

Witness Name: Charles
Hamilton Massey
Statement GMC-00218
Dated: 15 May 2026

ELJAMEL INQUIRY WITNESS STATEMENT OF CHARLES HAMILTON MASSEY

I, Charles Hamilton Massey, of the General Medical Council ('GMC'), 3 Hardman Street, Manchester, M3 3AW, will say as follows: -

Part A – Your qualifications, roles and responsibilities

1. Please set out your qualifications. If there is more than one contributor to the statement, please set out the qualifications of each, with a description of which part(s) of the statement each one contributed and why.

1.1 My name is Charles Hamilton Massey. I have a Master of Arts degree in History and a Master of Philosophy in Social Anthropology and International Development conferred by the University of Cambridge.

2. Please explain your professional/ occupational background, in particular focussing on roles and the responsibilities which you held/ hold relevant to or potentially relevant to the neurosurgical department of Ninewells Hospital or Mr Eljamel. If you wish, you may exhibit a CV/ CVs with your statement.

2.1 I am the Chief Executive and Registrar of the General Medical Council ('the GMC'), and I have held this role since 1 November 2016. Prior to this, I worked in a variety of roles across government and the wider public sector. None of these roles were relevant to the neurological department of Ninewells Hospital nor Mr Eljamel, however, immediately prior to starting at the GMC I was one of the Director Generals in the Department of Health (England) with responsibility for workforce, acute care and system and professional regulation.

2.2 I provide this statement in response to a request under Rule 8 of the Inquiry (Scotland) Rules 2007 dated 7 November 2025 ('the Rule 8 request') and also the notice under sections 21(2)(a) and 21 (2)(b) of the Inquiries Act 2005 dated 29 January 2026 ('the

Section 21 notice') . I adopt the contents of this statement on behalf of the GMC and am able to address the matters contained within it. If any further technical, operational or historical detail is required following oral evidence, the GMC will provide supplementary information to the Inquiry in writing where appropriate.

2.3 This is my first witness statement for the Eljamel Inquiry ('the Inquiry'). I understand that the Inquiry relates to the professional practice of Mr Eljamel, a consultant neurosurgeon at NHS Tayside's Ninewells Hospital in Dundee between 1995 and 2015.

2.4 We welcome the opportunity to contribute information to the Inquiry's investigation into the professional practice of Mr Eljamel, including systemic issues at NHS Tayside which have led to adverse outcomes for many of Mr Eljamel's patients. I would like to extend my deepest sympathies to Mr Eljamel's many former patients and their families, whose lives have been seriously and adversely affected.

2.5 We note the Inquiry's interest is in the period between 1995, when Mr Eljamel commenced employment with NHS Tayside, and 2015, when he successfully sought voluntary erasure from the register of medical practitioners maintained by the GMC ('the relevant period'). Since the GMC did not start regulating physician associates (**PAs**) and anaesthesia associates (**AAs**) until December 2024, the focus of our statement and supporting evidence (except where otherwise stated) relates to our regulation of doctors.

2.6 We note the Inquiry's interest in the wider contextual and systemic issues at NHS Tayside and how these may have contributed to Mr Eljamel's ability to practise without scrutiny. The GMC are keen to support the Inquiry's work as far as possible and have borne this in mind in both answers to its Rule 8 request and Section 21 notice, and in preparing our documentary disclosure.

2.7 This statement covers information about our current processes, a number of which have evolved and changed since the relevant period, including the period of time when concerns were raised with the GMC about Mr Eljamel. I reference the procedures in place at the time and relevant historical guidance where helpful.

Part B – Structures and key individuals

3. Please provide an overview as to the role, function and responsibilities of the GMC over the relevant period, in particular with regard to functions of relevance to the

provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under the control of NHS Tayside providing neurosurgical services.

3.1 The GMC is the independent regulator of doctors, physician associates (**PAs**) and anaesthesia associates (**AAs**) in the UK. We work with registrants, their employers, their educators, and others to:

- a) set the standards of patient care and professional behaviours registrants need to meet;
- b) make sure registrants get the education and training they need to deliver good, safe patient care;
- c) check who is eligible to work as a doctor, PA or AA in the UK, maintain a register recording this and details relating to their registration (such as whether they hold specialist registration), and check they continue to meet the professional standards we set throughout their careers;
- d) give guidance and advice to help registrants understand what is expected of them; and
- e) investigate where there are concerns that patient safety, or the public's confidence in doctors, may be at risk, and take action if needed.

