167:24 168:8 death 112:16 205:21 decade 31:12 decades 68:20 December 38:1,14 49:2 51:19 120:4 122:19,22 133:13 217:22,25 221:7 221:20 decide 23:6,8,9,22 87:16,24,25 90:18 109:14 128:9 143:25 decided 94:20 96:8 128:6 135:19 deciding 109:24 139:7 decision 22:14 23:5 33:7 41:25 57:23 76:4,5,9 83:4 105:5,6 106:12 107:20,21 108:6 109:10	112:8 114:3,9,20 115:4,7 117:9,20 125:10 126:16 135:6,16 136:16 136:24 137:1 138:14,20,24 139:8,10 141:3 141:10,13,25 142:16 143:1,3,5 143:6,10,12 145:4,6 150:11 151:16 158:12 decision-maker 59:14 76:23 137:3 decision-maker's 110:1 decision-makers 22:13 decision-making 59:7 117:2 119:13 137:10 145:13 decisions 5:18,19 10:16 27:16 39:24 47:6 55:7 57:16,20 61:25 87:5 89:17,19 90:23 95:13 105:11 109:16 117:10 123:13 138:11 141:11 declarations 67:22 79:13,25 dedicated 175:11 175:13,24 229:12 deduced 70:8 deem 126:8 deemed 8:12 59:5 83:24 95:7 98:7 99:21 108:23 defence 143:18 defend 23:4 defer 40:5 132:8 deficient 82:19 deficit-laden 63:11 define 18:12 32:5 32:6 56:18 63:14 defined 13:6 17:18	44:7 55:4 210:3 defining 20:8 45:15 63:13 definition 204:16 204:18 213:13 definitions 204:5,7 definitive 29:25 degree 22:20 41:16 50:19,21 55:19 57:7 69:10 69:12 77:7 90:25 109:10 138:22 140:11 143:8 158:24 delay 111:2 delegated 171:24 181:21,23 deliver 9:12 12:14 26:1 56:3 94:2 137:15 delivered 18:19 180:12,20,25 delivering 14:9 180:9,10,19,22 delivery 12:11 13:1 15:10 16:20 32:4 48:12 demonstrate 18:4 36:5 69:1 71:15 74:4,7 79:4 88:21 118:18 demonstrated 65:23 66:5 79:11 department 5:5 11:2 54:18 96:4 161:11 167:10,15 167:17,21 175:12 210:13,20 212:1 214:25 departments 163:4 167:8,11 167:12,22 departure 88:4,8 depend 32:5 141:5 229:2 depending 102:1 103:20 175:16 depends 44:18 53:4 62:18 200:6	219:7,7 deploy 22:5 describe 13:20 18:22 33:13 35:20 36:19 38:21 60:11 132:19 183:21 described 11:8 17:19 26:21,25 27:24 30:25 35:9 36:23 45:4 51:25 52:4,18 57:19 62:9 63:8,10 64:20 78:9 86:8 96:23 109:18 115:1 136:2,8 138:2 140:12 154:23 169:8 178:2 183:6 187:17 describes 35:15 describing 20:24 34:17 37:2 description 104:25 177:3 design 215:2 designated 164:20 designation 65:22 designations 66:10 designed 48:24 61:17 78:5,10 desirable 97:25 despite 145:7 155:3 destroy 199:13 destroyed 196:23 197:23 198:11,23 199:4,15,24,25 200:4 detail 32:7 33:13 34:13 42:13 43:11 46:1 55:5 60:17 76:20 105:10 115:8 140:11 229:2 detailed 150:15 185:18 225:4 details 9:15 17:4 21:16 41:10	73:18 80:2 99:15 101:8 155:15 156:1 160:4,5 173:17 201:21 212:22 217:17 224:7 determination 83:4 207:13 determine 57:12 118:25 determined 73:21 97:20 207:11 determining 36:24 134:2 develop 13:22 42:8 73:12 developed 16:16 16:17 development 37:2 37:3 56:2 developments 161:13 devolution 7:13 diagnosis 112:17 dialogue 161:12 161:15 differ 172:23 difference 91:14 104:23 117:3 118:22 119:5,9 172:22 187:7 different 6:3 17:10 17:24 31:14 35:21 41:5 44:3 46:4 50:10 72:7 77:19 78:1,4 80:6,22,24 81:6 86:20 89:19 91:10 98:23 101:21,23 103:21 103:22,23 116:22 117:11 130:21 141:3,10,13 155:8 158:1 170:25 172:20 173:1,1,2,21 174:6 175:1,2,3,9 175:18 176:20 177:15 180:2,21
---	---	---	--	--

180:22 182:5 183:15 187:8,22 192:15 193:7,24 195:18,19 200:23 203:6 204:19 213:6,17 220:16 difficult 112:17 113:20 116:4 125:16 143:20 144:6 178:13 difficulties 139:19 difficulty 26:10 111:7 167:3 178:11 diligence 132:14 194:19,20 195:17 196:3 197:19 220:8 226:17,23 227:1,8 direct 30:2 33:14 direction 47:7 Directive 166:6,10 directly 24:16 26:6 28:24 43:1 64:8 68:6 133:2 151:19 director 2:10 6:9 12:10 26:12 44:23 115:22 120:6 149:14,16 163:9 169:1 170:17 171:8,15 171:17 181:18,24 182:20 184:24 186:11 189:24 211:4 225:5 227:25 director's 182:2 directorate 42:25 directors 5:4 26:8 disagree 35:14 disappear 101:18 101:20 102:4 disciplinary 19:4 63:9 102:2,3 103:5,12,14,16 103:20 104:23 107:24 109:7,23 117:7 118:23	126:25 130:22 133:4 140:3 158:14 206:6,8 207:4,8 discipline 66:13,15 disciplined 20:4 disclose 22:11 disclosed 80:3 disclosure 99:25 discovered 118:3 discretion 55:7 58:14 discrimination 82:17 discuss 47:19 55:14 86:3 153:8 discussed 89:24 108:25 130:22 135:11,20 150:4 152:2 161:3 166:16 228:22 229:11 discusses 163:6 discussing 49:7 87:3 94:7 104:8 104:22 116:5 159:25 discussion 40:8,21 122:3 161:5 174:1 228:19 discussions 120:14 121:25 152:5,8 230:5 dishonest 84:16,17 113:25 166:1 dishonesty 24:14 82:17 84:12,15 138:4 disputed 116:9 disseminated 201:4 dissemination 201:8 dissimilar 24:9 distinct 5:15 206:8 distinction 119:1 119:11 distinguish 103:7 doctor 9:13 21:12	22:11,25 23:4,12 23:17 25:19,25 27:16 28:10 32:16,25 33:19 34:18 36:25 37:6 40:1 49:3,17 57:10,17 60:4 62:16 63:12 65:25 66:14,14 67:15 72:21,22 72:22 75:17 76:1 77:14,16,18 78:6 78:11 79:20 80:10,14 81:4 85:21 86:2,11,15 86:16 88:1,21 90:4,11,12,15,19 90:20 91:13 92:3 92:14 93:19 94:1 98:1,16 100:19 102:18 105:2,18 106:16 107:17 110:3 114:1 116:19 117:12 119:20 124:16 125:4 131:12,14 131:24 132:17,19 136:10,10 137:21 143:18,23 144:22 146:2,9,16 149:15,24 doctor's 21:5 22:19 39:16 40:16 60:12 62:19 70:17 85:24 87:19 88:3 88:19 89:22 92:9 97:7,18 98:2,9 100:3,24 101:1 102:9 107:1,7 114:1 124:17 128:8 129:2,6 132:23 137:14 142:4 144:4 doctors 5:19 6:1,4 6:6,8 7:21 8:2,2 8:5,19,20 9:5,23 10:7,17,20 11:19 11:22 12:13,23	13:10 14:10,21 17:5,13,16,24,25 18:1,2,7,13,15,20 18:23 19:11,15 19:16 20:2,9,11 20:13,20,21 21:2 24:5,8,17,24 25:6 25:16 26:10 27:12,18 28:7 29:11 31:3 32:15 33:2 36:5,8,16,16 39:14,17,17,19 47:1 48:14 49:6 49:21 50:23 51:4 53:6 54:13 55:23 58:6 60:1,18,24 61:10,21 66:9 68:8,24 69:1,5 71:10 73:15,25 75:6 77:12,24 79:7,10 80:21 81:1 85:18,19 89:25 90:2 91:1 92:21 93:4,24 103:8 116:21 132:11 149:18,19 153:2 156:23 162:21 163:8,10 163:14,18 164:3 164:5,5,13,18,22 165:7,9,12,16,22 166:1,7,21 167:1 167:14 168:6,11 168:16 169:2 172:3,4,8,20 182:3 doctors' 50:20 51:2 55:12 65:12 117:11,24 123:14 125:17 document 19:14 46:5 60:17 120:2 148:21 160:1 162:1 166:16 180:12 199:5 200:10 documentary 63:5 67:22 97:6 115:13,15 140:12	documentation 22:6 64:6,18 71:21 74:16 80:10 124:3 137:9 138:2 documented 224:23 225:9 documenting 180:24 documents 61:8 74:18 75:24 119:24 152:17,18 153:1,7,13 169:24 193:18 197:9,10 199:6,9 199:20 200:12 230:25 doing 13:25 18:22 27:7 81:5 187:11 199:2 201:10 208:14 209:14 215:21 domain 210:13,20 211:10 doubt 8:5 105:22 108:8 113:3 169:22 Dr 122:5,23 123:2 123:17 149:12 150:8,15,19 160:1,9,19 161:10 171:7 186:20 dramatic 101:7 drawn 136:4 dreadfully 157:23 driven 37:14 drove 133:11 due 19:20 21:17 74:10 132:13 164:14 194:19,20 195:17 196:3 197:19 202:24 209:6,18 220:8 226:17,22 227:1 227:8 Dunn 170:11,12 170:13,15,20 176:3 191:10
--	---	---	---	---

227:16,19 228:7 228:16,17 230:14 232:3 duration 71:11 duties 39:20 duty 93:21	15:9,17 16:9,13 27:23 31:4 63:23 63:25 165:13 167:23 educational 31:11 educators 9:8 effect 53:1 83:6 96:7 157:10,11 157:13 effective 14:15 51:18 55:6 56:3 effectively 6:20 16:15,18 22:17 35:24 40:22 44:18 51:7,20 53:15 60:21 61:4 75:17 84:14 92:11 94:11 100:3 101:8 102:17 103:21,22 103:25 106:15 111:12 145:22 150:25 154:25 165:21 177:19 182:8,10 190:6 193:4 214:15 effort 186:12 efforts 118:19 eight 133:24 134:4 137:24 139:17 141:17 199:8,9 199:11 either 17:16 23:11 56:9 67:4 83:5 103:19 107:6 124:15 147:12 150:16 205:20 222:19 ELA 34:17 35:14 35:14 40:9,22,22 42:17 120:8,10 152:3,6 161:15 161:19 ELA's 121:8 elapsed 103:2 ELAs 35:2 electronic 191:5 194:1 197:12,13 200:4,6	electronically 101:23 element 89:24 113:7 elements 73:6 166:5 eligibility 66:6 eligible 9:13 eliminated 85:23 Eljamel 30:6,9 38:2 41:9 42:15 43:7,15 55:16 56:15 59:4,20 65:9 69:25 70:21 73:18,21 74:2,13 75:11,22 76:15 79:1 100:9,14 108:22 112:11 113:13,24 115:10 115:24 116:9 118:1,9 119:19 120:15 121:2 122:16,24 123:2 124:10,21 125:5 126:5 129:16 130:2,6 133:22 134:14 136:5 137:5 146:19 147:24 149:18 150:25 153:3 155:21 157:3,24 158:10 159:4 160:18 173:11 186:10 195:1 196:12,14 197:21 216:10 217:3,10 219:1 225:22 226:19,21 227:13 229:25,25 230:10 Eljamel's 19:23 26:20 27:2 38:13 41:19,22 57:18 65:14 66:5 67:6 71:24 99:10 100:18 106:4 108:11 110:9 111:19 114:7 116:23 117:19 120:20 123:25	124:19 126:6 127:23 128:15 129:12 136:11 138:14 157:10 173:23 188:2 220:13 230:4 email 201:13,15 embedded 29:2 121:18 emergency 62:22 167:9,10,15,21 168:5 emerging 15:23 eminent 133:21 emotional 82:15 204:13 emphasis 61:7 emphasises 208:19 employ 129:17 employed 55:15 57:11 141:21 employees 205:11 employer 22:2,2 26:4 30:15,17 33:11,15,16,21 33:24 34:3,9 35:5,6,14 36:10 38:20 42:4,6,24 45:10,19 49:9 100:6,8,23 126:24 127:19 147:12 148:15 156:8 158:18 employers 9:8 30:3,5,22 33:10 37:13 42:25 45:12,15 48:20 51:1 53:25 100:25 123:13 146:4,13 147:7 employing 127:13 129:24 employment 19:24 67:20,25 68:3 69:18 70:6,10,12 71:12 127:4 130:5,7 enable 17:22 56:2 116:2 168:19	203:22 enabled 69:1 73:9 165:16 enables 17:5 164:3 enabling 70:2 encourage 206:9 206:22 endeavour 185:15 endemic 168:3 endorse 203:11 enforce 132:20 engage 28:22 93:7 93:8 engaged 126:7 engagement 13:11 30:3,5 37:13 38:19,22 42:12 48:10 121:2 126:6 engaging 35:24 140:15 153:21 England 5:8 6:14 11:2 26:18,23 28:7,13,18 29:1,4 81:25 82:25 96:5 English 22:9 28:15 67:19 69:16 74:8 83:2 enhance 203:23 enhanced 13:20 enormous 153:10 159:2 enquiries 57:19 125:22 enquiry 59:18 148:18 ensure 82:1 165:12 183:5 184:15,24 190:10 201:20 208:15 211:18 ensuring 171:21 181:11 201:22 ENT 175:2 entire 101:19 entirely 56:25 109:8 123:1,12 141:9 entirety 58:17
---	--	---	--	---

148:20 149:25 entitled 75:18 76:1 entries 84:18 entry 102:4 environment 14:21 16:20 25:15 31:19 32:21 37:22 77:19 174:13,17 174:18 175:20 177:4,24 178:3,5 178:20,21,22 179:8,15,16,23 180:8,22 182:23 183:7 184:22 208:1,2,19 209:13 228:21 environments 13:19 14:16 26:14 31:23 45:18 62:1 174:25 175:10 208:24 229:8 episode 179:16 equalised 68:16 equally 60:12 equipment 179:2 181:5 equivalent 18:7 68:3 74:23 75:10 equivalents 11:3 erase 23:12 102:1 144:6 erased 40:17 99:17 101:20 117:13 130:13,23 131:10 131:18 erasure 99:5 101:6 101:11 102:2,11 102:15,24 103:3 103:5,6,7,8,14,15 103:18,20 104:23 105:4,11,13,17 105:17 106:4,8 106:12,23 107:6 107:13,20,24 108:3 109:7,14 109:23,24 110:2 114:10 117:2,7,8	117:15 118:9,12 118:23 119:5,18 119:23 130:19,21 130:22 131:3,19 134:15,18,19 136:6,14,15,24 138:10,15 139:10 140:3 141:18,25 143:4 144:8,13 144:20 145:10,23 146:12,18 147:15 148:1 149:18 151:16,23 152:10 155:15 158:11,14 161:20 erroneous 155:17 error 39:7 84:3 117:25 errors 158:17 209:5,17 escalate 93:1 169:3 183:8 211:3 escalated 44:22 214:20 escalating 45:16 escalation 167:4 especially 186:25 essence 65:18,24 70:5 92:23 essential 151:3 205:2 essentially 5:16,25 10:22 12:2 13:21 17:4 36:4 47:4 49:20 50:25 55:2 56:11 62:19 63:7 63:10 72:12 83:4 86:9,14 87:7 94:23 95:17,20 102:19 112:12 117:15 118:8 119:16 125:22 147:10 establish 58:5 200:21 203:20 established 15:22 26:4 65:17 83:13 88:21 96:14	establishing 48:19 53:24 88:19 establishment 174:11 189:4 establishments 14:3 ethical 19:11 62:10,12,20 207:20,24 European 165:3 166:6,10 event 39:1,4,9 40:2 40:16 43:25 44:1 44:6 115:21 122:6 123:18 154:11,24 187:3 187:4,9,10,16,18 187:19,20 188:1 188:2 192:7,19 200:9,14 204:9 204:12 205:18,24 206:4 207:2 208:5 211:1,2 212:21,22,24 213:25 214:1,2,7 214:8 215:9,15 215:17 216:15,22 217:2 218:2,4,15 218:16,19 219:12 219:14,16,21,21 220:11 221:19 222:3 223:6,7,8 223:11,13 224:9 225:15 227:4 228:24,24 229:2 event' 217:13 226:3,10 events 41:7 43:3 43:24 45:1 198:10 207:18 213:14 215:10 219:10,18,24 224:24 225:10,17 227:3 everybody 72:23 231:8 evidence 8:24 11:4 12:9 15:14 22:10 26:17 27:15 29:9	43:4 44:17 46:13 47:19 55:19 58:22 59:8 64:9 67:22 70:16 80:5 84:9 85:8 88:12 88:13,16 92:13 97:4,6,6,7,10,11 99:3 104:9 109:17 113:15 114:1 115:3,5,10 115:14,15,17,19 115:23,24 116:6 116:16 119:9,21 122:7 124:5 125:6,8,15 126:10,12 128:11 129:20,23 130:10 135:21 136:7 138:21 139:23 140:4,13,20 141:20 142:14,21 143:9,23 150:16 157:5 165:19 166:22 168:20,24 169:14,18 172:2 178:14 187:17,23 189:10 190:13 204:1 224:23,25 225:9,15 227:20 229:24 230:13,14 230:17,22 evidential 57:3 109:11 116:23 141:9 142:22 evidently 113:20 evolution 187:12 evolved 48:11 ex 181:19 exact 28:19 32:23 150:10 exactly 8:19 21:7 33:24 37:11 45:11 64:21 65:24 73:3 76:25 80:20 92:4 145:17 150:5 185:16 192:12 199:2 221:13 exam 78:15	examine 64:2 examined 99:3 examiner 114:20 134:2,12 137:19 138:6,12,25 139:6 142:20 143:5 examiner's 87:16 137:6 142:25 examiners 22:14 22:22 27:15 39:24 56:12 57:15 58:3 87:24 88:18,24 91:8 97:3 105:7 106:13 109:9 110:14 111:25 112:6,21 113:17 114:8 115:4 116:4 119:17 133:18 135:2 148:13 examiners' 87:4 106:24 example 10:19 11:15,18 13:8 19:12 24:11 25:18 30:6 32:20 42:11 43:6 58:4 62:22 70:18 73:5 79:10 80:9,22 83:18,25 90:19 91:20 97:19 98:1 98:24 101:15 108:4,10,22 119:9 131:14 146:14 156:6,14 163:5 175:12 178:14,25 182:12 182:19 183:15,24 184:21 189:21 192:4 193:23 195:15 196:21 198:1,9 199:22 200:1,7 202:21 212:9 213:7 215:21 221:5,25 223:18 224:19 examples 78:22
--	--	--	---	---