3.2 The GMC is independent of government and the professions it regulates, and accountable to the UK and Scottish Parliaments. Our powers are given to us through the Medical Act 1983 (**'the Act'**) and the Anaesthesia Associates and Physician Associates Order 2024 (**"AAPAO"**).

3.3 Our role and functions are well-established, having been the regulator of doctors in the UK since 1858. We have expanded on our education, registration and revalidation, professional standards and fitness to practise functions in paragraphs 7.4 – 7.40 below to assist with the Inquiry's understanding of how each of our regulatory functions operate.

4. Please provide an explanation of the areas related to the care of Mr Eljamel's neurosurgical patients in which the GMC (a) had exclusive responsibility; and (b) had shared competence with other government departments, agencies, public or private bodies over the relevant period for systems relating to the provision of neurosurgical care at Ninewells Hospital, Dundee and in other hospitals under the control of NHS Tayside providing neurosurgical services. As regards (b) please set out how the GMC's responsibilities overlapped or interacted with the responsibilities of those other bodies in that regard.

4.1 Our primary concern is patient safety, and we primarily uphold this through overseeing the registration and regulation of individual doctors. We have regulatory oversight of healthcare systems through the education lens, where we are responsible for overseeing training environments and employing enhanced monitoring where necessary.

4.2 However the GMC's functions do inevitably interact with those of other system and regulatory bodies, so it is important that we understand the context of a doctor's practice, for example when considering fitness to practise concerns. To support the early identification and management of risks to patients, we work collaboratively with system partners, sharing information where appropriate, aligning approaches to standards and concerns, and contributing to a coordinated system-wide view of patient safety, while remaining clear that responsibility for organisational governance and service oversight rests with local providers. We have set out in further detail how we work with system partners in question six.

4.3 One of the main ways in which we liaise with NHS boards is through our Employer Liaison Advisors (**ELAs**), who are a key interface for sharing information, supporting Responsible Officers (**ROs**), and helping identify and manage fitness to practise concerns at an early stage, such as advising on local management options. An RO is a member of staff accountable for local clinical governance processes at an NHS trust or board, and who is responsible for overseeing revalidation of doctors with a prescribed connection to the designated body, which is normally a healthcare organisation and a doctor's main employer, such as an NHS trust or GP practice. We have set out further information about the role of an Employer Liaison Advisor, and how this role operated during the relevant period, in question eight.

5. Please provide a high-level overview of the structure of the GMC and a list of key individuals and their roles within the GMC over the relevant period, insofar as relevant to the neurosurgical service provided by it and the matters covered by the Inquiry's Terms of Reference and List of Issues by way of organogram, if necessary.

5.1 The GMC is an independent statutory body governed by a Council responsible for setting its strategic direction and overseeing its regulatory activities. I oversee the GMC's operational activities as Chief Executive and Registrar, supported by an executive team.

5.2 The organisation has changed significantly over time, both in terms of size and structure.

Our historical records are limited but I have set out three organisational structure documents at GMC-00001 which outlines key individuals at Chief Executive, Director and Assistant Director level for 2013, 2014 and 2015 (covering the period during which we received the majority of the fitness to practise complaints made against Mr Eljamel). Comparable data does not exist for the earlier part of the relevant period.

6 Please explain how the role of the GMC over the relevant period fitted with the role/ remit of the following key organisations which did or could have had a role in the oversight of aspects of the professional practice of Mr Eljamel:

- (a) NHS Tayside or its predecessor organisations;**
- (b) The Scottish Executive/ Scottish Government;**
- (c) Insofar as relevant to the provision of healthcare over the relevant period, the UK Government;**
- (d) Healthcare Improvement Scotland and its predecessor organisations;**
- (e) NHS Education for Scotland and its predecessor organisations;**
- (f) The Department for Medical Education;**
- (g) The University of Dundee;**
- (h) The Royal College of Surgeons;**
- (i) The Royal College of Surgeons (Edinburgh);**
- (j) Other Royal Colleges which may have had a role or a possible role in relation to the practice of neurosurgery within NHS Tayside over the relevant period;**
- (k) The British Medical Association;**
- (l) The Health and Safety Executive; and**
- (m) Any other bodies which held a remit relevant to matters falling within the Inquiry's Terms of Reference.**

6.1 The GMC regulates registrants as one part of a much wider healthcare and regulatory system. This includes, but is not limited to, other professional regulators (such as the Nursing and Midwifery Council (**NMC**)); systems regulators and improvement bodies, like Healthcare Improvement Scotland; health boards; statutory education bodies like NHS Education for Scotland and the Scottish Deanery and individual regulated professionals. The GMC also works constructively with Scottish Government to offer regulatory expertise that informs policy development and provide insights into workforce and patient safety issues. For regulation to work properly each organisation must be robust and collaborative in the way that it shares information.

6.2 Over time, the GMC's approach to regulatory collaboration and engagement within the wider health landscape has evolved to reflect both changes in healthcare delivery and patient safety. Historically, the GMC's work focused primarily on the regulation of individual doctors, with limited formal interaction with healthcare organisations or other system regulators. The introduction of revalidation in 2012, which I have commented on further at paragraph 11.1, signalled a shift from a more reactive approach to regulation to establishing a two-way flow of information between us and employers.

6.3 In recent years, we have increasingly sought to work in partnership with NHS boards, professional healthcare regulators, and other relevant bodies, recognising that effective oversight of individual practice happens locally. This development has included the establishment of a team of regional and national Employer Liaison Advisors (**ELA**)s, as discussed in paragraphs 8.2 to 8.4, the development of joint protocols for sharing fitness to practise information, training and organisational oversight data with other regulators, and participation in multi-agency forums to support early identification of concerns and the promotion of consistent professional standards across the health system.

6.4 We now have over 160 data sharing agreements, around 35 memoranda of understanding, and 25 joint working operational protocols in place with organisations across the UK, including Healthcare Improvement Scotland and the Health and Safety Executive. We established the memorandum of understanding with Healthcare Improvement Scotland in February 2015 [GMC-00002], which was reviewed and updated in 2021 [GMC-00003] and again in September 2025 [GMC-00004]. Our memorandum of understanding with the Health and Safety Executive started in 2012 [GMC-00005] and was renewed in January 2022 [GMC-00006]. Other organisations with whom we have agreements in place include system regulators, public protection bodies and NHS agencies, to share knowledge and escalate emerging concerns to reduce patient safety incidents

6.5 University of Dundee

6.6 In relation to the University of Dundee, the GMC approved the University to award a primary medical qualification (PMQ) in accordance with the process and our remit set out at paragraph 13 below. Students who were taking a course leading to a PMQ from the University will have undertaken training and education across a range of settings, including hospitals within NHS Tayside. As part of that approval, the University was required to

provide evidence to show that its training met the GMC's standards and was of the required quality and safety.

6.7 After a university has been approved as able to award a PMQ, it must maintain our approval on an annual basis. The GMC undertakes quality assurance for this purpose. Prior to 2016, this quality assurance was carried out through an annual submission process for all medical schools, known as the Medical School Annual Return (MSAR), although the GMC does not have knowledge of the exact date that this process began. These submissions included updates on concerns identified by the medical school. The GMC reviewed those submissions and provided feedback to the school where appropriate.

6.8 In addition to the MSAR, in 2012, the GMC introduced a regional model of quality assurance visits. Through this process, the GMC visited each region of the UK in turn and met with students, trainees, educators and senior staff at medical schools, local education providers (LEPs) and deaneries. However, the Scotland review did not take place until 2017, which falls outside the timeframe specified by the Inquiry.

6.9 Prior to 2012, there was a visit process through the Quality Assurance of Basic Medical Education process. However, the GMC's knowledge of the detail of that process is limited due to the length of time that has passed.

6.10 *NHS Tayside*

6.11 The GMC only became responsible for postgraduate medical education and training in 2010. From that date, the GMC was responsible for quality assuring NHS Education for Scotland (NES), which was responsible for the quality management of all health boards across Scotland, including NHS Tayside.

6.12 During the relevant timeframe, although the GMC is unclear how far this process dated back, NES reported concerns it was managing at health boards through an annual Dean's report. The GMC reviewed those reports and provided feedback to NES where appropriate.

6.13 In 2014, the GMC undertook visits to 12 Local Education Providers (LEPs) across the UK, comprising six obstetrics and gynaecology sites and six surgical sites, to examine issues relating to bullying and undermining. One of the surgical sites visited was Ninewells Hospital within NHS Tayside. Following those visits, feedback was provided and a report was produced.

6.14 From 2014 onwards, for any enhanced monitoring cases within Scotland, the GMC supported NES with the process for addressing concerns identified at health boards. More detail on this process is provided in paragraph 7.17.

6.15 Postgraduate organisations were also involved in the GMC's regional review process, which began in 2012. However, Scotland was not visited as part of that process until 2017, which falls outside the timeframe specified by the Inquiry

6.16 *UK Government and the BMA*

6.17 The GMC also maintained high-level stakeholder relationships with the UK Government and representative bodies such as the British Medical Association ("BMA") during the relevant period. These relationships focused on matters such as professional standards, medical workforce issues, patient safety, education and training, and wider healthcare policy and regulatory reform rather than involving discussions about individual cases or organisations. The BMA did not have a regulatory role in relation to doctors' fitness to practise or registration but acted as a professional association and trade union representing doctors' interests.