82:13 164:13 166:20 167:18 Excellent 75:21 exceptional 56:20 56:22 57:24 58:9 58:12 59:1,11 exceptions 62:22 71:9 exchange 126:23 exclusively 18:1 exec 7:7 executed 3:2 executive 2:6 4:22 5:10,11 36:13 47:10 170:17 171:7,15,17,23 171:24 181:8,9 181:22,23 186:10 190:12 211:4 217:22 225:3,5 227:25 230:6 executives 173:22 exemption 74:13 exercise 11:9 89:7 113:5 exercised 90:3 exist 45:7 46:9 57:4 64:7 79:1 85:20 107:19 148:9 195:9 existed 30:10 63:4 73:9 141:20 188:12 191:21 194:11 198:11 201:3,7,24 220:17 existence 186:3 existing 57:16 59:17 exists 56:24 99:12 154:9 185:4 207:21 expanded 10:8 expansion 37:15 expect 10:20 13:9 19:6,16 20:25 30:10 38:18 39:9 39:19,21 41:24 42:3 43:9 50:3	50:24 60:18 86:2 93:21,23 114:22 116:17 152:6 expectation 40:7 132:12,21 151:17 expectations 13:7 49:15 61:8 63:14 expected 9:21 18:20 42:12,24 82:22 101:11 121:1,5,21 161:7 165:23 experience 4:4 8:10 67:17 69:15 76:8,21 77:17 171:25 174:16,17 186:13,25 191:7 194:7,8,10 195:22,25 196:20 223:24 expert 22:7 33:21 97:6 115:6 125:21 133:16,20 133:24 134:3,3,8 136:1,7 137:22 139:18 141:17,21 142:5,17,19 143:8 229:5 experts 115:2,3 explain 3:21 11:10 12:15 17:1,11 21:17 46:20 50:9 50:12 71:5 110:23 123:23 131:9 155:18 176:10 179:10 217:1 221:16 226:25 explained 108:6 155:14 217:16 explains 4:7,8 162:14 explanation 52:14 152:16 154:6,25 188:14 213:17 explicitly 114:21 115:7 140:20 167:16 explored 168:7	exploring 173:18 express 169:16 230:21 expressed 20:17 114:20,23 115:7 expression 20:23 101:5 137:16 expunged 101:9 111:13 extant 130:12 131:1 extended 98:13 extensive 117:16 152:15 153:12 extent 54:10 75:18 185:22 201:1 external 122:8 124:2,19 190:15 externally 167:25 extra 176:15 extract 80:25 164:5 extreme 80:22 212:19 extremely 73:20 170:1 eye 27:8 eyes 114:8 220:5	160:2 162:6 169:20 178:12 180:2,4 195:6 196:4 197:18 211:15 224:8 factor 109:21,24 110:1 119:12 factors 76:5 109:2 109:2,8 126:7 137:20 142:24 144:12 facts 88:21 factual 97:5 failed 158:20 failing 82:20 failings 84:4 failures 55:20 205:20 fair 8:6,7 14:23 20:5 36:12,19 38:11 61:16 77:20,21 106:1,2 106:5 117:12 119:14 142:12 176:1 205:3 207:16 209:20 fairness 58:23 208:24 faith 78:2 fall 105:25 202:22 219:11 falls 7:16,22 82:6 191:4 211:8 false 84:18 familiar 38:25 68:18 95:24 184:10 195:6 familiarity 174:24 families 157:23 158:16 159:3 family 111:11 112:15 135:21 137:4 fantastic 72:23 far 3:16 33:1 38:5 40:17 64:17 66:19 67:7 71:22 92:18 105:16 117:3 134:17	141:2 171:10 188:19 193:16,19 193:20 197:8 219:3 fashion 3:25 32:12 fault 162:6 207:7 favour 205:1 fear 206:23 feature 10:14 85:14 86:8 89:6 90:8,9,10 93:22 95:2 101:12 165:20 211:8 features 12:7 210:25 February 74:16,21 75:23 160:12 feed 22:2 111:5 feedback 25:3 64:4 80:13,14,23 80:25 163:12 203:3 feel 22:23 140:9 144:3 167:1,14 169:2,4 208:25 feeling 164:13 169:3 fell 191:17 218:18 felt 41:18 59:17 95:20 143:9 165:1,8 167:19 Fernbrae 129:25 130:1 134:6 136:21 field 176:25 177:20 Fifth 62:2 file 150:17,18 151:7,9 filed 200:5 fill 41:9 filled 149:1,12,15 final 64:25 102:6 155:14 finalised 226:8 finally 62:3 financial 207:20 207:23 find 65:8 68:12
---	--	---	---	---

71:5 82:7 188:7 196:15 197:6 198:5 202:6 214:19 finding 88:7,8 95:11 143:24 findings 97:22 142:5,16 162:25 fine 11:17 111:16 186:24 224:1 finely 137:20 finished 159:7 199:6 first 1:4,15 2:2 5:9 18:25 19:8 21:5 38:12 42:6 43:16 44:5 61:21 69:7 75:4,7,13 76:11 89:2 93:24 98:10 107:9 108:15 120:1,17,19,22 123:9 134:21 135:7,15,24 136:3 146:19,22 147:17 174:6 188:16 193:22 210:11,19 211:9 215:11 221:25 firsthand 129:15 firstly 106:21 112:6,10 fit 25:9 36:6,9 49:23 90:20 203:2 219:4 fitness 2:10 4:6 6:9 10:9 21:14 22:19 23:8,10 27:22 34:2 36:24 39:12 39:14 42:25 43:23 44:23 45:2 47:9 60:1 79:13 79:25 81:9,11 83:6 85:15 87:19 88:20 94:7 100:2 101:2 102:9 103:12,17 105:6 106:11,13,18,19 106:20 108:5,14 108:19 124:10	131:5 135:3,8,14 135:17 145:2,15 146:2 147:11 148:16 149:25 151:25 fits 219:4 five 25:7 36:7 49:9 49:19 50:4 56:13 71:8,17,20 77:14 79:12 103:2 130:24,25 134:4 137:23 139:17 141:16 224:20 five-year 49:25 55:14,25 56:10 56:11,16 57:10 57:21 58:17 80:11 flagged 30:11,22 flavour 32:7 flaws 209:2 flip 20:10 floor 177:11 178:2 178:17 181:1 183:5 flow 48:19 53:24 flurry 43:15 focus 44:5 60:9,10 86:15 128:12 129:13 137:13 158:11 focused 29:4 48:13 67:8 166:11 208:15 focusing 27:8 follow 40:3 95:25 113:9,17 149:24 205:12 follow-up 150:7,10 150:15 151:11 followed 64:19 81:10 83:12 116:14 129:19 217:1 following 64:4 82:11 122:7 124:1,9 127:10 210:2 215:10 226:4	follows 126:19 182:1 230:19 footing 95:24 force 11:20 foreign 68:12 118:25 131:16 132:1 forever 107:18 forgive 34:13 136:17 forgotten 50:4 form 28:9 54:17 55:2 73:23 76:6 76:18 94:15,23 95:5,6 113:12 124:5 128:25 147:16 148:4,8 148:14,15,21,24 148:25 149:1,22 149:24 151:1,6,8 159:23 161:6 164:19 210:23 formal 17:25 18:2 18:8 34:20 35:7 48:14 53:5 60:19 88:2 123:24 126:25 133:13 136:7 146:1 156:5 224:23 225:9,15 formalities 1:14 104:8 formality 47:18 formally 42:14 226:12 format 189:8 198:14 200:2 201:16 formats 200:5 formed 119:16 former 131:14 146:12 155:21 157:13 217:3 forms 24:14 66:25 164:25 Forum 28:4 forward 113:2 found 80:3 99:3 102:10 103:17,18	112:14 116:22 137:23 150:18 162:3 166:22 196:16,18 216:22 218:18,23 230:17 foundation 17:15 75:4,7,9 162:20 163:8,10,13,18 164:5 four 17:6 43:14 50:4 57:19 66:25 70:22 74:14 76:7 218:22,25 219:24 220:20,23 Fourth 61:25 framework 54:13 66:23 181:12 183:2,24,25 205:18,25 206:5 207:3 frank 155:23 frankly 205:1 fraud 84:14 free 10:18 111:14 170:2 231:3 freedom 57:7 freely 117:21 frequently 79:3 163:23 164:7 165:25 168:15 Friday 231:10 front 10:24 11:8 112:14 148:14 full 52:9 67:4 70:20,21 71:16 72:11 74:22 75:3 75:10,16,22,25 76:1,4,10 77:6 99:16 100:20 150:3 162:13 full-time 112:18 137:21 fully 8:15 77:8 84:21 114:14 192:1 function 4:6 10:14 21:10 35:8 37:12 52:22 86:9,22 184:14	functionality 191:9 functioning 8:15 175:1 functions 10:6,10 14:3 95:3,9 193:10 fundamental 60:3 fundamentally 33:9 further 2:23 46:10 48:17 66:22 73:16 78:22 79:6 97:4 105:9,12 121:11 134:5,10 136:18 139:13 141:6,8,14 142:1 144:14 149:11 151:11 156:13 159:17 189:9 194:15 207:17 210:1,16 214:10 217:16 228:10 231:7 future 57:16 86:6 86:13,17,19,24 114:18 116:7 117:6 138:17 204:3 206:17 208:12 FY1 75:13
G				
gained 75:16 gaining 122:11 gamut 21:19 gap 221:23 gather 15:1 22:10 47:16 87:21 195:17 gathered 28:13 97:4,11 196:6 general 2:7,11 4:1 4:5,13,22 5:4 6:7 6:17 8:20 9:1 51:10,20 62:23 65:5 66:15 80:23 81:9,17 95:16 149:7 156:24 160:8 162:19,22				

166:23 172:8 173:18 175:8 194:7,8 201:8 203:25 211:2,22 212:4,11 generally 20:2 68:2 77:23 152:8 156:17 175:13 176:20 generate 148:18 217:2 generation 169:22 230:25 generic 13:9 60:16 60:18 62:5 gentlemen 1:10,14 47:15 104:6,17 110:25 159:7,17 159:20 169:11,12 getting 35:25 37:10 48:6 75:3 95:22 137:18 141:18 145:14 155:19 give 11:15 16:24 19:4 20:8 21:16 31:2 43:13 46:18 48:22 52:7,9 63:9 69:24 100:10 125:15 153:14 154:6,10 169:14 204:12 215:5 227:9 give[s] 9:20 given 4:4 8:10,25 8:25 10:3 14:24 24:19 42:17 44:16 45:25 48:5 51:25 64:10 83:13 98:5 101:17 105:1 108:24 114:24 116:16 124:18 129:11 132:4 135:21 137:8,10 138:10 139:14 140:3 141:2 143:1,6 148:9 149:17 153:1	158:8 173:7 180:2 186:25 197:22 210:17 213:13 216:11 224:10,11 229:11 gives 31:6 32:7 giving 6:20 187:11 Glasgow 70:2 74:12 gleaned 41:11,13 globally 156:18 GMC 2:15 5:4,10 6:10,18,21,25 7:4 7:4,12,16 8:10 9:4,5 10:1,12 11:12 12:16 15:15,18 16:6,18 18:22 19:2 20:10 20:19 21:10,19 21:22,25 24:7,21 26:6 27:7 28:5 32:2 34:19 35:23 36:20 39:9 40:3 40:14,23 41:8 42:21 44:1,2,18 46:2,6,19,25 49:13 50:7,11,20 51:5,8 52:19 54:10,17 63:9,12 63:24 65:5,16,20 66:24 67:14,25 68:3,25 69:22 72:16,21 74:9 77:20 78:2,22 81:18 82:1 85:6 85:15 87:8 90:13 92:21 93:3,19 94:4,20 96:2,20 97:16,18 105:23 106:6 107:22 117:3,18 119:3,4 120:18 123:9,24 124:17 126:22,23 126:25 127:3 129:19 130:5,7 131:12,12 132:3 133:17 134:22 135:16 137:13 148:12,19 149:17	149:20 150:19 153:15 157:7,18 161:9 162:9 163:16,22 167:23 GMC's 12:7 24:2 43:10 45:2,22 48:9,13 54:16 86:22 89:20 94:17 156:2 GMC-00024 120:2 GMC-00054 162:2 GMC-00104 148:22 159:22 GMC-00202 126:14 GMC-00218 2:17 GMC-00219 3:8 go 2:22,23 3:11 9:2 17:14,17 20:22 24:7 28:11,20 38:6 44:19 45:5 55:4,10 62:2 68:13 72:5 76:13 78:8 82:9 86:18 89:21 90:2,11,15 94:6 96:8 104:5 119:25 120:13 121:11 123:16,22 126:15 133:9 143:15,25 144:11 148:23 153:12 154:17 159:22 162:13 170:2 171:6 173:17 176:9 185:17 192:14 196:13,15 213:14 216:19 224:7 228:11 231:3 goes 18:22 75:21 93:13 97:14 106:20 109:20 124:7 169:15 174:9 178:8 192:21 208:17 213:3 215:5 going 4:14 16:2 18:2,7 25:16 32:1 33:18 37:9	38:10 46:10 66:17 68:21 74:23 77:5,13 78:6 92:10 96:8 103:11 104:2 106:15 109:22 110:10 111:20 130:15,17 133:5 135:19 139:2 145:9 154:20,23 173:17 174:4 175:25 178:16 183:19 194:14 206:23 210:16 212:22 228:8 good 1:3,4,10,25 9:12 12:3,14 18:24 19:7,13,16 19:19 20:12,21 21:6 25:15 26:15 36:16 61:13,22 62:10,12 63:3,13 63:14 67:19 69:16,23 70:11 70:15,19 79:14 80:1 85:19 92:22 104:17,21 129:4 132:16 184:17,19 229:21 govern 187:21 governance 14:16 25:2,13,14,21 26:13 27:4,20 28:8 32:21 53:6 168:25 171:19 181:9,12,13,14 182:9,11,24 183:1,20,22,23 183:24 184:1,3,4 184:9,13,17,19 184:20,21,23 185:5,6,7,8,9,10 185:11,12 188:15 189:3,5,6,12,15 189:19,21 190:8 190:11 203:11 governed 184:16 governing 46:22 47:4 54:13	government 7:6 10:1,13 11:7,18 96:8 189:3 governs 184:13 GPs 6:8 grade 68:3 176:11 216:5 grades 168:6 176:10,20 graduate 75:6 graduated 17:13 17:14 74:25 graduates 74:6 75:3 graduation 6:2 grant 67:14 76:4 78:21 108:23 114:9 145:4 granted 17:12 66:12 67:10,25 70:3,20,21 71:7 71:10,13 73:22 74:12 75:11,22 106:23 107:6 108:13 118:9 119:18 130:19 134:15 135:4 granting 70:14 72:10,10 119:23 135:13 139:9 144:13 grateful 170:1 gravitate 94:1 gravity 59:15 158:9 Great 67:12 215:5 greater 57:6 61:7 140:11 158:24 gross 82:17 grounds 82:6,12 140:19 group 16:4 26:5 175:3 176:16 202:23,23 203:4 203:8,10 groups 15:20 167:7 guarantee 110:6 guaranteed 109:15
---	--	---	---	--

110:4 guess 158:7 guidance 9:20 18:19,23 19:2,11 20:17,24 21:1 49:14 54:6 56:12 60:9 61:11 62:7 62:13,13 74:18 98:5 105:10 119:16 145:22 208:6 guide 225:24 guided 81:24 208:5 guides 100:1,2 gynaecology 64:1	204:3 208:11 229:22 happens 39:4 40:16 101:10 145:11 172:3 177:4 178:22 191:4 215:19 223:4,12,14,15 229:6 happy 6:4 27:6 155:9,11 156:25 hard 29:25 43:12 68:19 113:17 114:19 156:17 157:24 hard-copy 193:18 197:10 harder 113:21 136:2 harm 16:3 36:17 39:8 84:3,4,6,7 86:19 123:15 157:8,11,13,16 157:20 158:10 204:10,13 205:8 205:8,9 206:4 207:2,18,19 209:5,17 213:10 222:19 harmed 159:3 Harold 50:19 51:16 head 20:10 182:4 211:2,22,22,24 212:1,10 health 5:5 7:15 8:1 8:6 10:24 11:2 12:23 13:2 15:21 22:8 24:22 26:8 26:8 28:2,2,15 30:12,12 38:13 42:14 44:4,10,11 44:11,16 48:10 54:18 62:3 83:1 92:25 96:5 98:3 101:18 107:1 115:14 116:18,18 127:6 149:8 168:7 169:5	171:20 179:11 180:11,13,17 182:14,20,22 189:5,11 191:2 194:2 healthcare 15:17 16:7 28:22,24 29:1 32:3,21 48:12,15 54:2 176:19 179:9 182:17,18,23 184:6,7,18 208:4 208:6 hear 1:10,12,21,25 27:6 48:1,2 52:21 104:18,21 110:25 159:19 163:10 165:7 212:15 heard 11:4 12:8,9 15:14 26:17 43:5 80:5,8 101:5 121:2 164:18,22 166:20 167:7,12 167:14,17 168:3 170:24 172:2 176:24 178:14 hearing 10:23 23:1 23:1,3 89:1 95:15 97:4,5 103:16 105:8 143:3,16 231:10 heavily 70:1 held 4:25 6:12 11:25 46:3,5 67:15 181:17 213:24 215:10 Hello 110:25 help 7:10 9:20 18:19 51:14 133:8 173:5,8 175:22 188:17 191:20 helped 186:24 187:2 194:18 200:9 helpful 1:13 25:17 35:16 41:11 46:1 71:4 73:20 81:13	92:18 111:8 126:11 134:24 139:1 152:17 187:15 227:22 helpfully 8:25 35:17 76:13 81:8 98:5 139:14 141:2 162:3,7 216:8 helping 69:20 197:18 hierarchy 174:7 176:4,21,22 183:10 high 21:20 129:5 206:14 212:23 high-level 19:14 61:18 higher 162:20 214:20,21 highest 216:5 highlight 159:24 221:22 highly 140:2 142:11 hinges 52:25 historic 55:20 57:4 57:8 80:19 101:9 historical 64:18 73:20 101:14 186:15 197:17 historically 29:4 46:25 48:12 168:15 history 43:6 52:7,9 68:21 97:7 100:2 101:19,24 108:9 110:15 111:25 155:25 hit 199:7 hold 5:13,14 9:16 171:18,23 172:13 195:21 199:17 227:24 228:5 holds 172:7 homework 95:21 honest 110:16 112:1 164:24 186:22	honestly 143:4 147:19 honesty 60:3 62:2 109:1 126:4 hoped 38:22 121:1 hopefully 1:12 32:7 48:2 104:21 215:3 hospital 44:8 64:3 64:15 156:15 162:18,21 167:24 173:20 182:11,13 183:18 213:7 223:10,14 hospitals 182:15 hour 104:7 211:4 hour's 104:10 hours 164:12,14 164:19,20,24 165:2,8,9,10,12 165:17,21,23,24 166:2,9 210:24 HR 164:23 huge 79:8 human 117:25 hundreds 18:10 hybrid 194:12 hypothesis 31:24 hypothetical 11:14 100:18 hypothetically 100:8
halfway 166:17 handed 198:15 handing 177:9 handle 34:5 handling 34:9 224:21 hands 209:1 happen 39:5,6 51:24 69:19 82:11 101:12 191:3 203:12 209:9,10,22 213:7 215:18,19 215:23,24 216:3 216:4 220:25 happened 27:4 30:8,14 38:3 65:18 69:21 85:25 86:3,18 121:5 123:23 133:3 137:8 147:16 150:7 179:17 180:16 188:7 194:23 195:19 204:1 208:1 213:19 215:1 218:5,13 222:18 223:16,20 223:22 229:14 happening 35:25 50:2 160:24 161:18 178:13	H			I
				IAMRA 156:20 idea 15:23 20:10 31:17 205:12 207:5 216:2 ideally 131:7 identification 29:15,22 179:3 203:22 identified 13:23 52:2 160:1 213:25 216:14 217:9 224:13 identify 29:22 87:8 illness 98:4 illustrate 11:16 imagine 43:19

90:24 111:10 128:15 138:6 174:25 immediacy 110:3 immediate 127:17 138:15 223:9 immediately 17:16 133:6 211:3 impact 58:22 228:4 impaired 22:20 23:9,10 83:7 88:20 102:10 103:17 impairment 143:25 implementation 189:15 202:22 203:10 implemented 184:25 190:11 implements 181:11 implication 16:19 implying 101:7 importance 21:4 29:10 50:10 89:21 95:2 137:11 155:21 important 10:13 10:15 11:11,13 15:20 20:18 27:13 29:14 30:1 33:9 36:2 37:18 44:16 45:1 46:6 52:21 53:20 54:2 59:25 60:12 72:24 80:15 84:19 85:14 86:21 89:2,24 90:3,12 93:22 95:7 109:2 117:4 119:2 154:2,13 172:7 181:3 194:25 205:11 206:7 210:4 229:14,16 impose 23:11,23 91:15,15 124:14	128:6 129:21,22 imposed 77:13 91:23 98:10,11 98:17,22 99:5,9 100:21 101:16 102:12,22 124:22 126:18 128:20 140:3 142:3 imposes 129:16 212:14 imposing 97:19,23 imposition 124:17 impossible 83:19 143:22 impression 48:5 125:15 139:14 improper 82:14 improve 51:1 205:25 206:11 208:9 improvement 15:18 28:22,24 29:1,3 32:3 208:4,6 inability 124:20 inaccurately 165:2 165:9 inappropriate 165:8 209:3 incidences 125:23 incident 86:14 183:8 185:1 187:3,9 191:4 192:2,20 193:23 201:3 204:8 205:7,14 206:7 207:9,10,11,12 207:25 209:10 210:10,12,15,20 210:22,23,25 211:9,19 213:22 213:24 214:4,6 214:16,24,25 215:20,25 216:13 218:6,6,8,8,23 219:5,10,12,15 220:11 221:9 222:13,17,20,23 222:24,25 223:5	224:3,4 226:5 229:6,9 incidents 190:20 191:3,10,11,14 191:15 193:5,9 193:22 198:19 203:1,19 204:15 205:13,19 206:2 206:15 209:9,12 209:22 210:8,24 211:14 213:1 218:25 include 47:2 69:9 82:13 84:16,17 84:18,20,21 97:5 117:23 204:12 205:2 included 43:6 124:2 215:6 226:22 includes 82:20 89:11,12 including 13:3 15:16 22:6 43:8 47:9 50:11,18 51:11 55:9 68:5 76:6 81:10 107:2 124:6 134:10 217:4 inclusive 14:18 incompatible 144:4,5 incomplete 135:25 incorrect 143:6 increasing 37:12 incumbent 228:1 230:21 indent 136:22 independence 11:11,24 independent 9:5 10:1,12 11:23 94:25 95:14 141:22 indicate 4:13,14 88:3 indicated 4:1 136:13 indicates 119:20	indication 216:11 227:9 individual 25:19 26:9,23 27:2,8,10 27:12 32:15,16 32:17,24 33:2,10 33:19 34:18 36:25 40:1,13 48:14 58:6 80:2 89:22 117:9 131:11 146:13 155:23 180:13 226:21 individually 31:23 individuals 14:9 14:25 26:9 110:17 112:2 172:18 180:14 205:21 209:12 infer 1:11 inferring 115:5 125:7 influence 10:18 95:14 inform 15:2 28:11 126:25 127:3,10 130:5 information 15:11 15:14 16:24 22:15 29:18,20 29:24 30:2 31:9 32:9 33:1,4 35:7 41:3 44:8,21 46:1,5,13,18 48:19 49:6,11 53:25 58:3,4 65:5,8 73:1,16 79:15 80:4,8,13 81:3,20 98:25 99:20 100:10 101:1,1 105:12 108:10,21 114:11 114:13,14 118:13 119:19 120:17,23 121:21 126:23 131:15,16 132:5 133:1,2 143:6 146:23 147:8 148:12 149:17,19	150:3,8,21 151:19 152:21 153:10,19,19 154:1,4,9,11,14 154:22 156:10,19 156:23 160:20,23 161:3,18 164:16 167:5 174:8 178:16 181:2 185:20 188:11,24 192:10,20 193:21 195:1,5,10,12,18 195:24 196:6,7 196:16,25 198:3 198:5 202:10 206:16 210:17 215:5 216:9,21 220:17,18 229:16 informed 41:8 61:24 122:11 132:4 informing 78:24 inherent 88:6 inhibit 58:2 initial 77:25 87:4 91:18 96:4 124:4 207:11 226:8 initially 67:9 initiate 34:22,25 initiating 30:13 injury 204:11 205:21 innovation 188:21 input 7:25 80:6 95:19 inquiries 50:18 inquiry 1:15,22,24 2:14 3:6,25 4:2 7:15 19:21 24:20 46:9 54:11 60:15 77:22 94:16 95:8 95:11 144:16 152:21 153:8,22 153:23 158:11 159:11 163:1 169:16 170:1,14 170:22 173:5 195:13 227:22 228:2 230:21
--	--	---	--	--

232:3,4 Inquiry's 105:14 153:5 inserted 159:25 insight 13:24 15:8 32:1 39:22 84:10 85:14,21,24 87:20 92:4,9,14 92:20 insights 230:23 insist 154:16 insisted 155:2 insofar 58:22 190:4 204:14 inspecting 68:6 inspections 68:4 instances 88:24 98:3 167:2 instigate 222:14 instigated 45:3 institutions 146:13 instructed 139:18 instruction 26:25 integrity 62:2 intelligence 15:2,5 15:21,23,25 27:25 28:4,13 intended 95:23 206:4 207:2 intention 122:24 136:13 intentions 114:18 135:22 interact 168:11 interaction 48:14 167:8 interest 19:21 25:10,12 45:22 46:8 52:15 54:11 56:19 58:7,8 59:1,5 60:5 61:5 105:14 106:21,22 124:14 125:12 168:25 197:16 interested 52:20 94:13 110:9 156:12 173:18 174:2 179:22 194:17 216:18	interesting 38:7 57:5 65:5 68:21 interests 97:25 98:1 114:3 131:13 interference 10:19 interim 23:16,21 23:23 97:1,17,20 97:20,21,23 98:6 98:7,8,16,23,25 99:1,6,6,9,21 100:11,19,22 101:16 108:24 117:19 124:11,12 124:15,22,23,25 125:11 126:16 128:5,18 129:2 130:19 133:4 156:6 160:13 internal 44:15 221:3 internally 27:21 222:21 international 74:6 156:20 internationally 119:7 interpret 84:2 interpretation 83:25 86:22 interpreted 84:1 interviewed 173:21 intimate 155:22 intimated 147:25 intimately 169:22 intimating 122:23 intimation 120:23 146:11 147:2 148:9 151:8 155:17 157:9 intramedullary 225:23 intrinsically 184:5 184:8 introduce 53:2 introduced 49:1 51:18 65:11 99:25	introducing 54:16 introduction 19:22 36:3 48:16 invariably 159:8 invested 45:9 investigate 58:14 87:9 158:23 215:25 investigate[s] 9:22 investigated 82:5 114:14 145:12 208:2 215:7 222:4 investigating 148:13 167:25 investigation 21:24 22:5 25:18 27:5,18 28:6 32:20 34:22,25 35:11 39:25 55:8 56:17,21 57:13 57:14 58:1,20 59:19 81:12 83:12,20 87:17 87:18 94:18 95:15 96:15 97:18 103:14 105:6 106:18 113:6,12 115:9 124:10 125:5 127:21 130:2 133:5,7,12,15,19 135:3,8,18 136:4 136:19,23 150:13 151:13,19,22 152:1,9,11 153:3 156:2 161:1,13 161:14,22 162:9 197:17 207:10,12 207:14 208:7 214:10 217:24 218:19 219:6 222:14 223:4 224:24 225:9 229:5 investigations 20:9 24:3 32:23 34:8 57:17 82:10 85:16 131:1,6	135:25 162:10 163:2 188:1,2,6 216:9,12 219:3 228:23 229:13 231:1 investigative 14:24 21:11 95:9 129:7 140:20 investigator 229:3 invite 41:20 227:17,23 invited 26:19 38:9 43:3 173:12 inviting 121:6 169:14 involve 34:3 227:12 229:14 involved 6:20 12:16 14:9 15:16 37:10 54:10,11 69:22 103:13 125:16,17 144:16 169:21,23 173:25 178:12,24 196:10 203:8 210:12,19 220:9 228:23 involves 7:2,3 39:7 79:20 181:11 involving 217:3,9 IOP 160:12 IOT 124:12,14,20 Ireland 11:3 66:4 Irish 66:2 irrespective 45:17 210:20 211:10 irrespective/reg... 210:13 Isles 82:24 isolated 166:20 issue 22:24 23:9 28:19 34:5 40:14 59:25 88:1 111:12 115:12 121:8 166:13,18 168:3 220:21 226:9 issued 3:24 issues 14:16,19 25:10 27:4,11,18	32:14,19 34:9 37:6 41:9 56:18 60:21 64:2 68:23 70:24 79:17 108:25 113:23 122:1,10 124:18 137:14,25 138:1 141:19 145:2 148:16 163:6,7 163:21 167:8,19 168:10 issuing 88:2 iterations 200:23 J James 171:7 January 38:18 51:17 66:7 76:16 124:1 133:14 151:15 222:3 jeopardising 169:5 job 55:4 81:4 100:9 211:11 jobs 84:19 join 18:3 58:3 joint 31:16 181:9 186:12 jointly 181:17 183:12 journey 178:20 179:13 judged 59:14 68:14 137:20 judgment 19:17 78:19 100:16 112:4,20 128:25 129:10 judgments 12:2 29:5 81:2 July 200:23 217:19,24 221:16 226:4 jump 67:6 213:16 June 3:3 41:18 42:1 67:11 94:15 95:4 96:13 123:6 134:22 135:1 222:4,6 226:8 jurisdiction 145:11
--	---	---	--	---

jurisdictions 117:11 just' 206:10	175:25 178:2 181:4 193:7 196:5 199:8 202:25 223:7 227:25	leadership 13:11 62:14 169:2 176:7 201:17 212:13,16 leading 5:11 43:3 165:15 Leads 166:25 learn 39:21 207:21 208:11 213:19 learning 208:8,16 208:19 228:1 leave 64:12 102:5 103:9 led 38:16 72:12 84:3,4 174:15 175:4 left 112:11 legal 6:20 54:13 94:22 137:12 154:1 203:19 207:20,23 legally 95:1 165:14 legislation 5:25 17:3 52:12 54:15 55:3,5,24 56:7,8 56:24,24 58:16 71:10 95:8 96:7 96:9 184:16 legislative 8:11 legitimate 131:24 length 52:11 LEPs 63:25 lesion 225:23 lesson 68:21 lessons 205:15 213:19 let's 44:19 100:19 letter 72:22 122:1 126:16 218:8 letters 224:10,11 level 17:5 21:20 42:13 43:20 52:2 68:17 69:2,6 78:7 122:7 140:5 148:18 164:6 183:1 189:14 211:25 212:16,25 214:21,21 215:2 219:7,19 225:24	226:3 230:6 levels 193:24 203:7 liable 149:7 160:7 160:21 liaise 172:13,17 liaison 26:5 30:15 30:17 33:11,15 33:16,21,25 34:4 36:10 42:4,6,24 45:11,19 172:8 172:18 Libya 118:2,12 155:24 157:2,11 Libyan 118:6,16 155:19 licence 5:21 49:5 51:5 82:16 90:16 100:15 130:25 142:4 licences 55:12 116:21 117:11 licensed 49:3 licensing 51:3 lie 222:12 lies 180:18 210:10 life 23:14,19 24:10 70:18 103:9 204:10 light 92:25 94:13 135:2 liked 138:22,23 158:13 likelihood 107:2 109:21 117:5 143:10 likewise 131:3 limit 124:16 limitation 127:23 157:10 limitations 180:3 limited 48:14 67:4 67:8,10,14,21,24 69:4 70:3,15 71:7,10 72:10 73:22,24 74:2,10 74:14,17,19,24 76:10 77:11 82:13 93:13	127:24 197:20 limiting 23:18 157:11,13 line 76:9 127:17 202:14 225:16 lines 180:5 183:4 224:21 225:14 linguistic 67:23 71:22 72:2 74:3 78:14 linked 52:23 184:8 list 18:18 66:5 211:1 213:25 215:11 listed 127:11 186:19 listening 3:22 lists 46:3 literally 101:13,20 little 12:8 37:20 43:4 44:6 63:6 123:16 139:12 149:3,11 171:14 176:3 203:16 207:17 210:1 230:16,19 live 106:14 lobbied 55:13 56:25 lobbying 55:2 local 25:1,1,13 40:23 53:6 63:24 81:25 122:3,9 161:9 213:22 214:3,16,19,24 214:24 219:5,11 219:14 222:14 226:5 locally 22:17 34:5 34:10 37:13 51:2 161:19 locum 127:15,16 locus 132:20 lodged 134:21 135:1 log 179:14,15 191:7 195:5,10 195:18,24 196:7 196:20,24 197:3
K keen 48:5 139:12 keep 21:9 178:18 191:6 197:14 keeping 47:18 155:3 178:8 kept 23:18 178:15 197:9 key 5:9 7:5 15:1 21:10 57:24 133:11 220:12 kick 52:4 kind 11:13,15,20 27:7 31:8,9,24 36:19,24 39:13 41:16,17 43:13 49:24 51:23 59:12 61:19 62:8 63:10 68:21 70:22 73:4 76:23 78:16 121:20 125:1,15 134:1 134:11 137:2,18 144:15 168:22 180:1 191:11 194:12 201:13,14 knew 201:20 know 8:9 37:5 38:8 40:4 41:18 43:4,6,13 44:1,2 44:14,21 64:14 64:22 69:19,19 69:25 80:17 100:21,23 110:12 111:21,22 112:4 112:25 113:4,6 114:7 116:8,10 116:11,12 118:14 128:1 129:9 138:13,13 141:14 143:1,12,17 144:10 147:16,19 149:20 150:7 152:2 156:24 158:9,12,15 159:1 175:7,16	knowing 33:21 43:11 112:21 114:6 143:22 147:23 158:12 knowingly 82:16 knowledge 18:6,16 67:18,18 69:2,15 69:16 74:4,8 83:2 known 41:10 105:3 145:2 151:21,23 192:25 218:6,9 222:24 222:25 223:8,13 223:14,19 230:1 knows 44:4 93:14 223:16	L lack 113:2 138:2 139:6 140:12 153:17 167:20 lacking 110:16 112:1 land 143:24 landscape 48:11 language 22:9 74:8 101:4 largely 90:11 larger 184:4 206:16 largest 174:10 lasting 228:4 late 134:9 230:16 latest 199:19 law 5:18 39:16 53:5 166:11 lay 22:13 47:3 95:1 lead 39:12 136:4 139:23 167:13 174:18 181:8,9 183:12 189:24 211:24 229:3,3 leaders 7:8 189:16 leaders' 189:16		

197:8,8 logbook 179:10,14 logbooks 178:15 179:19 logged 191:7 221:2 221:4 226:3,9,12 logical 161:21 196:12 logically 37:5 182:1 logs 115:18 195:21 long 52:3 69:21 100:2 133:7 169:19 longer 59:4 99:23 131:11,12 159:12 165:23 166:7 198:10 199:16 look 13:15 14:12 14:14,16 27:15 28:11 29:7 55:18 55:22 56:13 57:8 57:18 66:22 73:17 83:12 85:20 90:18 99:12 108:11,13 126:14 134:3 144:17 148:22 163:5 188:10,17 190:13 193:20 198:8 200:10,25 201:22 203:1,16 204:1,21 209:22 213:4 214:19,21 216:24 220:7,15 221:5,6 224:19 225:8,13,20 227:9 looked 19:3 53:21 115:4 134:2,4 139:16,17 140:25 151:7,9 173:10 197:5 219:20,23 220:19 222:10,21 223:18 224:12 227:4 looking 19:23 26:4 27:12 28:6 32:15 32:17 38:4,5,6	50:7 52:17 57:1 60:15 64:18 69:21 70:25 80:2 85:17 96:19 121:13 134:12 155:5 158:22 159:23 174:12 180:9 188:18 194:9 205:13 217:14 219:17 220:9,10 looks 64:11 202:23 213:18 222:6 lose 169:20 loss 181:4 204:10 204:11 205:9,21 lost 167:6 lot 41:13 45:25 46:1 52:12,24 55:3 95:21 117:1 125:13,14 158:11 166:7 174:17 175:25 188:11,24 195:12 196:23 212:5 lots 51:24 180:21 213:3 low 87:7,14 lower 59:15 144:2 219:19 lunch 102:7 104:3 104:7 lying 84:14 M mail 189:2 main 9:3 48:24 54:23 66:25 69:4 81:22 128:2 maintain 9:14 11:21 12:17 17:3 18:21 49:22 153:18 maintained 11:11 16:13 154:18,19 maintaining 5:17 10:19 49:4 50:21 majority 4:9 78:13 105:25 making 5:19 21:5	25:5 26:15 27:16 44:12 45:22 51:4 61:24 78:23 89:19 90:22 105:10 112:5 125:10 142:25 189:18 mal-practice 206:5 207:3 manage 176:12 managed 22:17 49:9 71:5 management 6:24 7:5 13:2 24:25 29:15 44:15 62:15 162:21 163:11,13 183:9 185:2 187:3,3,9,9 187:20 192:2,7 192:17,20,24 193:25 200:9,14 201:3 203:21 205:18,25 208:5 218:23 220:11,11 222:13 229:10 manager 127:17 211:2,22 212:4,6 212:8,11 managing 203:19 Manchester 78:15 manifestations 35:21 March 134:21 225:6 226:7 mark 50:24 marked 103:19,23 107:8 marking 89:22 95:20 103:19 225:24 Massey 1:6,7,9,12 1:15,17 2:2,2,6 2:13,18,24 3:16 4:1,3,15,17,21 7:11 8:25 9:3 10:12,15 24:23 29:10 34:24 35:19 36:2 41:3 41:13 43:11	45:17 48:2,4,22 52:6,23 53:20 54:4,22 56:11 62:24 69:22 82:2 84:24 86:8,20 87:11,22 88:17 89:25 92:24 100:14 105:21 111:1,4 121:14 121:23 125:12 128:22 133:9 139:15 141:20 145:7,25 152:14 155:18 158:4,7 159:21 160:17 162:4 163:23 170:3 232:1,2 Massey's 4:10 7:9 9:2 24:1 29:8 81:14 82:8 94:14 102:8 104:25 material 54:6 108:9 116:1 150:19 154:7,16 154:24 197:20,22 materials 116:11 maternity 103:9 matter 53:11 78:7 87:8 91:22,22 98:14 112:25 116:9 118:24 119:2 132:1 152:13 155:20 156:1 159:18 178:6 222:17 matters 8:1,5 38:2 42:16 47:18 58:2 83:11 96:19 119:8 137:13 153:6 173:22 190:3 maximum 71:8,14 May/June/July 134:12 mean 11:24 17:2 20:7 30:1,21 36:15 38:12 58:19 69:10 75:17 80:22	89:14 91:10 92:14 102:15 107:16 119:7 137:19 157:25 174:10 179:25 180:8 186:12 194:14,15 195:23 196:18 198:2 201:5,6 212:5 215:17,18,24 219:5 221:1 meaning 88:9 111:5 177:19 meaningful 72:25 means 10:23 11:23 14:5 21:6 29:16 49:5 69:12 88:20 95:5,6 97:16 102:20,23,24 104:18 105:18 106:22 107:13 142:10 145:1 156:11 167:5 169:13 171:20 208:14 210:17 215:19 221:4 meant 29:21,23 89:9 94:23 95:12 112:18 150:14 measure 72:3 176:7 mechanism 38:9 42:21 43:4 50:1 51:7 69:5 78:11 82:5 173:12 202:14 mechanisms 44:7 44:17,19 51:1 81:20 215:20 medic 180:10 medical 2:7,11 4:1 4:5,14,22 5:22,24 6:3 8:21 9:1 10:4 12:9,22 13:14 14:4 16:13 18:24 19:7,14,16,19 20:1 22:13 23:2 23:21 26:7,12 37:25 48:6 50:14
--	--	---	--	---