6.18 *Royal Colleges*

6.19 Since 2010 the GMC has been responsible for approving postgraduate specialty curricula, designed by royal colleges, and for adding doctors to the specialist and GP registers, based on recommendations by royal colleges. Further explanation can be found in paragraphs 7.12 - 7.14. These recommendations are governed by contract [GMC-00192 and GMC-00193] and formerly by a previous contract between 2013 – 2018 [GMC-00194]. We do not hold any contract information before 2013.

7 Please explain the main principles of policies and practices governing the role of the GMC, including how and when these evolved over the relevant period, insofar as they were relevant or potentially relevant to the practice of Mr Eljamel, relating to:

a) Appointments of consultants over the relevant period, including but not limited to the process by which consultants' professional qualifications and competence are verified (ToR 1);

- b) Broad systems of clinical governance, in place over the relevant period and how they evolved, including corporate governance, professional governance and whistleblowing (ToR 3);**
- c) Broad systems and rules about work patterns within the NHS, balancing work between the NHS and the private sector (ToR 2/ 3) and about supervision/ training of junior colleagues (ToR 2); (**
- d) Complaints and feedback systems within the NHS (ToRs 4 and 5);**
- e) Internal and external information sharing systems, candour, including with professional bodies and the GMC (ToRs 7 and 13);**
- f) Rules and practices relating to clinical supervision, suspension, dismissal and removal of the name of a neurosurgeon from the GMC medical register (ToRs 8 to 11);**
- g) Investigations undertaken into the professional practice of consultants in the NHS in Scotland over the relevant period, such as those covered by ToR 12;**
- h) The creation and maintenance of effective document management systems within health boards such as NHS Tayside over the relevant period and subsequently (ToR 14); or**
- i) Any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues.**

7.1 We note the Inquiry's interest in a range of different areas; however, not all of these are relevant to our work. We have commented below on the areas that are relevant. We are unable to comment on all other areas.

7.2 In reference to question 7(a), whilst the GMC is not involved in the appointment of consultants, we do assess whether an applicant has the knowledge, skills and experience required for specialist registration in the UK. Depending on the route to specialist registration ("SR"), this may involve clinical evaluation of all evidence submitted in support of the application, including qualifications. We have included a history of the specialist and GP registers, which outlines the routes to registration [GMC-00195].

7.3 In reference to question 7(b), the GMC does not hold responsibility for clinical governance systems. However, we do set the professional standards expected of individual doctors.

7.4 In reference to question 7(c), since 2010 the GMC has set and quality assured standards for the supervision and training of doctors in training. These standards include both educational and clinical supervision.

7.5 In reference to question 7(d), the GMC does not hold responsibility for complaints and feedback systems within the NHS.

7.6 In reference to question 7(e), since the introduction of revalidation in 2012, Responsible Officers (“ROs”) have been responsible for making recommendations to the GMC about whether a doctor is fit to practise.

7.7 In reference to question 7(f), we have not commented on clinical supervision, as this was not a condition placed on the doctor’s registration and exists within healthcare settings independently of regulatory action. We have also not commented on dismissal, as this is not a regulatory action undertaken by the GMC.

7.8 In reference to question 7(g), we have set out our investigations process in paragraphs 20.3 to 20.6

7.9 .In reference to question 7(h), the GMC does not hold responsibility for the creation and maintenance of effective document management systems within health boards such as NHS Tayside.

7.10 We also note that question 7 focuses on the policies and practices in relation to the Inquiry’s areas of interest in place over the relevant period. However, to assist with the Inquiry’s understanding of how those policies and practices work, we have set out across the majority of the rest of the statement an overview of our different relevant regulatory functions as they currently operate, alongside relevant policy documents and guidance that demonstrate this.

7.11 The legal framework governing regulation of doctors is currently being reformed, as part of a commitment to modernise the outdated legislation underpinning the GMC’s regulation through a process of introducing amendments to the Act in the form of a new GMC Order, which will be consulted upon by the Department of Health and Social Care and require approval by the UK and Scottish Parliaments. The reforms, which started with the introduction of PA and AA regulation in December 2024, will pave the way for a more flexible, responsible regulatory framework over the coming years. This will, however, also mean substantive changes across the regulatory functions as we have described them here.