50:15 51:8,11,19 51:21 55:11 61:13 62:10,12 63:3,13,23 65:5 65:13 66:13 67:16 69:9,12 73:7,24 74:6 75:6 77:7 79:15 84:19 86:12,24 88:25 91:20 92:22 93:6 94:8 94:25 95:16,19 95:20 99:13 105:2 106:25 109:12,14 110:5 115:22 117:24 120:6 127:3,5,14 130:5 133:4,18 134:2 137:15 138:7 139:8 141:24 142:8,15 143:11 144:4,5 144:24,25 147:24 148:10,11 149:7 149:13,16 156:18 156:21 160:8 169:1 171:7 172:9 173:21 174:12 180:7 181:18,23 182:2 182:20 183:12 184:24 186:10 189:24 191:11 225:5 medicine 10:20 49:3 77:22 85:20 90:8,10 167:9,10 167:15,21 168:5 medics 172:12,22 182:21 meet 9:10,17 18:5 18:15 59:5 74:9 78:4 122:13 142:21 meeting 7:5 12:3 77:19 120:3,6,13 120:24 121:25 122:19,21 133:12 143:10 162:23	163:8 meetings 7:7 47:5 162:20 meets 21:24 33:4 88:14 member 7:3 83:6 118:2 190:1 191:16 members 46:23,24 47:3 89:11 94:25 95:17 124:13 168:5 180:6 207:19 memoranda 31:15 31:18 memory 134:8 142:18 199:2 220:5 mental 83:1 mention 46:19 51:6 53:21,22 54:21 59:24 61:11 63:1,17 84:24 91:6 102:7 144:18 183:22 188:13 190:21 mentioned 10:12 12:8 14:2 16:25 19:25 37:22 50:9 58:25 61:20 75:12 85:13 87:22 94:8 97:8 103:4 108:2 115:9 120:7 121:3 139:1,2 145:5 148:8 168:9 175:9 180:1 183:10 185:1 188:14 198:1 205:5 226:10 mentions 84:24 87:22 merited 43:22 56:20 merits 57:2 58:20 met 55:20 70:9 73:21 76:3 78:23 78:25 83:19	85:11 87:25 140:2 142:11,12 166:21 167:7 214:5 method 68:11 200:6 methodology 217:5 middle 121:17 210:18 midwife 32:17 midwifery 16:6 32:16 171:20 172:14,15,17 182:19 millennium 52:1 Miller 228:11 mimicking 28:25 mind 53:12 104:7 110:1 128:23 137:7,17 138:12 138:18 142:25 163:24 minimise 157:19 minimising 157:20 minimum 78:7 minor 219:8,11 222:17 minute 67:7 158:8 minutes 47:16 76:12 minutes' 47:21 misconduct 19:3 20:8 24:12,13 63:13 82:13 misrepresent 165:21 misses 203:20 204:2 205:19 206:15 210:8,25 mission 37:7 mistake 117:18 118:6,7,15 146:21 147:14 mistaken 112:5,20 137:8 mistakes 39:15,17 39:18 85:19,19 158:15 209:1	mitigate 86:5 mitigated 85:22 mixed 195:15 model 56:6 moderate 219:8,13 219:15 modern 55:6 76:18 90:9 modernise 54:15 modify 102:17 modules 193:7,8 moment 6:1 16:24 37:22 43:24 47:14 85:13 103:4 104:2 108:2 115:9 139:10 165:19 185:1 208:25 moments 17:19 159:12 monitor 14:3 179:7 184:1 202:19 monitoring 13:19 13:21 14:5 164:12,16 165:11 165:18 179:6 202:18 month 161:2 monthly 117:20 months 23:25 42:1 42:13 76:20 77:16 98:11,12 126:19 144:23 226:6,8,9 months' 76:8 mood 20:6 morning 1:3,4,5 1:10,25 3:23 4:12 55:14 move 8:24 19:1 20:2 34:1 35:22 53:22 75:9 91:1 95:23 175:17 184:23 moved 72:12 194:1 movements 54:25 moves 179:12	moving 76:10 97:8 MPT 89:1 97:3 102:10 105:8,9 MPTS 94:15 96:10 97:21 98:6 124:11 multiple 57:10 193:10,11 multitude 213:6 N name 40:16 42:19 101:8 107:7 120:20 131:18 171:6 176:6 189:7 193:17 230:1,4 names 153:2,13 173:1 national 15:6 30:25 64:19 127:6 164:1 168:18 nature 28:8 30:10 32:5 51:22 62:18 63:5 69:11 89:6 105:23 107:4 128:13 129:11,12 130:12 150:22 151:7 153:9 160:24 186:15 187:19 205:2 near 50:24 84:7 159:11 203:20 204:2 205:7,19 206:15 207:25 210:8,12,25 nearly 50:24 necessarily 42:8 45:2 50:16 71:1 72:15,20 90:4 95:13,21 138:9 211:25 212:23 219:9 230:19 necessary 23:18 23:20 67:17 69:14 83:2 97:24 99:4 103:18 124:13 190:4 222:15
---	---	--	---	---

need 9:10,12 11:18 12:14 13:8 18:4 33:20 34:10 40:14 49:6,18 52:2,15 55:18 66:16 78:18 79:18 80:2 92:25 93:7 94:1 97:4 97:10 98:18 100:15 103:1 104:2,4 106:21 116:6 123:13 125:3 128:7 131:2,20 132:23 144:1 153:20,22 154:13 164:20,24 175:14 179:3,24 184:14,20,22 201:18 204:15 209:22 211:14 228:9 needed 9:24 99:5 128:25 133:15 145:3 186:16 189:11 203:2 needing 50:13 84:25 130:4 needs 22:16,17 23:24 89:3 137:13 214:20,21 negatives 71:1 negligence 82:17 206:4 207:2 neither 131:6 network 15:15,22 15:25 45:10 53:4 neurosurgeon 76:16 122:3,9 133:21 neurosurgery 66:21 175:2,12 175:24 neurosurgical 174:5 179:23 229:12 never 39:1,4,9 40:2,16 43:24,25 44:1,6 96:7 211:2 212:22,24	214:1,8 215:10 215:15,17,18 216:3,4 217:13 218:2,4,13,15,16 219:10,21 226:3 226:10 new 7:22,22 54:17 132:6 201:9 203:12 204:25 newsletter 201:14 NHS 10:13 12:10 12:25 13:3 15:9 15:17 17:6 19:18 19:24 39:6 41:8 42:21 63:21 64:4 64:15 68:2 76:8 113:14,18 115:12 115:13,14 116:21 120:7,21 123:2 123:24 124:5 129:25 140:13 146:23 147:3,23 148:5 149:2,13 149:14 170:18,22 173:7 174:11 181:10,11 182:13 188:20,25 190:9 191:1 193:8 194:6,22 200:14 201:22 203:18 204:9 205:18,22 207:16,20,23 208:2,18,23 212:7 224:25 225:3 227:25 228:3 230:2,24 NHST-00075 220:7 NHST-01553 200:10 nineteen 134:1 Ninewells 64:3,15 64:22 162:10,12 162:18 173:20 175:7 182:13 non-executive 189:25 non-sterile 177:7 non-technical	60:11 norm 105:24 normal 74:24 109:3 120:22,25 133:17,17 174:20 196:24 198:11 normally 35:4 68:8 92:2,3 176:13,17 223:8 230:5 Northern 11:3 note 59:21 120:3 121:24 122:21,25 152:5 199:1 noted 199:3 219:1 220:3 221:7 226:23 notes 123:16 178:18 179:20 180:1,3,6 226:20 notice 37:8 notification 117:17 126:19 158:19 notified 118:5,11 118:16 130:7 notify 117:23 notwithstanding 57:3 November 122:18 nowadays 93:2 nuanced 39:13 number 15:10 19:8 22:5,22 31:13,15 44:20 50:10 61:14 78:17 79:8 93:14 119:10 120:2 126:7 133:10 144:11 163:6 174:18,22 190:22 206:14 216:12 217:18 220:9 numbers 64:11 79:3 174:8 numerous 29:12 155:4 nurse 32:17 170:17 171:15,17	171:18 174:15,20 175:4 176:5,6,9 176:25 177:3,6,7 177:7,13,18 178:2,17 179:5 180:10,24 181:1 181:8,24 182:4 182:19 183:6 184:24 211:25 212:11 227:25 nurses 172:20,23 173:25 174:7,8,8 174:10,11,14,19 174:22 175:8,10 175:17,19,23 176:8,11,13,17 177:5,23 178:24 182:6 228:19,20 228:22 229:1,7 229:11,15,19 nursing 16:6 32:16 171:19 172:9,14 172:14,17 181:7 182:4 211:2,22 211:23,24 O o'clock 231:6,8 oath 1:16 objective 72:3 85:4 89:10 objectives 205:17 obligation 63:22 130:4,12,16 146:7,8,16 206:14 211:6,8 222:16 obligations 129:16 130:14 131:13 148:9 149:16,19 152:24 154:2 obliged 39:16 93:8 223:10 observation 86:21 observations 178:25 227:18 obstetrics 64:1 obtained 114:15 obtaining 22:6 obvious 208:24	obviously 32:4 38:16 41:14 44:3 45:6 52:21 55:18 64:17 79:22 80:1 83:11 100:7,16 106:3 112:6 125:21 128:17 143:15 148:17 150:11 153:17 158:8,12 166:2 169:15 174:11 176:5,21 186:14 191:19 194:14 195:22 196:23 201:15 215:24 223:23 226:16 occasionally 34:13 occasions 29:12 190:22 occur 207:18 occurred 40:2 142:8 216:15 occurrence 204:9 210:24 213:9 214:2 occurs 39:9 43:25 44:1,6 210:15,22 October 66:4,24 offence 82:24,25 offences 24:11 offer 86:12 92:3 227:20 office 7:4 8:16,17 42:20 44:23 officer 26:13 33:16 34:1,5 36:8 40:9 40:11,21 45:9 49:12 50:2 52:25 53:13,19 54:1 81:2 93:2 133:19 148:11 161:10,16 169:1 172:4,6,11 172:22 182:3,8 officer's 81:4 officers 26:7,15 35:3 42:9 45:18 49:14 53:5,15 151:19 189:25 offices 78:16
---	---	--	--	--

officials 7:6,8 officio 181:19 Oh 212:1 okay 1:25 4:20 14:1 21:21 28:6 34:11 39:9 40:2 64:10,12 65:4 69:8 71:21 87:22 95:2 102:5 104:1 104:21 111:8,16 112:24 118:21 119:24 120:13 121:11 122:23 129:16 133:3 134:17 139:12 141:2 148:8 150:24 159:19 181:19 187:24 190:17 192:19 194:9,17 199:4 200:8 202:5 203:8 208:17 212:10 230:12 older 55:22 58:14 58:19 197:24 omission 149:5 160:6,20 225:11 omissions 82:20 160:10 Omo 1:6,8,9,18,20 2:4,4,10 3:5,9,19 4:3,17 6:9,11 7:10 8:10 21:8 21:10,13 35:13 40:7,18 43:2 51:13,15 52:9 54:22 56:5 81:8 81:17,19 100:24 101:12,22 102:16 104:22 109:18 125:13 128:2 132:9 143:14 151:12 156:4 158:4 159:5,6 160:16 161:7,14 170:4 232:1,2 Omo's 81:7 on-call 113:14 115:11,16 116:1	116:20 once 74:21 98:20 100:4 161:14 164:16 167:4 once-and-done 50:3 one's 84:21 onerous 77:13 ones 108:3 134:3 180:16 186:19 214:15 224:11 ongoing 49:25 57:16 86:16 88:22 89:3 97:19 103:14 105:5 106:18 108:5,14 122:1 130:1 135:3,8,14,17 137:16 145:8 151:13,20 152:9 157:15 161:1,12 161:15 open 59:18 86:2 106:11,19 108:18 123:1 136:19 146:3 156:16 161:14 opened 124:9 openly 82:10 operate 16:8 66:17 85:7 183:18 201:2 operated 225:22 226:21 operates 76:1 operating 44:20 93:12,16 operation 46:19 48:25 102:19 177:9,20 178:12 179:17,18 180:5 180:15,17 181:2 186:3 218:9 221:24 222:8,23 223:15,20 operational 8:4 37:3,23 149:14 operations 47:10 opine 133:24	opinion 141:22 opportunity 147:6 147:7,12 160:19 227:21 oppose 147:13 opposed 78:24 219:20 option 106:24 107:9,11 options 22:22 107:5,16,18 132:4 oral 29:9 order 10:5 17:8 23:16,23,24 34:19 37:7 51:19 54:17 56:15 67:14 72:24 97:17,21,22,23 98:6,7,10,16,22 98:23,24,25 99:1 99:4,7,21 100:11 100:19,20,20,22 108:24 116:6 117:19 124:12,15 126:16 128:8,20 130:20 160:14 165:2 175:14 ordered 178:7 orders 23:21 97:1 97:20 98:8 99:9 124:11,24,25 125:11 128:5,18 129:2 133:4 ordinarily 71:7 74:7 105:4 ordinary 84:13 organisation 5:12 9:19 14:8 44:14 47:7 94:21 127:13 144:23 148:11 155:2 171:18 172:15 183:3,4 184:2,14 184:25 185:11,13 189:7 192:2,11 201:10,24 202:17 203:1,4,6,12,20 209:9 210:14,21	211:20 221:3 organisational 45:13 organisations 13:15,22 15:1,12 15:16 31:15 32:11,11 48:15 129:17,24 147:8 148:10 153:6,11 154:16 209:6,18 209:21 original 3:24 68:9 73:23 133:25 148:5 175:22 200:1 orthopaedic 162:22 166:24 orthopaedics 162:19 175:2 other[s] 217:6 ought 110:17 112:2 out-of-hours 127:15 outcome 52:18 109:15 110:4 138:9 139:7 140:22 141:6,14 142:7 143:20 225:18 outcomes 81:11 95:15 103:21,22 103:23 188:8 outdated 54:15 56:6 outline 61:20 outputs 49:10 outset 169:8 outside 24:12 107:3 119:20,22 127:4 130:6,8 overall 56:1 181:21 190:7 overarching 185:12,25 overlay 209:14 overly 55:21 155:10 overriding 157:6	overseas 6:5 18:1 68:24 69:5 78:12 83:5 117:9,14 131:8 132:11 158:20 oversee 13:14 24:24 overseeing 51:2 183:1 189:14 190:10 overseen 12:1 16:18,20 oversight 5:12 12:23 36:9 50:20 53:6 183:19 owned 49:8 owns 202:16
P				
PA 9:13 pack 64:9 138:21 packs 59:8 page 2:22,23,24 3:11,12 61:12 82:10 121:11 126:15 148:23 159:24 162:13 163:2,5,15 164:10 166:16,17 168:2 203:17 205:17 213:5,13 213:15,16 215:8 220:15 pages 18:10 PALS 81:25 paper 113:19 194:1,15 197:12 198:14 200:2 201:16 paper/computer 194:13 paperwork 18:5 18:10 41:12,14 113:4 125:7 147:22 paragraph 9:2,25 16:23 29:8,10 48:7,17 54:8 63:1,4,17 65:9 67:12 73:17				

81:14 82:8 84:25 87:23 88:17 94:14 97:1 104:24 134:24 144:17 162:13 163:5 164:12 181:10 205:23 210:1,18 216:19 paragraphs 76:11 parameters 183:2 183:25 parliament 7:17 7:20 8:4,12 11:7 52:11 94:19 96:11 Parliament's 7:23 parliaments 7:13 10:3,22 12:5 54:20 part 7:24 8:3,15 12:11 15:19 24:6 27:11,14 30:20 40:8 42:7 43:16 50:25 52:21 53:16,20 54:2,2 54:14 61:1,5,6 62:8 64:9 80:10 80:12,15 81:3,16 86:20 87:3,9,9 88:11 89:3,10 94:16 105:14,15 113:3,12 114:24 115:1 121:24 124:4 129:9 133:4 134:11 135:24 138:21 145:9 149:6 151:12 156:5 160:6,10,21 173:18,19 179:11 183:19 185:7 186:16 187:11 190:2 195:16 196:23 198:11,15 198:16 214:6 220:9 226:17 229:5 participating 180:4	particular 4:4 7:2 11:10 27:1 29:12 32:15 46:8 52:19 60:5 63:22 64:16 65:7,22 66:10,13 76:24 84:8 96:22 102:18 110:7,8 111:17 142:16,23 161:12 163:4 185:24 187:19 194:17 212:14,19 216:18 228:20 particularly 24:20 43:21 52:15 61:8 84:9 94:12 113:8 158:25 parties 72:9,14 127:10 159:10 228:10 partly 138:1 partners 29:17 31:20 partnership 61:23 partnerships 182:14 parts 70:17 78:20 185:14 party 209:2 PAs 7:21 9:6 10:17 12:13 pass 22:3 78:20 132:5 passage 24:1 53:21 58:21 135:22 188:13 217:14 passages 71:22 190:21 pathologist 80:24 pathway 79:6,8 pathways 17:10 patient 9:9,12,23 11:4 12:14 16:3 20:12 24:4,9 25:16 28:4 48:12 55:20 60:4 79:23 80:6,9 81:21 82:4 84:3,4 90:21 93:25 114:4 166:3	167:20,23 171:25 178:21 179:1,7 179:11,16,20 180:9 186:13 191:7,14 195:21 195:25 196:20 203:24 206:11 217:9,21 223:21 224:11,13,19,20 224:22 225:2,8 225:13,20,22 226:11,14,20 patient's 178:19 patient(s) 217:4 patients 13:11 19:6 20:25 21:5 24:15 29:16 39:8 49:24 60:21 61:4 61:21,24 62:4 79:20 80:13,14 81:1 82:1 84:5 84:16,17 86:17 89:12 90:21 113:25 114:25 122:11 123:15 126:2,3 138:16 155:21 157:14 158:16 159:3 186:4 207:19 213:9 216:10 217:3 224:9,17 224:18 227:5 228:4,6 pattern 58:5 Paxton 42:17,18 42:20 120:7 121:15 peer 68:14 203:4 peers 86:3 people 3:21 44:20 45:19 46:3,5,24 77:23 78:1,3 93:14 125:16 157:12 170:25 175:4 176:13,14 178:7 179:24 180:21,25 196:10 201:11,16,20,24 202:8 203:4,5,6	204:15 206:22 214:18,24 people's 180:3 perceived 8:9 perception 10:18 perceptions 78:3 perfectly 103:10 perform 66:18 performance 22:8 47:8 82:19 88:4 122:9,10 149:8 performed 59:23 226:2 performing 102:18 177:14,25 180:14,15 period 19:22 26:3 37:24 38:4,7 46:8,9 50:22 51:25 52:16 53:16 60:14 67:20 71:8,14 73:12 77:14 102:2,21,24 126:18 130:9 131:9 133:11 134:7,14 142:4 146:5 173:20 194:10,13 199:7 201:6 periods 74:14 permanent 98:22 100:20 permission 167:4 person 93:2,14 95:1 127:13 177:13,14,15 180:18 182:4 210:11,19 211:9 personal 42:8 112:15 137:4 169:17 personally 28:4 persons 204:11 210:11 perspective 52:20 63:11 117:4 157:22 pertain 152:8	pertained 41:4 61:9 pertaining 131:13 173:23 197:21 pertains 5:8 41:6 194:18 pertinent 152:10 pharmacists 182:21 philosophical 37:3 phone 44:22 phrase 20:24 83:25 103:4 184:9,10 physical 83:1 204:12 physician 5:20 9:6 10:5 47:2 66:16 Physicians 70:2 74:11 pick 14:2,6 24:23 101:3,14 131:4 155:12 picked 14:7 118:10 picture 48:23 piece 18:23 181:4 pieces 46:13 179:2 181:2 187:7 pin 2:19 PLAB 78:20 79:1 place 23:2 24:3,12 30:17 36:21 37:13 40:25 41:21 61:6 64:16 68:1,24 74:19 92:21 96:12 99:7 100:1,11,22 105:13 115:20 117:19 118:4 120:3 122:22 172:17 183:11 184:14,16 185:10 186:1 187:21 189:7,12 196:6 196:12 200:22 202:7 207:20 209:13 211:17,19 214:2,4,6 215:22
--	---	--	--	--

217:23 218:11 226:5,6 228:3 placed 7:10 33:3,6 52:8 69:6 123:5 129:1 places 35:19 51:7 196:19 197:5 placing 117:24 129:6 plan 13:22 77:8 96:4 play 8:2 27:11 172:10 229:1,9 please 2:17,22 3:8 3:11 9:2 16:11 29:7 37:1 47:16 48:7 54:5,8 63:16 65:10 73:17 81:15 96:25 104:17,24 120:2 121:11,12 123:22 126:15,15 127:2 148:23 159:22,24 160:4 162:2,13 166:17 170:12 188:10 200:10,11 203:17 213:5 216:19 217:1 220:7,15 225:20 pm 104:11,13 110:18,20 159:14 159:16 170:8,10 228:13,15 231:9 point 7:11 11:16 13:3 21:18 23:3 29:9 30:7,11 34:12 35:23 38:19 41:23 49:2 49:25 68:16 74:21 76:20 98:17 99:17 101:3 112:8,10 114:9 115:8 118:8,16 120:1 121:9 128:24 129:23 132:10 136:19 137:1 139:5 146:17	150:4,14 156:24 158:2 159:8 160:2 166:14 174:13 182:25 188:21,23 189:6 194:1 198:22 199:16 200:2 206:19 223:19 227:20 pointed 44:17 108:16 173:23 187:1 191:19 points 112:6 158:18 187:22 212:10 policies 172:16 186:1 187:2,12 187:20 188:12 199:5 201:8,9,18 201:23 202:21,24 203:12,13,14 208:5 216:10 policy 98:19 99:25 171:21 199:14,15 199:19,21 200:9 200:14,21,22 201:1,4,21 202:2 202:4,8,10,11,11 202:15,16,18,20 202:22,23,25 203:2,5,10 204:14,20,21 205:1 206:13 207:22,25 210:3 214:13 215:14 216:13,16 218:24 219:5,17 222:13 223:11 224:24 225:10,17 political 10:18 52:2 54:24 pool 206:16 pooling 15:25 poor 125:24,24 167:19 pops 29:12 81:23 portfolio 18:5,12 poses 86:16 88:22 position 6:12	35:17 40:19 62:24 111:2 121:16,20 134:17 146:22 150:25 153:5 169:5 172:7 176:22 197:25 210:14,21 214:14 223:25 positions 46:4,6 positive 19:5 56:2 163:10 positives 71:2 possessed 67:17 69:15 possibilities 85:10 possibility 14:2 27:10 38:2 91:8 152:25 156:10 157:16 161:19,22 161:24,25 206:21 213:10 possible 30:23 37:6 41:2 80:18 110:11 111:21 131:19 151:20 155:22 197:15 210:23 222:15 223:5 possibly 34:15 56:9 156:19 post 77:1 post-qualification 67:17 69:14 post-Shipman-e... 96:22 postdates 60:14 postgraduate 12:22 13:4,13,15 13:18 14:4 16:13 60:19 61:10 62:8 66:3 posts 68:3,6 74:1 127:5 potential 10:18 55:9 81:11 135:12 203:22 205:7 207:19 potentially 115:18 116:14	power 132:20 powers 10:3 94:22 123:3 practical 37:22 48:24 practicalities 42:16 practice 11:19 18:24 19:7,14,17 19:20 20:11 23:18 24:13 25:19 26:1,20 27:2 28:7 30:6,9 38:14 39:5,17,21 41:19,22 46:25 49:5,22 50:20,22 51:3 59:4 60:12 61:13 62:10,12 63:3,14,15 68:2 68:25 69:6,7 70:17,23,24 73:15 79:2,18 89:22 90:16 91:20 92:5,7,22 93:6 94:2 97:18 99:16 102:16,18 102:20,23 107:2 107:3 110:11 111:20 112:11 114:7 115:12 117:5,20 119:12 123:6,14,25 124:17,20,22 127:5,7 128:15 129:2,6,12 130:24 131:4 133:17,17 138:3 138:14,17 144:4 144:5,11 153:14 153:16 155:24 157:11,16 160:18 171:21,22 172:15 172:16,19,21 173:23 176:18 184:6,7 188:3 205:25 206:11 208:9 214:12 219:17 practices 49:3	125:18 practise 2:10 4:6 6:6,10 10:10,20 21:14 22:20 23:8 23:10 25:9 27:22 34:2 36:6,9,25 39:12,14 42:25 43:23 44:23 45:3 47:9 49:23 60:1 74:1 76:2 79:13 79:25 81:9,12 83:6 85:15 87:20 88:20 94:7 98:2 100:2 101:2 102:9 103:13,17 105:6 106:11,13 106:18,19,20 108:5,14,19 122:13 124:10 131:5 135:3,8,14 135:17 145:2,15 146:2 147:11 148:16 150:1 152:1 157:3 193:22 practised 79:12 practising 23:17 29:11 60:24 79:16 82:16 103:9 110:4 112:12 114:18 124:16 137:5 practitioner 6:7 55:11 80:23 106:25 109:12,15 110:5 133:20 138:8 139:8 141:24 142:8,15 143:11 180:11 practitioners 23:2 23:22 89:1 94:9 189:17 pre-2011 194:9 pre-existing 70:16 pre-redacted 152:20 pre-redaction 152:23 precise 32:6
---	---	--	---	--

precisely 139:22 141:12,21 156:22 198:2	213:15 214:10	112:1,7 113:2,12 114:5,16,21,24 116:3,5,19 122:10 126:4 137:25 138:4,23 139:20 140:7,10 140:16,23 141:7 141:19 159:1	136:8 139:22 140:21 153:8,12 154:15,17,18,23 155:15 160:14 164:11 169:23 196:10 207:8 209:11 217:1	progress 34:3,8,20 39:25 57:20 59:3 59:13 88:10 151:22 153:20
preclude 89:18 90:22	161:2 163:12 193:11	137:25 138:4,23 139:20 140:7,10 140:16,23 141:7 141:19 159:1	155:15 160:14 164:11 169:23 196:10 207:8 209:11 217:1	progressed 58:25 60:19 99:16 143:3
predicated 21:2	prima 97:9 125:1	problem 92:15 93:5 113:16 220:12	processes 57:11 73:9 96:18 136:16 155:16 167:21 181:13 185:25 187:21 203:22 209:14,21	prominence 137:9
predominantly 152:23	primarily 48:13 68:4 89:16	problems 36:18 70:17 203:23	produce 153:7 produced 3:25 4:7 62:7 64:5,24 152:19 226:16	promote 22:4 55:8 56:17 61:5 87:16 206:13
prefer 154:15	primary 56:7 59:12 67:16 69:9 73:6 117:24 180:18 205:24	procedural 91:7 144:15,19 145:20 146:1 147:13 158:17 209:11	producing 154:22 production 226:17	promoted 35:10 56:21 57:12,13 57:25 136:23
preference 107:12	principle 33:2 49:21 87:2 157:7 211:11 223:2	procedure 3:22 124:23 206:6 207:4 225:4,25 226:1	profession 83:7 95:20 121:19	promoting 62:3 125:4
preliminary 92:12	principles 61:15 61:18	procedures 19:5 122:12 175:15 187:13 206:9 210:3	professional 5:6 9:10,17 10:9 12:1 13:9 16:4,5 16:8 19:17 25:5 31:20 60:16 67:23 74:3 78:14 82:19 88:5,9 123:25 126:21 171:19 183:9,22 184:3 201:17 202:16 206:4 207:3 210:7 219:23	prompted 50:13 151:10
premium 211:13	prior 5:3 65:12 67:3 97:4 192:3 198:10 201:15	proceed 91:22,23 138:7 159:13	professionalise 95:18	promulgate 131:15
preparation 195:16 196:3	private 19:18 24:10 112:13 127:7 138:3	proceeding 110:5 proceedings 45:3 58:23 59:17 63:9 127:1 149:5 150:1 160:6,10 160:20,22,23,25	profession 83:7 95:20 121:19	promulgated 81:21 186:4
preparatory 52:13	privately 113:14 115:11,15,25 116:20	process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	production 226:17	prone 11:23
preparing 169:21	privilege 34:15	process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	pronounce 99:2
prescribed 5:24 83:8	privy 42:5	proceed 91:22,23 138:7 159:13	profession 83:7 95:20 121:19	pronounced 99:22
prescriptive 19:15 55:5 56:7 61:18 80:20	proactive 20:20 203:21	proceeding 110:5 proceedings 45:3 58:23 59:17 63:9 127:1 149:5 150:1 160:6,10 160:20,22,23,25	professionalise 95:18	proof 85:3,5,6
present 23:4 109:17 167:22	probably 11:15 19:13,19 31:12 32:13 36:11 39:11 40:5 70:10 86:1 112:5 133:9 140:7,13,14 152:14 162:6 175:25 186:22 188:24 194:23 219:13 229:20,21 230:17,19	proceed 91:22,23 138:7 159:13	professionalise 95:18	proper 27:9 31:21 81:5 183:19
preserved 71:9	probe 59:24 139:12 144:14	proceeding 110:5 proceedings 45:3 58:23 59:17 63:9 127:1 149:5 150:1 160:6,10 160:20,22,23,25	professionalise 95:18	properly 142:20
pressing 52:2	probed 140:10	process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	property 204:11 205:22
pressure 163:14 165:9,20 178:25	probing 140:22 141:6,8,14	proceeding 110:5 proceedings 45:3 58:23 59:17 63:9 127:1 149:5 150:1 160:6,10 160:20,22,23,25	professionalise 95:18	proportion 50:22
pressured 165:1	probity 59:22,25 60:3 61:1 93:24 109:1 110:16	process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	propose 91:12
pressures 164:15		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	proposed 92:14
presumably 7:24 33:3 77:18 87:2 98:22 107:17 151:21 160:22 190:2 214:18 229:14		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	proposing 88:24 91:9
pretty 109:22 126:8 163:23 223:11		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	proposition 110:12 111:21,22
prevalent 37:24		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	prosecution 95:25
prevent 35:24,25 86:5 204:2 208:11		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	prospect 22:19 83:18 85:9 87:12 87:15,25 88:7,19
prevented 205:8		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	prospective 39:16 86:10 89:6 100:23 127:19
preventing 36:18		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	prospects 138:16
prevention 157:7 203:23 206:17 211:17		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	protect 85:4
previous 79:12 163:15 168:2		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	protected 163:20
		process 21:17 28:14 36:4 41:25 49:8,16 54:16 57:14 68:13 71:6 76:17 78:14 80:7 80:16 81:9 83:15 86:9 91:10 94:6 94:7,12 96:14,15 96:16,16,21 105:3,13 107:23 108:5 109:13 110:2 116:7,8 117:13 119:3 120:1 121:18 124:4 129:10 130:23 133:14	professionalise 95:18	protecting 62:3

protection 88:22 89:4,9,10,11,12 90:14 97:24 124:13 138:15 152:24 171:25 protocol 19:15 protocols 31:16,17 prove 71:1 85:6 88:12,13 97:10 142:23 143:16 proved 23:10 109:11 proven 114:6 138:1 139:23 provide 3:5 18:23 19:2,10 21:6 25:16 26:14 37:17 40:12 49:14 73:16 81:2 82:21 88:2 105:12 110:6 115:13 116:2,6 119:16 129:20 133:21 138:15 141:21 144:22 146:16 147:6,7 147:12 149:17,19 151:1 159:2 160:4,19 217:17 provided 2:13 46:4 60:2 64:5 74:18 75:25 76:6 76:13 81:14 99:15 105:12 121:21 124:7 126:2 133:22 137:24 139:9 144:24 145:23 146:23 147:3 150:8 151:2,18 152:15,21 154:7 170:22 185:20 187:25 188:11 189:10 193:11 195:13 200:12 216:8 217:18 230:24 provider 28:15 Providers 63:25	provides 12:2 56:12 80:10 providing 7:25 14:4 20:20 34:4 61:22 112:18 151:18 154:16 160:5 proving 22:19 139:19 provision 18:19 86:24 144:25 146:4,8 204:10 provisional 75:5 provisionally 75:8 provisions 51:12 prurient 155:10 psychiatric 98:3 psychological 204:13 psychologists 182:21 public 12:11,25 15:9 16:20 24:8 32:4 50:18 56:19 58:8 59:1,5 62:4 85:4 88:22 89:4 89:9,10,11,13,14 89:14,16 90:5,14 97:24,25 100:21 101:9 106:21,22 114:21 124:13,14 137:15 138:24 153:15,21,22 154:15 155:7 157:8,20 171:25 public's 9:23 24:5 public-facing 100:5 publication 98:19 99:25 publicised 156:6 published 18:25 19:7 60:16 117:20 pull 35:6 196:11 pulling 158:7 186:15 punishment 86:23 purpose 68:11	77:17 83:20 88:2 145:5,14,16,17 174:3 202:15 203:2,25 205:24 206:9 purposes 16:17 154:14 165:11,17 165:22 pursue 36:25 113:20 129:7 pursued 109:7 pursuing 109:12 116:4 purview 7:23 52:10 53:7 push 154:20 pushed 15:24 113:21 put 13:19,20 22:12 23:3 27:25 37:21 68:15 72:6 84:5 109:4 110:7,9 111:18 113:1 115:24 121:8 133:20 141:4 142:8 143:18 147:24 159:10 166:5 178:11 189:6 193:9,23 195:23 211:13,17 228:3 putting 84:18 134:13 209:1	quality 12:25 13:14 14:8,13,21 25:12 26:13 28:16,25 29:3 31:4 32:20 163:25 167:23 quantitative 15:5 30:25 quantity 13:2 queries 131:16 question 14:24 24:18 31:8 33:14 33:17 38:13 39:13 40:20 60:3 69:3 87:19 100:6 106:19 111:3,13 114:15 116:19,25 125:3 127:25 151:25 155:1 156:25 165:24 175:22 186:2 201:7 216:25 questionnaires 80:9,18 questions 1:14,24 4:15 8:4 21:10 27:19 34:14 39:22 54:9 60:20 65:6 81:7 104:19 114:22 117:1 126:1 138:23 140:7,17 142:14 142:19 143:7 144:8 158:5 159:9 164:2 168:16,19,23 169:10 170:14 185:19,21 186:7 186:9,18 187:25 196:14 200:25 204:6 227:16 228:10,17 232:3 232:4 quicker 211:15 quickly 119:25 150:12 quite 33:19 37:14 38:6 55:4,17 56:6,6 68:19	73:11 83:22 87:7 111:8 112:15 113:17,19 114:19 117:16 138:5 147:19 148:8 157:24 159:7 165:25 166:2,11 169:19 175:25 207:6 212:5 229:9 quote 119:19
R				
radar 121:8 radiological 225:25 radiologist 66:16 raise 27:19 28:16 81:18,21 117:13 155:1 159:18 166:2 228:10 raised 21:12,19 28:14 38:13 41:19 42:3,14 43:12,14 49:24 50:17 55:16 57:10 64:20,24 82:4 113:7 124:18,21 126:1 126:3,4,5 133:10 133:23 134:6 140:16,18 142:19 142:19 158:24 161:20 163:7 raises 33:5 87:19 raising 19:13 60:22 62:14 169:6 210:10 ran 94:22 range 124:18 126:7 164:15 rapid 125:10 rationale 71:20 114:19 115:6 137:3 138:20 RCS 122:8 124:3,6 RCS's 124:1,18 reach 34:18 78:6 132:24 133:1 138:5				
Q				
qualification 65:15,19,21 67:16 68:13 69:9 73:7 76:3 117:25 qualifications 65:12 68:9 73:7 qualified 18:1 68:24 76:7 78:12 95:1 118:1 193:22 217:6 qualified' 217:11 qualify 6:2 qualitative 13:24 15:7 qualities 72:18				

reached 47:17 111:3 141:10	recalling 126:11	193:5,6 198:9,19	192:25 220:8	46:25 65:21 75:8
reaching 29:5 115:4 142:15	receipt 124:9	217:20 221:9	230:7	77:8 99:14
reacting 20:22	receive 21:22	recording 9:14	referring 12:20	101:24
reactive 36:21	121:20 146:19,20	71:11 180:16	89:16 126:9	registering 5:19
45:14 48:18	153:9,19	181:1	150:1 160:13,15	registers 5:25
53:23 203:21	received 27:1	recordings 115:19	refers 103:15	registrants 9:7,10
read 16:24 201:23	38:17 71:11	records 46:9 69:20	204:8,14,23	9:11,20 89:18
202:2,4	118:17 133:13	84:14 99:12	205:5 212:14,20	176:18
reading 46:12	136:6 223:21	131:17 178:8,19	reflect 48:11 86:3	registrar 2:7 4:22
101:10 137:2,17	225:1,2,5	178:23 179:2,5	reflected 79:24,24	5:14,18 76:8,21
207:17	receiving 14:14	180:13,17 186:15	reflecting 109:10	77:1,2,17
reads 125:19	receptive 163:11	195:19 196:22	reflection 209:8	registration 9:15
ready 1:23 47:25	recipients 154:3	rectified 118:8	reflections 80:13	9:16 10:8,16
104:9,14 159:12	reciprocity 90:25	recurrent 113:16	230:23	17:2,12 22:21
228:12	recklessness 82:18	recurring 115:21	reformed 54:14	50:15 65:11
real-life 78:18	recognise 17:22	redact 153:25	reforms 56:1	66:12,23,25 67:3
realise 158:10	188:24 206:10	154:13,14	refuse 107:11	67:8,10,14,21,24
realistic 22:18	210:11,19 227:24	redacted 153:13	refused 108:3	68:11,22 69:4
87:11,15,24 88:7	228:3	154:4,5,25	109:6 134:21	70:3,15,20,21
88:19 90:10	recognised 65:13	redaction 154:5	135:25	71:7,10,12,17
reality 110:12	65:15 68:2 76:15	redactions 153:9	regard 7:10 32:9	72:10,11 73:22
111:23 131:23	136:25 218:11	154:9,12 155:3	34:14 55:18	73:24 74:9,11,14
really 12:20 27:13	223:21 228:2	refer 22:25 27:16	63:22 119:11	74:17,22,24 75:3
29:19 33:20,21	230:3	57:24 88:25 97:3	137:14 139:21	75:6,10,16,22,25
36:17 37:8 39:5	recognises 203:18	98:18 106:25	146:7,11 157:8	76:1,4,10 77:6,11
56:2 59:25 119:4	211:5	139:7 141:23	201:2 213:4	78:21 98:9,11
119:8 125:20	recognising 208:9	191:10 229:25	regarding 122:10	99:13,15,17
129:13 138:21	208:10	reference 84:25	123:25	101:19 105:4,18
140:5 141:5,5	recognition 209:8	169:24 211:21	regards 7:19	126:22 127:11
143:1,2 189:3,11	recollect 145:21	referenced 59:10	regime 38:20 41:4	131:10
201:6 207:22	recommendation	59:16 116:13	41:6 48:23 51:3	registration' 74:19
213:9 225:18	36:7 49:13 168:2	162:5 230:3	82:2 83:8	regular 40:8 47:19
realm 137:18	recommendations	references 136:18	Region 162:24	125:18
reapply 136:13	94:17	referencing	regional 167:23	regularly 47:5
reason 44:14	record 99:23	204:20	register 5:17,22,24	163:22
57:25 59:3,12	100:3,4,5,25	referral 35:1,5	6:1,5,7 9:14	regulate 7:21
108:8 154:10	101:9,14 102:3	38:16 123:24	11:22 16:25 17:1	25:22 172:14
194:17 197:21	103:19,24 116:18	124:2,5,9 125:10	17:4,9,23 18:4,14	regulated 8:19
198:14 204:18	120:19 156:5	126:9 129:23	18:17 40:17 65:6	131:11 132:15
reasonable 138:11	164:14 165:1,9	133:11,13 136:20	65:13,14,17 66:1	regulates 10:2
reasonably 101:11	165:10,16 178:15	146:2 151:14	66:8,11,17 70:4	regulating 73:1
reasoning 217:5	179:1,4,5,8,9,11	167:11	72:13 76:19	regulation 5:6
reasons 103:12	179:12 180:19	referrals 36:22	90:19 98:17	7:15 8:2 12:4
111:4 129:4	191:2,5,12	63:9 125:23	101:8,13,20,22	20:1 24:22 28:17
135:20 150:3	198:13 202:9	referred 22:18	101:25 102:11,25	37:4 48:13,18
153:14,25	226:19	23:1 86:1 105:8	103:11 105:2,19	53:24 54:13,16
recall 64:8 199:2	recorded 164:18	106:12 124:11	107:8,17 130:14	56:3,6 86:24
	178:22 179:4	149:7 160:8,22	132:13	125:17 137:12,12
	190:21 191:15,17	161:1 172:19	registered 46:24	165:4 172:8,10

regulations 51:11 51:21 52:25 53:13,14	173:11,22 186:10 186:18 188:2 217:23	73:13	64:5,23,25 82:8 93:19 94:3 113:9 115:6 116:13,16 124:3,6,19 125:9 125:20,22,25,25 133:16 134:8,24 136:1,9 137:23 139:16 140:18 141:17 142:6 143:8 162:3,16 165:6 166:19 167:2 173:10,13 173:15 190:3,15 194:19,20,24 196:3 197:19,22 206:2,14,23 207:6,25 209:1 210:8,10 213:3 222:16 223:11 224:3,8 226:7,10 226:18,23 227:1 229:19	requested 27:3 requests 79:15 177:10 require 18:7,21 34:20 36:5 54:19 69:2,8 71:24 79:10,13 80:12 100:15 153:6 177:25 required 22:11 28:10 35:1 49:11 51:24 56:15,18 67:18,23 69:15 72:17,18 74:3,7,9 78:13 80:9 94:18 144:2 146:24 147:9 164:25 166:8,10 168:12 requirement 51:4 51:10,20 80:17 92:22 96:11 163:16 165:15 requirements 18:13 37:25 41:22 55:19 62:9 70:5 73:21 74:9 76:3,9 79:6,7 109:11,19 126:20 145:20 146:1,11 155:7 203:19 212:19 requires 13:21 35:6 36:6 82:3 148:15 213:23 requiring 88:23 132:19 146:21 215:7 requisite 71:16 93:3 research 73:20 reserve 7:16 reserved 8:3 resolved 145:8 215:2 resource 37:12 respect 61:25 66:12 208:24 231:2 respond 131:15
regulator 9:5 10:7 11:20 28:10 36:15 55:6 79:15 90:25 117:14 118:5,6,11,12,16 118:25 132:2,6 132:12,16 156:12 158:20 169:9	relation 4:5 5:16 5:21 6:4 13:8 19:12 24:6 32:24 38:2 43:14 50:19 55:15 58:5 59:19 65:7,8 69:25 72:3,15,16 79:23 83:15 104:8 113:10,23 114:25 115:10,25 125:5 126:2 128:20 137:25 138:4 140:6 149:8 153:6 154:6 157:2 158:25 161:12 166:1 171:11 172:3,7 173:5 186:2 187:2 190:19 216:9,10 223:17 224:21	rely 197:2 relying 72:8 78:24 remain 20:15,16 25:9 58:8 75:8 98:8,17,20 107:17 130:12 159:11 175:20 remained 45:19,23 remains 84:11 98:18 133:17 145:1 169:16 remedial 206:3 210:9 remediate 85:22 remediation 39:23 84:11 86:4 87:21 remember 46:12 53:11 152:4 206:7 remembering 109:13 remind 162:9 remit 24:20 164:10 189:8 remote 8:12 remotely 1:6 removal 56:25 105:2 remove 55:24 58:16 90:18 removed 25:4 56:22,23 58:10 58:13,13 99:7 101:13 102:25 103:24 105:19 107:7 226:2 removing 95:19 128:3 render 149:6 160:7,21 repeated 88:5 repeatedly 115:11 replied 196:5 report 22:7 33:13 38:17 48:7 63:17	reported 164:13 165:1 207:12 211:14,19 218:6 218:25 220:4 222:25 reporting 96:11 206:5,10,20 207:3,9 210:23 211:6 Reporting/Inves... 206:8 reports 142:17 190:15 193:24 203:10 211:15 repository 191:1,6 191:18 197:14 198:16,17 representative 40:22 representatives 136:11 162:23 represented 19:25 represents 88:4 reprimanded 115:21 116:11 request 2:14 3:24 100:25 101:1	
regulators 16:4,5 16:8 22:3,4 31:20 37:19 48:15 89:23 90:13 117:9,22 117:23,24 119:10 131:8 132:22 156:18	relationship 30:3 30:21 33:9 42:9 45:8 60:4 168:4 relationships 82:15 relative 34:17 relatively 38:21 92:11 129:5 150:11,13 164:7 170:6 relevance 39:23 163:1 164:10 relevant 7:8 22:7 58:21 67:20 76:24 85:3,5 87:6 92:19 93:2 94:22 100:2 117:23 119:25 128:9,16 145:13 148:12 151:18,25 155:23,23 198:6 201:23 206:3 210:9 211:4,21 217:5 229:15 reliance 72:4			
regulatory 14:25 27:9 29:5 48:9 82:7,12 83:5 97:7 156:21 157:25	reject 150:12 relate 43:21 183:16 190:4 202:11			
related 59:22 64:21 65:1 68:2 72:21 75:23 96:19 113:13 126:12 134:4 139:20 140:18 144:20 160:25 163:3,4 172:3 191:14 195:1 217:4,18 218:8	relates 7:25 12:11 92:20 152:14,20 152:23 162:16 168:22 178:8			
relating 8:5 9:15 14:19 24:2 28:9 29:10 41:9 64:2 64:6 73:18 74:17 98:6 117:2 126:20 136:21 152:25 168:10				

136:11 responded 136:12 188:3 responding 54:9 response 2:14 22:12 33:14 88:3 88:23 105:15 128:4,8 143:23 160:9 185:21 responses 4:18 157:24 responsibilities 5:9 8:13 14:25 112:19 118:14 137:22 171:15 172:1 176:15 181:7 184:23 189:13,22 202:17 responsibility 4:5 5:5 12:18 26:7 27:9 29:2 51:2 53:5 73:14 171:18,23 172:13 179:25 180:5,11 180:18 181:17 182:3,22,24 183:5 186:14,20 201:19 206:2 209:24 210:7,9 222:21 223:24 responsible 5:11 12:21,24 13:1,4 24:21,25 25:2 26:12,14 28:17 31:23 33:16 34:1 34:4 35:3 36:8 40:9,11,21 42:9 44:15 45:8,18 49:12,14 50:2 52:25 53:4,12,19 54:1 81:1,4 93:2 94:24 148:11 161:10,16 169:1 171:4,21 172:4,6 172:11,22 175:6 180:16 182:3,5,8 182:17 183:13 210:22 212:8 rest 8:20	restoration 103:1 restored 100:15 131:1 restrict 92:5 97:17 102:17 restricted 90:4 122:13 restricting 123:14 restriction 76:2 102:20 117:19 157:10 restrictions 23:17 23:24 74:1 102:16 123:6 129:6 restrictive 88:23 rests 85:6 result 20:22 27:5 34:23 39:22 58:25 73:19 95:7 107:7,24 141:25 142:1,2,3 206:15 resulted 205:9 resulting 205:8 results 64:19 164:1 resume 47:25 104:9,14,19 228:12 retain 131:13 195:22 retained 195:24 196:23 198:15 199:6 retention 196:24 198:11 199:5,15 199:21 retire 101:19,25 retired 137:21 160:18 retiring 101:5 105:20 106:10 109:4 110:10 111:20 retraining 92:6 return 107:2,2 revalidate 49:4 revalidated 25:6 revalidation 10:9	36:3,4 37:25 48:6,16,23 49:1 49:13,17,21 50:10,14,25 51:12 53:3,4 80:7,12,15 183:16,21 review 23:19 26:19,23,24 27:2 30:13,16,19 38:9 38:15 41:21 43:3 80:11 121:7 122:8 123:7 124:2,19 128:13 173:12,19,19 202:24 213:22 214:4,9,16,24 217:18 219:12,12 219:14,16 220:8 220:9,24 225:4 225:16 226:5 227:8 229:6,6 reviewed 23:25 49:11 98:12 219:19 reviews 26:21 195:18 213:17,18 227:4 228:24,24 right 1:7,11 3:3 5:1 6:15,16,21,22 6:25 7:17 15:18 16:21,22 21:9,9 21:12,13,19 24:19 33:23 35:13,16 37:11 40:25 42:18 47:11,25 50:7,17 51:9 60:13 62:25 65:1,21 67:4 68:10 71:25 75:15,19 77:9 80:11 81:18 83:9 83:16 85:8,25 89:4,5 91:4,17,24 93:9 95:22 96:2 97:12 99:10 100:22 104:18 107:9 108:17 109:25 110:21	120:4,5,8,11,12 120:15,16 122:20 123:4,5,20 126:11,12 128:10 132:3 134:19,20 135:9 145:24 146:9,24 147:18 148:2,6 149:9,21 151:3 152:11,12 153:15,16 161:11 168:13 171:1,4,8 172:16 173:2 176:23 177:16,21 178:1 179:21 181:15 183:7,20 183:21 186:5,11 192:5,8,21 193:3 193:6,12 195:23 196:15 199:14,20 199:24 200:15,19 200:23 204:3,16 205:15 206:24 207:6 209:19 211:6,23 212:17 212:20,24 213:1 214:11,22 216:5 217:25 218:2,13 218:20,24 219:22 220:7,13 221:20 222:5,10 223:6 223:12 225:18 227:5,10 rights 167:11 rigour 158:25 rise 19:4 20:8 25:20 63:9 123:19 204:12 risk 9:24 11:23 22:16 24:3,4,7 31:22 32:5 37:17 84:5,11 86:16 88:22 89:4 90:5 128:5 137:18 167:22 203:21 207:20,24 risk-taking 209:3 risks 15:23 29:15 85:20,22 86:5 RO 152:3,7	robust 190:12 215:22 robustness 25:13 202:24 role 4:7,25 5:3,14 5:15,16 7:2,3,24 9:1 10:6 12:7,12 12:21 21:11 25:3 28:24,25 33:14 77:4 92:8 171:14 171:16 172:3,10 172:12,20 173:7 177:3,14 179:7 181:11,15,20 182:4 189:15,20 227:24 228:5,19 229:1,9 roles 9:3 17:6 77:3 178:7 189:13,16 202:16 roll 191:25 roll-out 192:21 rolled 192:1 rota 163:17 164:20 rotas 164:2 165:2 roughly 198:20 round 146:22 147:1 209:23 route 14:11 18:8 68:7,7 74:23 75:1 77:6,11 78:7 79:2,11 109:7 117:15 207:13 routes 17:10 135:12 158:1 Royal 13:6 16:17 18:11 26:18,22 30:13 38:15,17 41:20 62:8 66:3 68:5 70:1 74:11 113:8 116:13,15 121:6 123:7 125:8,19,25 128:12 139:15 140:15,18 173:12 173:25 229:18 rule 2:14 3:24 55:15,25 56:10
---	---	--	---	---

56:11,11,16,22 57:11,21 58:17 186:17 187:12 195:14 196:5 197:18 199:3 226:24 rules 6:3 17:24 20:3,15,16 36:20 45:19,22 50:6 61:1,5,6 62:10,17 62:20 72:25 92:20 96:1 run 18:9 23:21 47:11 94:20 97:21 209:21 run-down 220:16 running 8:1 78:16 95:17 177:11 178:4 runs 171:6 174:23 190:8 199:11 Russell 122:5,23 123:2,17	satisfying 59:11 Saudi 118:4,5,11 155:17 saw 173:10 229:18 saying 38:10 42:5 58:7 72:23 90:19 100:14 150:20 196:1 212:16 says 2:25 7:11 81:17 82:10 88:17 100:3 105:1 122:2,18 127:2,8 134:25 144:21 149:13 160:3 164:10,12 166:19 203:17 204:7 205:17,23 206:19 207:16 209:16,25 210:6 210:18 213:23 215:8 217:19 222:5 224:20 225:14,21 scale 144:10 scan 223:21 scanned 197:13 SCEA 187:16 217:11 219:17,25 220:5 223:18 224:1,5 226:4,6,7 226:10,15 SCEA' 217:2 scenario 28:20 34:16 93:11 108:15,16 118:22 scenarios 44:6 scheduled 163:9 163:17 school 6:3 75:7 schools 13:14 scope 71:11 Scotland 6:25 7:4 7:25 8:6,13,13,16 8:19 11:3,5 12:5 12:10,11,25 13:1 15:9,10,15,17,18 15:20 16:8,21 28:20,23,24 29:1 32:3,4 42:6,10	120:8,11 157:14 162:24 189:4 208:4 Scotland's 208:6 Scottish 7:6,13,20 7:23 10:3 11:7 16:4 54:20 189:2 screen 2:17,19 3:8 63:19 67:13 104:17 169:15 scroll 127:2 149:3 149:11 162:25 200:17 216:24 217:8 224:19 225:7 scrolls 163:15 204:7 scrub 176:25 177:3,5,7,13,18 scrubbed 177:19 177:24 179:24 scrutiny 190:13 sealed 66:5 search 81:23 117:25 118:3 searched 152:16 searches 80:4 130:10 198:4 202:6 seat 228:16 second 24:6 107:11 122:12 134:14 135:1,7 135:18 136:5,15 146:20 147:1,14 207:17 211:8 221:5 secondary 56:8 secondly 61:22 112:13 section 51:13,17 63:20 73:23 74:5 74:13 82:3 144:18 sections 171:3 200:13 see 1:10,12,25 2:18 7:24 33:24 47:20 48:1,2 58:18,24	70:25 83:13 92:11 104:18,19 116:16 125:13 149:3,3,12 150:20 162:8 163:2,13,16 164:9 166:13 177:13 185:7 195:23 200:17,21 212:1 219:18 220:20 228:20 seeing 31:22 seek 97:15,17 103:1 105:2 109:14 129:1 132:15 seeking 128:19 149:18 seeks 203:20 seen 42:19 72:15 125:7 138:20 158:13 165:25 166:14 173:11,15 184:9 192:5,25 217:11 sees 84:6 165:20 212:4 segment 164:3 selected 67:19 69:17 70:6 selecting 227:7 self-report 92:21 send 23:20 136:7,9 sending 150:21 senior 6:24 7:3,8 22:12 72:22 76:23 77:3,16 162:21 164:6 171:17 174:15,20 174:22 175:4 176:5,5,9,11 193:24 211:19 seniority 176:12 sense 31:6 34:20 43:19 90:6 95:12 96:16 137:19 173:7 175:8 195:2 196:7 204:23 210:17	218:15 228:21 sensitive 153:10 sent 2:15 135:5 sentence 207:17 separate 62:7 65:14 80:8 94:17 95:3,25 96:1,5,11 179:10 207:5 219:9 222:24 separated 95:10 separately 94:21 separation 206:20 September 1:1 5:1 220:4 231:11 sequence 41:7 43:3 series 27:21 84:4 serious 24:11 28:8 39:8,15,18 41:20 55:12 82:15 84:1 84:2,3 88:15 93:19 116:19 122:7 123:19 128:23 139:17 141:17,22,23,24 142:5 166:3 187:16,18 188:1 213:14 214:6,15 215:1 219:16,21 220:11 222:15 224:9 seriously 42:2 118:14 137:24 141:7 168:17 seriousness 43:20 88:14 service 8:1,6 23:3 23:22 55:11 94:20 95:19 127:6 204:10 service[s] 127:15 services 12:11 13:1 15:9 16:20 32:4 39:6 86:13 86:24 137:15 144:24,25 206:12 session 169:13,19 sessions 163:19 set 9:3,9,17 12:12
S				
S 66:6 72:11 sadly 39:6,8 168:14 safe 9:12 12:14 25:16 165:13 209:1 safeguard 11:12 safely 10:21 20:11 60:25 safety 9:23 11:4 24:4,9 28:4 48:12 93:25 166:3 167:23 203:24 sake 47:18 56:9 153:5 sample 227:9 sanction 91:23 102:10 144:3 sanctions 23:12 55:12 sat 71:23 satisfied 67:15 69:9 92:12 satisfy 142:15				

12:19 13:7 16:14 19:5 33:10 36:10 56:7 60:17 61:17 71:19 74:17 75:24 76:11 94:20 96:5 105:10 109:8 124:6 138:20 181:7 186:21 190:8 set-up 190:10 sets 19:14 49:2 61:14 126:17 183:25 setting 7:14 20:12 25:4 76:24 94:23 126:16 settlement 7:14 seven 199:22,23 severe 219:9,15 severity 140:4 207:11 212:23,25 219:10 224:4 229:7 sexual 24:13,13 82:14,14 shadow 94:15,22 95:5,6 shaken 27:4 shape 25:15 share 31:10 155:8 156:19 157:22 169:18 shared 32:10,13 33:4 64:13 120:18 156:8 201:9 sharing 15:11,15 15:21 29:17,24 31:9,13,14 33:1,2 37:19 118:13 156:23 sharper 110:8 111:18 sheets 152:25 shift 48:18 53:23 176:15 Shipman 50:19 51:16 94:16 95:8	95:11,22 short 26:3 47:15 47:23 104:12 110:19 159:8,15 170:6,9 228:8,14 shortcomings 13:23 shortly 53:2 65:20 104:22 159:13 160:17 163:9 228:12 show 85:9 101:23 102:2 226:14 showing 85:10 shown 92:14 147:2 shows 40:9 150:19 220:23 side 16:9 47:11 162:12 sight 34:7 169:20 sign 16:18 164:21 signal 19:1 signalled 20:18 48:17 signature 2:24 3:12 signed 3:2 149:24 171:10 significance 6:23 52:17 63:2 144:16 211:18 significant 37:14 39:7 88:4,8 119:10 122:6 123:18 168:10 174:16 176:21 187:3,4,9,10 205:24 211:1 212:13,16,21 213:25 214:7,22 215:9 216:15,21 217:2 218:19 221:8,18,23 222:12 223:23 225:11 227:4 228:24 229:9 significantly 37:12 45:10 63:7 Signs 201:11	similar 11:6 28:19 91:23 96:12,18 132:22 157:19 158:23 172:9,24 204:2 219:25 Simon 170:11,12 170:13,15 232:3 simple 147:10 148:15 simplistic 34:14 simply 4:18 20:12 20:21 37:9 49:25 87:18 106:9 131:25 simulated 78:18 single 45:8 125:23 177:13,14 sir 1:4 4:12 35:19 47:13 48:1 102:6 104:1,15 170:5 227:16 231:7 sit 71:24 74:3 78:13 186:13 189:22 site 215:11 217:10 217:12 site-level 31:2 sites 64:1,1,3 sits 8:11 181:22 185:12 sitting 26:24 27:10 201:1 219:18,19 situation 34:17 67:6 91:17 108:4 109:4,5 120:14 129:18 140:9,25 220:1 situations 44:3 61:16 70:7 73:2 78:18 207:23 six 23:25 42:13 46:23 47:3 61:19 63:25 64:1 98:12 162:17 220:19 227:4 sixteen 133:25 sixth 227:12 size 174:23 skill 67:18 69:15	skill-set 175:14 skills 13:9 18:6,15 60:18 62:5,6 69:2 72:19 74:5 74:8 slight 111:2 slightly 11:14 36:21 37:9 58:10 80:5 81:6 125:16 137:17 155:8 172:23 182:5 slips 191:12 small 44:20 smaller 176:16 SMT 162:22 166:25 Social 10:24 11:2 54:19 182:14 solely 161:6 solicitor 6:14 somebody 101:5 101:16 130:23 174:16 176:7,12 177:7,10 178:3 191:4,12 someone's 119:11 131:10 son 112:16 soon 210:23 222:15,25 223:5 223:8,11 224:1,3 sorry 11:13 34:12 53:17 68:11 111:2 118:7 139:5 145:19 147:15 190:6 196:2 212:15 213:16 230:17 sort 33:5 34:13,23 37:3 46:10 47:10 48:22 51:23 52:1 53:16 54:23 70:25 75:1 91:6 91:7 97:9 106:9 135:23 161:11 164:7 171:25 172:24 174:6,7,8 179:24 181:19 184:3 185:24	186:1 193:17 197:17 204:25 220:16 sorts 12:15 14:10 25:20 163:21,22 174:2 192:9 215:6 sought 106:8 107:13 124:17 129:23 140:20 source 197:1 sources 30:1 spaces 95:21 speak 4:13 123:9 140:8 175:23 209:1 229:19 speaking 12:15 26:17 68:23 72:20 80:19 174:6 185:20 speaks 212:18 specialism 66:18 66:19 specialist 6:5 9:16 17:2,4,8,12,17,23 18:3,14,17 65:11 65:12,14,15,17 65:19,21 66:1,8 66:11,12,17 72:12 76:18 99:16 212:9 specialties 175:2 175:11 specialty 13:4 162:20 175:17,20 specific 4:4 11:2 46:8 54:21 61:7 61:15 62:13 63:20 81:7,13 156:25 166:18 175:16 179:16 186:2,18 202:13 specifically 16:10 43:25 59:10 65:1 79:22 114:16 175:7 194:7 specifics 32:23 213:3 specified 74:1
--	--	---	--	--

speculate 140:5,22 142:6	139:2,4 140:1 143:10,17	statements 3:23 22:6 92:19 169:22,25	subject 31:5 61:11 71:8 118:21 122:11 127:11	155:1
speculating 70:14 129:8 138:19 141:11	standards 9:9,17 10:9 11:20 12:2 12:4,17,18 16:12 18:21 25:5 60:9 62:21 72:25 77:20 78:4,23,25 83:14,14 88:5,9 89:13 109:20 168:12 171:21 190:14	states 184:21 stations 78:17 statute 83:9 96:10 98:14 statutory 11:5 51:7 82:2 85:4 86:22 89:10 96:10 172:12 173:1 184:15	subjective 83:24 submission 186:17 187:12 199:1 226:24 submitted 134:14 187:17 226:18 subsequent 70:19 73:7 95:8 96:7 100:20 225:4 subsequently 65:16 79:5 99:2 101:17 137:8 165:1 225:1	supersede 98:23 superseded 130:19 supervised 70:23 supervision 14:13 31:4 41:22 68:1 69:6 73:15 74:2 74:15 76:2 77:15
speed 211:13 sphere 80:6 spinal 127:9,24 128:4,13 129:12 226:1	standing 79:14 80:1 93:15 132:16 start 4:11 46:10 85:17 144:2 178:20 189:8 started 38:5,8 168:23 191:25 starting 5:3 230:16 starts 19:23 state 184:19 199:21 208:7 statement 2:14,20 3:2,3,5,9,12,14 3:17,19,25 4:7,8 4:10 7:9,11 9:2 10:11 12:1,12 17:9 19:6 24:1 29:8,13 35:20 49:1 51:6 53:22 61:12 66:23 81:14 82:3 86:20 102:8 104:25 123:22 144:17,22 145:1,14,21 146:4,8,9 147:1,6 147:7,9 152:20 155:15 158:18 162:5 170:21,21 170:24 171:6,10 181:6 185:15 186:20 195:14 196:5 197:18 199:18 200:25 216:20 230:25 statement' 144:25	stays 100:3 103:24 step 25:4 155:22 155:25 stepped 112:12 steps 72:17,17 85:22 86:5 96:6 156:13 sterile 177:6,8,20 177:22 178:5 180:4,14 sterilised 178:1 stick 16:10 141:19 stood 166:12 stop 102:18 103:8 106:15 111:4 stopping 23:17 110:3 store 195:17 stored 192:10 198:14 200:3 straight 148:23 straightforward 45:6 108:16 strategic 47:7 straying 11:14 strength 109:19 string 66:1 stronger 141:8 strongly 15:24 struck 101:4 structural 96:12 structure 190:12 structures 46:2 183:9 201:17 sub-committee 190:16,17 sub-species 103:5	subsequent 70:19 73:7 95:8 96:7 100:20 225:4 subsequently 65:16 79:5 99:2 101:17 137:8 165:1 225:1 subset 184:3,5 substance 91:13 substantial 30:4 substantive 4:9 76:8,21 77:16 success 109:21 successfully 226:2 sufficient 50:20 67:18 69:16 74:8 141:18 142:21 sufficiently 41:20 93:18 121:18,19 suggest 4:18 84:10 153:21 224:8 suggested 92:5 202:6 208:4 suggesting 161:18 suggestion 110:10 111:19 123:8 suggests 18:15 22:16 24:2 119:21 122:25 176:6 suitable 67:20 69:17 70:6,9,11 165:13 suite 27:14 49:14 50:25 150:3 summary 20:6 77:21 81:17 95:22 139:1 162:14 superimposed	supplement 55:1 62:12 133:10 supplementary 19:11 supplied 218:7 219:2,24 supply 186:16 support 20:11,12 20:20 26:14 34:9 139:24 147:12 176:19 179:7 209:21 215:20 supported 169:23 supporting 7:4,6 36:16 49:6,10 61:24 80:12 124:3,5 169:1 172:15 175:15 177:8,11 178:4 supportive 62:1 suppose 90:8 120:10 137:10 179:20 204:21 227:24 sure 9:11 21:21 25:5 26:15 33:19 34:6 37:16 44:12 45:22 47:17 49:1 53:10 64:13 70:13 77:18 78:5 78:23 81:4 86:18 93:14 111:8 117:17 129:3 132:8 145:12 148:19 149:25 150:2 153:12,13 172:16 181:24 182:25 183:18 189:18 197:14 201:11 202:7 204:22 228:1

surely 110:24 surface 32:19 surgeon 93:15 122:13 177:8,10 180:24 226:19 surgeons 26:18,22 38:15,17 41:21 66:4 70:2 74:12 113:8 116:13,15 121:7 123:7 125:9,19,25 128:13 140:15 173:12,25 175:15 Surgeons' 139:16 140:18 229:19 surgery 43:8,22 59:23 64:22,24 65:24 66:15 102:19 113:24 122:7 127:9,23 127:24 128:4,16 128:21 129:12 134:5 136:22 162:19,22 166:23 178:17 212:8 215:12,14,21 217:11,19,23 218:11,12 220:1 220:20 221:14 223:15,19,22 225:8,14,24 226:2,9 surgery' 217:12 surgical 64:1,3 66:2 122:12 162:12,17 168:6 175:9,11 176:24 212:11 220:3 225:4 228:21 surprised 30:14 survey 15:6 31:1 64:19 164:2 168:18 suspect 129:10 137:3 suspend 122:14,24 suspended 123:2 suspends 124:15 suspension 23:11	97:20 99:4 102:11,15,20,21 102:22 142:3 suspicion 35:16 sustain 124:20 sustained 206:11 sworn 1:17,20 170:13 232:2,2,3 system 5:6 29:17 31:20 35:22 44:24 48:15 50:14,14 51:21 52:4,16 53:2 54:24 65:20 68:15,18 72:20 78:2,2,5 80:8,19 81:9 92:17 93:7 93:23 96:12 172:9,24 181:12 182:18 183:20 184:12 185:4,5 185:21 189:17 191:1,5,8,18 192:3,4,8,12,15 192:16,17,20,23 193:1,8,14,14 194:13 196:21 197:9 198:1,9,10 198:13,18,18,22 199:11 202:1,3,5 202:7,9,13 205:19 206:20 207:9 213:18 217:20 219:1,6 219:20 220:12 221:2 222:4,8 223:1,2,25 224:18 systemic 24:20 25:21 26:24 27:3 27:19 28:14 32:14 40:13 systems 12:23 25:1 25:2,3,13,14 26:24 27:10 28:9 28:17 54:2 73:9 73:11 78:1,4 79:19 81:25 92:25 132:22	152:18 183:9,13 183:16,17 185:25 186:4 191:21 193:11,14,15,19 194:11 197:24 201:3,22,24 204:23 205:25 209:2,6,18,21 227:2,10 T T 66:6 72:11 take 9:24 10:25 14:18 16:3 22:4 24:3,17 25:10 30:17 32:1 47:15 52:10 60:5 71:17 90:17 101:25 103:8,11 109:3 117:10 118:13 121:17 132:10 141:7 144:1 145:3 155:9,11 156:16,25 158:2 162:1 166:15 168:17,21 176:14 180:3 195:20 206:2 209:11 214:1,4,6 taken 25:12,22 40:24 85:1,21 86:5 95:13 96:6 108:7 114:3,16 115:20 116:21 117:15 127:1 133:18 138:6 141:2,4 155:22 155:25 156:11,14 218:11 takes 23:2 24:12 talk 26:9 35:2 48:5 65:10 89:21 91:7 156:20 talked 16:15 37:20 63:2 81:8 135:11 143:17 158:19 183:16 talking 19:3 33:25 54:8 57:7 63:21 73:13 83:23	126:10 130:18,20 144:19 149:4 150:6 194:5,6 221:11 talks 21:6 123:17 task 180:14 209:15 tasks 177:25 taught 146:15 Tayside 13:3 19:24 30:10,14 38:23 41:8,18 42:2,21 43:20 63:21 64:4,15 112:13 113:18 115:13 116:2,17 120:7,21 121:6 123:2,24 129:25 133:25 138:3 140:13 146:23 147:3,23 148:5 149:2,13,14 151:14 160:18 161:2,23 170:18 170:22 173:7 181:10,11 182:13 188:20,25 190:9 191:1 193:8 194:6,22 200:14 201:22 203:18 205:18,22 207:16 207:20,23 208:2 208:18,23 212:7 224:25 225:3 227:25 228:3 230:2,24 Tayside's 124:5 205:1 teach 205:14 teaching 16:19 163:19,19 team 6:24 7:3 33:11 43:23 162:21 167:23 173:19 174:19 176:12 180:7 186:12,13 191:7 194:24 195:22,25 teams 36:11 tease 29:20	technical 60:10 72:18 223:1 technically 112:9 technological 204:24 tell 5:22 7:2 14:12 33:12 39:3 41:4 63:3,6 64:21 65:9 66:22 67:12 74:22 76:25 94:9 97:1 102:14 128:6,17 129:17 130:16 141:12 143:4 147:20 150:10 171:14 174:5 181:10 188:16 202:1 226:15 229:22 telling 31:3 54:1 130:14 197:2 216:20 tells 82:2 87:11 145:22 200:18 220:18 temporarily 124:15 temptation 141:16 tempted 142:6 ten 51:22 52:18 199:12 ten-year 199:19 tend 32:18 72:8 85:20 154:15 178:18 229:8 tended 19:2,10 tends 32:13 tension 167:13 term 84:13 204:8 212:7 terminologies 187:13 terminology 77:2 208:3 211:24 terms 5:17 10:15 10:16 11:21 13:10,12 14:17 14:19 15:5 17:22 17:24 20:8 25:4 26:15 27:15,23
--	--	---	--	--

30:24 31:8,11,22 34:8 36:18,23 37:19 45:10 47:8 53:6 55:7,17,22 60:24 62:23 64:22 68:22 70:2 70:14,19 79:17 79:24 80:3,25 86:2 89:17 101:7 107:20 110:3 112:15 113:6 115:4,17,18 116:4,7 117:4,10 125:7 126:8 129:5,19 131:5,7 132:19 133:14,22 137:11 138:2,3 138:16 140:14 141:4 142:22 143:24 144:10 151:14 155:10 158:9,17,17,19 164:4 166:5 168:15,18,20,24 168:24,25 169:7 169:8 192:9 223:10 territory 4:16 11:14 test 22:15 57:24 58:8,12 59:1,2,5 59:11 65:24 67:24 70:13 71:23 72:3 74:4 78:20 85:11 87:7 87:12,15,16,25 89:2 90:3 97:23 142:10,11 tests 31:9 36:23 78:22 79:1 thank 1:7,18,21 2:1 4:20 5:22 6:9 8:23 12:7 14:1 16:9,23 18:18 19:19 20:23 21:8 24:1,18 25:17 28:19 29:7 35:18 35:19 37:21 38:25 41:2 42:16	43:24 46:18 47:13,21 48:4 51:6,16 53:9 61:11 63:16,19 64:14 65:4 66:22 71:4 72:2 73:16 75:21 77:5 81:6 82:9 84:24 85:13 88:17 91:6 92:1 94:6 96:25 102:6 104:1,6,10,15 116:25 118:21 119:24 120:22 121:24 122:23 123:1,11 126:11 126:14 146:6 152:13 157:4 158:4 159:5,7,13 159:19,22 162:1 166:15 169:10,11 170:2,3,4,7 171:14 172:24 176:23 181:6 212:17 216:18 218:17 227:15,19 227:24 228:6,7 230:12,12,15 231:3,4,8 thanks 169:16,17 230:22 theatre 44:20 93:12,16 115:18 174:13,14,25 175:19,21 176:8 177:4,12,24 178:3,4,9,15,21 178:22 179:8,15 179:19 180:22 theatres 175:1,5 175:19 thematic 15:23 28:1 32:14 theoretically 108:18 229:1,12 theories 222:12 theory 59:6 71:14 206:22 214:18 they'd 175:23 thing 25:11 59:21	75:1 93:11 102:6 129:13 133:5 143:14 154:13 164:7 179:25 186:1 192:9 195:9 204:25 209:10 215:20 225:21 229:21 things 8:8 12:19 13:10 16:2,9 19:4 20:3,5,13 21:4 29:5 33:12 33:15 34:7 35:25 35:25 37:19 38:5 39:15 41:14 44:19 45:5 51:12 51:24 53:3 55:13 55:23 62:2,11,15 63:11 72:2,4 84:22 93:4,25 112:10 125:13 138:13 143:15 152:2,4 153:20 158:7 163:22 164:2 169:7 171:24 175:3 178:7 179:5 183:17 184:19 187:8 188:4 194:22 197:6,11 197:12,16 200:4 201:2 204:1,2,14 206:23 207:5 209:24 213:6,9 215:6 think 3:2 4:15 7:15 8:8 10:15 11:13 12:19 15:4,15 16:10,13,17 19:25 21:11 22:1 23:20 28:23 30:20 31:5,13 32:8 33:8,12 35:13,24 36:2,11 36:19 37:4,23,25 38:1,9,18,22 39:11,12 40:5,7 40:15,17,18 41:5 41:7,10 42:17	44:11,16 45:4 47:25 48:21 51:12 52:1,13,23 52:24 53:14,25 54:21 56:5,23 57:7 59:10 60:8 60:10,15 61:13 64:8 65:18 66:2 67:8 70:14 71:24 73:3,8,12 75:12 77:21 79:2,20 80:5 81:16 82:2 84:2,13 86:20,21 90:8,10,17,20 91:7 92:17,19 93:5,24 95:11 96:5 98:20 101:22,25 102:6 102:13 103:25 106:2 108:1,15 109:22 112:9,22 112:24,25 113:10 113:20 115:10 116:25 117:11 118:15 119:2 120:3 121:2,25 122:18,21 123:16 125:6,9 128:2,9 128:22 129:1,17 132:3,9,9,10,11 132:18,18 133:6 134:8,17,21 136:12 137:16 139:20 140:13,17 140:21 141:3,7 143:14,21 144:6 144:8,9,9,19 145:5 146:22 148:4,24,25 149:2,11,13 150:24 151:5,6 151:12 154:3 156:16 158:7,23 160:13,15 161:6 163:3 165:24 166:13,16,18 168:9 170:17,24 174:21,24 185:1 185:24 186:10,22	187:16,24 188:3 188:14 189:10 190:19 191:21 192:24 193:3,21 195:5 199:1,3 200:11,13,18 202:1,9,13 205:12 206:13,16 206:22 207:14 209:8,20 211:5 211:13 216:2,11 216:14 217:15 218:7,10,22 220:4,6 221:11 224:14 226:23 227:22 229:20 thinking 15:18 30:13 42:2 57:5 125:1 128:18 132:12 141:16 151:12 194:5 third 72:9,13 162:13 Thirdly 61:23 thought 4:16 92:2 99:2 128:2 173:4 196:2 197:5 thousands 18:10 three 5:25 43:6,11 79:12 144:23 145:25 151:2 182:14,14 187:8 220:6 threshold 20:7 21:24 33:5,17 34:2,19 35:4 87:18 88:14 214:5 thresholds 58:21 142:22 thrown 28:7 thrust 54:23 Thursday 1:1 tick 148:16,17,17 ticked 149:9 150:20 151:10 160:2 ticks 72:5 tighten 79:5
--	--	--	---	--

time 19:1,8 20:6 23:15 30:6,8,11 36:12,13 38:11 38:12 41:5 42:10 42:23 43:9 46:11 47:21 48:9 49:2 49:25 50:6,16 52:11 56:14 57:23 58:21 59:14 60:7 63:7 69:3 71:15 72:9 73:8 74:2,20 76:10,25 78:10 79:1 95:16,16 99:1 102:2,3 104:10 105:3 112:22 117:6 119:18 120:10,17 120:19,25 121:1 121:9 125:21 127:20 128:3,24 129:25 131:2 134:7 135:22 136:5,15,20 137:19 140:12 143:5,7 145:20 146:21,22 147:1 150:14 161:3 163:19 165:3 166:6,10,12,14 181:4 187:14,22 188:22,23,25 192:12,25 193:25 194:19 197:19 199:7 204:19 210:17 212:19 214:13,14 218:9 225:1 226:13,16 229:8 230:18 timeline 105:14 times 19:8 46:4 94:8 175:16,17 timescales 215:8 tipped 35:4 title 29:2 230:3 today 4:3 113:10 114:23 122:14 140:9,14,21 141:1,4 158:23	169:17,21 170:5 185:19 told 19:21 30:24 39:10 41:15,16 45:17 60:8,10 61:14 64:23 65:4 113:18 115:20 116:1,12,17 128:10 133:3 139:16 156:4 163:12 164:23 182:2 188:6 217:8 tools 22:5 177:9 top 40:12 165:15 212:24 214:11 225:7 topic 8:3 48:5 touch 151:14 155:19 158:2 touched 54:5 102:13 120:14 124:23 tracks 37:9 trail 113:19 train 37:9 trained 77:18,25 78:3 166:8 trainee 73:25 trainees 13:16 14:12,15 trainers 13:17 training 9:12 12:13,22 13:2,15 13:18 14:22 15:6 17:5,17,18,20,21 17:25 18:3,8 27:24 30:25 31:3 60:19 61:9 62:9 64:19 65:23 66:3 68:3 75:5 76:4 77:16,25 78:6 162:21 163:18 164:1,4,6,13,18 164:22 165:7,10 165:13,13,16 166:21 167:1,14 168:6,16,18 transferred 65:16	66:10 transitional 38:7 71:9 transmitted 156:10 trauma 162:18,22 166:24 treat 119:6 treated 77:24 treating 61:25 triage 21:23,23 23:14 35:8 57:11 57:14,23 59:7 83:15 85:1 87:4 87:6,7,18 94:11 96:15 124:4 triaging 81:10 triangulating 31:25 tribunal 22:18 23:2,6,15,21,22 27:17 55:11 89:1 91:15,18 94:8,9 94:20 95:1,15 99:1 101:18 103:15,24 106:25 109:12,15,16 110:6 116:7 117:13 124:12 125:11 126:17 128:5,18 129:2,5 129:10 130:23 138:8 139:8 141:24 142:9,15 143:3,11,15,19 143:24 158:14 tribunals 94:25 97:21,22 98:6 tried 185:15 tries 156:18 trigger 223:7 triggered 217:21 217:25 218:3,18 219:25 220:24 221:18 222:8,9 224:2,6 225:16 tripped 191:16 trips 191:12 trouble 20:14	63:12 206:24 true 3:17,19 27:17 72:24 171:12 trust 24:16 28:15 30:12 116:18 trusts 26:8 28:2 try 11:12 12:16 25:23 29:22 35:24 37:7,21 51:1 54:25 78:5 83:12 145:14 155:22 156:17 158:1,1 174:4 183:18 194:25 196:15 197:14 202:7 203:25 204:2 213:19 214:19 219:4 222:13 trying 15:1 20:9 20:11 36:17 37:8 58:4 68:12 86:10 87:7 139:5,11,12 139:23 145:10 179:10,22 188:17 191:20 196:11 206:13,19 207:14 207:22 209:11 214:25 221:22 223:2 227:8 tumour 226:1 Tun 8:18 turn 13:1 52:1 176:3 turned 112:4,20 137:7 turns 207:7 twice 134:19 two 1:5 3:22,23 15:20 17:15,17 26:21 29:19 44:5 59:10,15,21 61:20 75:2 76:11 86:7 95:2,9 105:7 107:5 112:10 113:23 114:24 119:1 134:10 135:12 143:14 173:20	182:9 214:10 220:25 221:1 222:24 223:3 224:9 225:14 228:22 two-way 48:19 53:24 type 25:21 37:4 109:5 187:18,19 types 24:15 26:21 84:15 163:21 213:17 228:19 typically 13:5 17:25 26:7 28:16 35:2 39:7 46:23 62:7 79:14 105:21 108:4 144:24 149:22 typified 36:13 typo 122:21
U				
UD8 148:24,25 159:23 UK 6:2 8:20 9:7,14 10:2,7,21 12:24 15:13 17:7,13 36:11 39:6 45:9 52:11 54:19 59:4 63:25 68:23 74:25 75:3,6 76:2 77:6,19 78:2,12 83:5 89:14,16,16 90:15,25 102:24 107:3 110:4 119:21,22 127:4 130:6,8 131:4 138:16 156:8 157:12 ultimate 85:10 ultimately 25:24 28:3 77:15 78:5 81:3 83:11 87:4 102:9 108:11 118:22 145:6 umbrella 95:12 unable 82:21 116:22 154:7,8 164:14 167:14				

198:8 unclear 164:15 193:25 198:12 199:25 223:17 226:22 uncover 141:8 undergo 92:6 undergraduate 12:19 69:10 undermined 24:6 167:18 169:4 undermining 64:2 65:2 166:19,21 166:23 167:2,20 168:4,14 underneath 174:19 176:19 underpinning 54:15 55:3 137:12 underpins 117:1 understand 2:6,13 4:25 5:3 6:14,23 9:21 16:11,15 18:20 27:13 37:1 38:5 44:13 52:10 64:17 65:3 69:20 77:12 90:13,14 93:23 99:9 107:5 117:3 118:24 122:15 125:19 135:6 137:9 139:2 148:19 150:2 155:7,20 155:25 156:12 157:8,12,17 158:2 161:17 174:3,4 179:22 182:8 185:16 187:1,7,24 188:19 193:19,20 203:5 205:11 212:4 218:17 223:1,3,23,25 226:25 understandable 112:22 understanding 16:1 17:9 31:16	31:18 37:17 39:3 41:6 51:16,23 53:15,17 60:23 67:3 68:19 71:3 71:21 80:20 91:1 129:15 139:13 152:22,24 153:4 172:6 185:19 194:11 197:24 202:15 214:3,13 221:10 224:14 understood 46:15 46:18 58:7 114:11 121:19 144:14 155:13 157:21,22 162:12 183:2 186:24 190:19 197:16 202:8,10 216:7 220:2 undertake 26:23 127:6,14 163:25 164:1 undertaken 25:19 26:20 68:4 162:18 194:22 198:5 225:25 undertaking 32:24 49:15 61:10 91:17 92:13 undertakings 22:25 88:25 91:9 91:12,15 92:1,3 undertook 63:24 128:17 231:1 underway 59:19 unethical 62:17 unexpected 204:9 unfinished 131:5 unfortunately 118:10 unit 149:14 174:5 174:9,21,23 175:24 179:23 229:12 units 166:24 university 74:25 118:2 146:15 unknown 41:17	unknowns 41:17 unlawful 82:16 unpack 138:21 unplanned 204:8 unproven 112:9 unredacted 153:7 154:17,22 unusual 121:9,10 126:8 up-to-date 197:15 update 200:18 201:9 updated 19:8 55:24 201:17 203:3 updating 56:5 151:22 upholding 89:13 upstream 36:14 169:9 use 18:11 20:23 80:22 149:22 184:10 191:1,2 201:20 useful 197:6 usual 3:25 usually 18:11 24:10 75:8 161:15 219:7 V vacuum 116:24 validity 108:8 110:13 111:24 value 112:10,23 variety 14:6 173:21 175:10 various 7:7 14:24 35:19,21 46:3,3 50:18 51:6 69:8 81:10 95:17 109:19 111:4 122:1 126:17 129:16,17 152:17 158:15 170:25 181:7 194:2 vary 178:18 vast 4:9 78:12 veracity 114:17 verdict 133:22	verification 72:17 73:4 verified 72:19 verify 154:8 verse 53:8 69:24 version 194:1 197:13 view 59:2 119:4 136:4 138:5,7 166:6 174:13 182:25 219:23 violence 24:13,14 82:14 virtue 176:6 visit 64:6,15 163:24 visited 64:3 162:11 173:20 visits 63:24 64:4 163:25 Vital 201:11 voice 1:21 volume 158:9 voluntarily 99:18 131:18 voluntary 101:6 103:7,8,20 104:23 105:3,11 105:13,17,17 106:4,8,12,23 107:6,8,20 108:3 109:24 110:2 114:9 117:2,8,15 118:9,12,23 119:5,18,23 130:18,21 131:3 134:15,17,19 136:6,13,15,24 138:10,14 139:9 144:8,13,20 145:23 146:12,17 147:14 148:1 151:16,23 152:9 155:15 158:11 161:19 W wait 35:1 waited 36:21 waiting 20:21	36:16 230:18 waived 56:16 Wales 6:15 11:3 82:25 walk 208:25 want 11:19 14:1 25:7 30:21 31:18 34:6,9 37:16 39:25 40:10 42:23 56:4 59:24 109:14 129:3 131:7 133:9 142:13 143:12 145:11 158:22 159:10 163:13 175:23 208:23,25 219:13 wanted 11:18 17:1 36:14 54:7 61:9 68:25 100:9 108:20 129:13 131:4 132:5 146:6 196:4 wanting 37:5 wants 106:15 ward 178:20 191:3 191:17 warning 22:24 23:9 88:1,2 warranting 22:20 wasn't 59:18 61:2 96:8 110:10 111:20 121:22 140:19 142:11,21 218:4,9,9 221:1 222:3 223:19,20 226:17,21 wave 106:9 way 4:8 8:20 16:12 20:16,25 23:15 31:12 32:10 35:2 35:7 42:10 45:13 50:11 51:1 52:4 55:4 62:16 68:15 68:25 72:6 73:10 75:25 78:10 81:5 81:22 85:14 93:5 96:14 106:9,16 106:17 109:18
--	--	--	--	--

110:5 111:14 113:9 114:22 119:8 131:6 132:10,14,18 139:24 143:13 144:3 150:16 152:14,16,18 154:19 155:3,10 158:3 166:8 168:10 172:11 173:11 174:25 177:24 178:1,6 178:11 182:5 186:20 190:8,19 201:2,10 208:8 208:14,15 213:18 220:10,18 224:17 227:2 229:18 ways 156:9 we'll 4:18 14:18 19:19 47:15,20 52:24 53:7 67:6 102:7 104:6 105:16 106:3 108:13 142:18 149:22 158:2 216:24 228:11 we're 5:18 10:23 11:1,22,23,24 12:3 24:25 25:2 27:24 30:24 31:21,21,23 35:1 37:16 38:4 52:17 71:4 73:13 80:20 121:13 125:4 129:3,3 130:20 150:6 159:7 198:12 205:12 219:17 226:22 228:7 229:20 we've 12:8,9 19:10 20:19 23:10 31:13,15,16 42:19 43:5 45:9 47:17 53:10,21 55:2,13,25 56:25 61:12 63:2 72:15 73:11 76:17 80:5 80:8 87:3 89:24	101:5 102:13 108:25 110:23 111:3 112:24 124:23 135:20 150:3 155:10 156:3 158:15 168:16 170:24 172:2 176:24 178:14 187:17 188:6 217:11 218:7 228:22 website 81:22,24 132:25 204:25 week 11:4 26:19 weeks 43:5 weigh 113:1 119:13,22 144:12 weighed 137:6 weight 125:6,8 135:20 well-established 10:6 went 77:8 93:18 133:7 173:24 192:15 193:24 196:22 208:10 229:19 weren't 30:15 57:25 111:8 114:6 193:17 Westminster 7:12 7:17 8:4,12 10:25 12:6 whichever 23:12 28:14 whilst 57:21 113:14 115:11,16 115:25 116:20 128:23 137:22 142:5 wide 173:21 175:10 wider 25:20 27:19 32:19 48:10 90:6 128:14 168:22 wife 112:17 willing 154:21 Willy 42:18 wish 111:14	228:10 wished 42:22 119:1 135:16 wishes 105:24 wishing 131:21 withdrew 231:5 witness 2:13,20 3:5,9 22:6 75:13 97:6 169:22 170:5,11,21,25 227:20 229:5 231:5 witnesses 1:4,5 3:23 4:12 43:5 104:3,16 110:22 158:5 wonder 17:11 59:2 173:8 188:10 wondered 46:20 wondering 58:24 154:21 182:1 word 85:13 101:7 101:10 words 56:16 86:8 work 6:24 9:7,13 13:25 15:8,12 17:5 19:18 24:2 26:6 27:23 29:16 30:25 33:4 46:2 47:9 48:13 50:12 52:13 55:25 75:18 77:7,14 81:24 86:10 89:21 90:1,3,20 104:4 112:13 113:14 119:22 125:14 127:14 130:15,17 132:22 144:3,23 145:10 145:14 146:5,14 165:23 166:9 168:12 173:5 175:1,5,9,10,18 175:19 177:20 182:18,23 189:17 191:3 192:11 199:18 203:6 208:19,25 209:14 214:25 227:2,3	worked 21:1 113:13 115:11 147:18 164:12,19 164:24 165:12 166:2 174:17 192:12 194:2 223:25 224:16,18 227:10 workers 176:19 workforce 5:5 174:10 working 6:8 12:23 14:15,22 21:7 27:14 28:10 31:16 32:22 61:22,23 90:5 115:15,25 116:20 119:20 135:23 164:14,19 165:3 165:8,10,17,21 165:24 166:6,10 176:8 177:23 183:6 190:12 194:10 202:25 229:7 workload 163:3,6 163:7,21 workloads 164:3 workplaces 208:23 works 66:13 71:18 72:7 156:15 221:3 223:1 world 45:7 89:15 90:10,21 117:22 worried 33:20 worry 49:18 worse 35:25 worsen 98:2 worth 19:13 28:23 42:5 100:14 109:13 112:5 128:23 wouldn't 25:21 70:11 96:21 100:24 139:4 140:2 156:5 215:25 230:5 write 72:22 writing 52:14	150:19 165:6 178:13 written 78:15 113:15 118:19 146:1 wrong 16:2,12 20:22 34:24 35:12 37:2 40:10 44:19 49:17 62:3 84:22 93:4,13,18 112:23 122:7 139:4 141:19 149:1 158:20 208:10 215:11 217:10,12 226:3 227:1 wrong-level 136:22 218:11 220:1 223:22 wrong-site 43:8,21 113:24 134:5 215:14,21 218:12 220:20 221:14 223:15,19 225:8 225:13 X X-ray 225:23 Y yeah 120:5,5,16 122:22 year 10:25 13:16 15:7 17:17 31:2 38:1 47:5 75:4,7 75:9,13,13 77:7 102:23 112:11 121:16,17 137:6 142:4 163:8,18 164:5 199:25 200:3 218:10 years 17:15 19:10 20:19 25:7,11 36:7 46:6 49:9 49:19 50:4,4,18 51:22 52:18 55:3 56:13 69:3,7 70:22 71:8,17,20 73:12 76:7 77:2 77:14 79:12 90:1
---	---	--	---	---

102:22 103:2,25 130:24,25 188:12 189:8 199:4,8,9 199:11,12,22,23 204:23 222:18 223:6 yes' 160:4	73:24 1986 67:11 73:23 74:16 1989 76:11 1990 70:21 74:16 74:21 75:11,23 1994 65:22 66:4 1995 18:25 19:7,24 21:1 46:11 63:3 1996 65:16 76:16 1997 17:3 65:11,17 66:1,9 1998 189:2 1999 53:14	200:19 201:5 204:17 220:4,4 225:23 226:4,6 2014 38:18 63:24 64:14 124:1 133:14 134:9,21 137:11 148:6 150:6 160:12 162:3,12 222:4,6 226:7,8 2015 6:17 46:7 108:12 134:11,12 134:16 135:1,4 136:12,21 137:10 145:7 147:1 148:1 150:24 151:16 161:4 2016 5:1 60:16 2017 56:23,24 58:13 60:16 199:24 2019 199:12 2020 6:23 2021 199:12,19 2022 51:19 225:3 2023 118:16 194:20 196:10 225:6 2024 10:5 2026 1:1 3:3,14 231:11 21 199:3 21.2 73:17 22 73:23 22(1) 74:5 22.10 134:24 22.11 134:25 22.8.5 144:18 23 196:3 23(5) 74:13 24 210:24 222:3 26 2:22 27 134:21 28 160:12 29 124:1 133:14 29A 51:13,17 29th 225:23 2nd 226:8	3 16:23 102:22 126:15 205:23 3.1 9:2 210:1 3.14 159:14 3.2 9:25 3.27 159:16 3.40 170:8 3.53 170:10 30 103:25 31 51:17 35C(2) 82:3 363 50:5 3rd 226:7	7.51 87:23 7.53 94:14 7.54 97:2 7.55 97:1 7.56 102:7 7.58 104:24
Z Zoom 200:11	21:1 46:11 63:3 1996 65:16 76:16 1997 17:3 65:11,17 66:1,9 1998 189:2 1999 53:14	2015 6:17 46:7 108:12 134:11,12 134:16 135:1,4 136:12,21 137:10 145:7 147:1 148:1 150:24 151:16 161:4 2016 5:1 60:16 2017 56:23,24 58:13 60:16 199:24 2019 199:12 2020 6:23 2021 199:12,19 2022 51:19 225:3 2023 118:16 194:20 196:10 225:6 2024 10:5 2026 1:1 3:3,14 231:11 21 199:3 21.2 73:17 22 73:23 22(1) 74:5 22.10 134:24 22.11 134:25 22.8.5 144:18 23 196:3 23(5) 74:13 24 210:24 222:3 26 2:22 27 134:21 28 160:12 29 124:1 133:14 29A 51:13,17 29th 225:23 2nd 226:8	4 4 135:4 163:2 203:17 4.1 210:16 4.2 29:8	8 8 2:14 3:24 136:21 163:5 186:17 187:12 195:14 196:5 197:18 199:3 226:24
0	2 2 3:3 136:12 162:13 2.05 110:20 2.12 181:10 2.20 226:23 20 3:14 74:16,21 75:23 214:2 2000 51:17 189:9 2002 51:20 200:23 2005 108:11 2007 66:24 67:3 222:3 2009 73:25 2010 12:21 199:23 2011 38:7 43:7,12 94:15 95:4 96:13 191:24 195:23 197:22 198:19 199:6,11 217:19 217:24 221:16 2012 26:4 33:10 36:4,20 37:24 38:8 43:15 45:12 48:16 49:2 115:22 191:25 192:1,21 217:22 217:25 221:20 2012/2013 191:25 2013 6:12 38:9,14 41:18 42:7,20 43:16 46:7,14 120:4 121:16 136:22 155:19 173:13 192:1	2015 6:17 46:7 108:12 134:11,12 134:16 135:1,4 136:12,21 137:10 145:7 147:1 148:1 150:24 151:16 161:4 2016 5:1 60:16 2017 56:23,24 58:13 60:16 199:24 2019 199:12 2020 6:23 2021 199:12,19 2022 51:19 225:3 2023 118:16 194:20 196:10 225:6 2024 10:5 2026 1:1 3:3,14 231:11 21 199:3 21.2 73:17 22 73:23 22(1) 74:5 22.10 134:24 22.11 134:25 22.8.5 144:18 23 196:3 23(5) 74:13 24 210:24 222:3 26 2:22 27 134:21 28 160:12 29 124:1 133:14 29A 51:13,17 29th 225:23 2nd 226:8	5 5 163:5 176:17 183:6 217:22 221:7 5.03 228:13 5.1 213:23 5.15 228:15 5.18 231:9 5.2 215:8 56 2:23 57 148:23 159:24	9 9 135:1 213:16 96 66:7
1 1 5:1 67:11 73:23 74:16 127:11 211:4 232:1,2,2,3 1.44 104:13 1.55 110:18 10 38:14 120:4 122:18,19,22 133:13 213:5,13 222:4,6 231:6,8 10.00 231:10 10.09 1:2 100% 50:24 11 61:12 221:17 226:9 11.1 48:17 11.12 47:22 11.29 47:24 12 46:23 63:24 76:8,16,20 77:16 164:12 12.44 104:11 120.1 216:19 12th 226:4,6 13.2 123:22,23 13.3 124:8 14 226:8 15 47:16,21 16 126:12 160 31:14 17 1:1 51:19 170 232:3,4 18 98:11 126:19 134:22 217:19 220:15 231:11 1858 10:7 1983 10:4 51:8,19	2 2 3:3 136:12 162:13 2.05 110:20 2.12 181:10 2.20 226:23 20 3:14 74:16,21 75:23 214:2 2000 51:17 189:9 2002 51:20 200:23 2005 108:11 2007 66:24 67:3 222:3 2009 73:25 2010 12:21 199:23 2011 38:7 43:7,12 94:15 95:4 96:13 191:24 195:23 197:22 198:19 199:6,11 217:19 217:24 221:16 2012 26:4 33:10 36:4,20 37:24 38:8 43:15 45:12 48:16 49:2 115:22 191:25 192:1,21 217:22 217:25 221:20 2012/2013 191:25 2013 6:12 38:9,14 41:18 42:7,20 43:16 46:7,14 120:4 121:16 136:22 155:19 173:13 192:1	2015 6:17 46:7 108:12 134:11,12 134:16 135:1,4 136:12,21 137:10 145:7 147:1 148:1 150:24 151:16 161:4 2016 5:1 60:16 2017 56:23,24 58:13 60:16 199:24 2019 199:12 2020 6:23 2021 199:12,19 2022 51:19 225:3 2023 118:16 194:20 196:10 225:6 2024 10:5 2026 1:1 3:3,14 231:11 21 199:3 21.2 73:17 22 73:23 22(1) 74:5 22.10 134:24 22.11 134:25 22.8.5 144:18 23 196:3 23(5) 74:13 24 210:24 222:3 26 2:22 27 134:21 28 160:12 29 124:1 133:14 29A 51:13,17 29th 225:23 2nd 226:8	6 6 121:11 127:12 164:10 6.13 63:17 6.2 48:7 6s 176:14	
		3	7 7 166:16 176:11 213:24 226:6 7.11 54:8,12 7.22 67:12 7.23 71:4 7.24 65:9 7.31 63:1,4 7.42 81:14 7.47 82:8 7.50 84:25	