Our education function

7.12 The way in which we have regulated undergraduate education has developed over the years. Some of the key documents setting out our historic approach are:

1975: The Merrison Committee [GMC-00196] made a number of recommendations about medical regulation and laid out the need for a coordinated approach across undergraduate, postgraduate and professional development.

1980: The report on *Recommendations on Basic Medical Education* [GMC-00197] was published by the GMC Education Committee

1992: *Recommendations on General Clinical Training* [GMC-00198] was published by the GMC.

1993: The 1980 *Recommendations on Basic Medical Education* was revised by the GMC's Education Committee. They produced a framework for basic education, *Tomorrow's Doctors* [GMC-00199], which was more detailed than any previous set of standards and introduced a “core curriculum” which defined the requirements that must be satisfied before a newly qualified doctor could assume the responsibilities of a PRHO (Pre-Registration House Officer) (equivalent to an FY1 trainee doctor today). Whilst this provided a “core curriculum”, it was still for medical schools to design the remaining content. It marked a change in emphasis from previous guidance — from gaining knowledge, to a learning process that includes the ability to evaluate data and develop skills to interact with patients and colleagues

2003: *Tomorrow's Doctors* [GMC-00111] was updated. The recommendations, replacing the 1993 version, put the principles set out in *Good medical practice* at the centre of undergraduate education. It also clarified what students would study and be assessed on during undergraduate education, required all medical schools to set appropriate standards, and introduced rigorous assessments leading to the award of a primary medical qualification.

Good medical practice [GMC-00013] is the GMC's core guidance describing what it means to be a good doctor (and, since 2024, physician associates and anaesthesia associates). The guidance describes the professional values and behaviours expected of any doctor registered with the GMC. Doctors are expected to use their professional judgement and expertise to apply the principles in the guidance to the various situations they face in their careers. It was first published in 1995.

2007: *Outcomes for provisionally registered doctors* [GMC-00200] set out the knowledge, skills and behaviours that FY1 doctors must be able to demonstrate before being eligible to apply for full registration, and this guidance remains in place today.

The standards for training in the Foundation Programme were published jointly by the GMC and the Postgraduate Medical Education and Training Board (PMETB) as *The New Doctor* (published online only in 2007 and in printed form in 2009 — see Exhibit GMC-00115). This document introduced outcomes for provisionally registered doctors and standards for training in the Foundation Programme, covering both F1 and F2 training.

2009: *Tomorrow's Doctors* [GMC-00112] was updated, specifically regarding scientific education, clinical skills, partnerships with patients and colleagues, and commitment to improving healthcare and providing leadership. It set out standards for the delivery of medical education with a new emphasis on equality and diversity, involving employers and patients, the professional development of teaching staff, and ensuring that students derive maximum benefit from their clinical placements.

2011: *The Trainee Doctor* [GMC-00116] was published and replaced the 2007 *The New Doctor*. This document integrated the generic standards for postgraduate medical education (including specialty and GP training) with the standards for training in the Foundation Programme. This followed the merger of PMETB with the GMC in 2010.

2015: *Promoting excellence: standards for medical education and training* [GMC00008] was published in July 2015 and set out 10 standards expected of medical training organisations covering all stages of medical training (undergraduate, foundation and specialty training). This replaced the 2009 *Tomorrow's Doctors* and the postgraduate training standards contained in the 2011 *The Trainee Doctor*.

These standards work in conjunction with *Excellence by design* [GMC-00009], which sets the standards and requirements for developing postgraduate curricula (noting that this was published in May 2017).

2017: The *Generic professional capabilities framework* [GMC-00010] was published, setting out the essential generic capabilities needed for safe, effective and high-quality medical care in the UK. Although this framework relates to postgraduate medical education and training, the approach is also reflected in *Outcomes for graduates*, published in 2018.

2018: *Outcomes for graduates* [GMC-00007] set out the knowledge, skills and behaviours that new UK medical graduates must be able to demonstrate.

Approval of undergraduate and postgraduate education

7.13 Part of the GMC's role is to ensure that registrants receive the education and training they need to deliver good, safe patient care across the UK. We set the standards that medical schools are expected to meet in delivering education and the outcomes that we expect students at UK medical schools to achieve in readiness for joining our register.

7.14 Our legislative remit covers both undergraduate and postgraduate medical education. We set the outcomes that all medical students must be able to meet by successful completion of their undergraduate medical education through our high-level 'Outcomes for graduates' [GMC-00007] and the Medical Licensing Assessment. The Medical Licensing Assessment is an assessment framework applicable from the academic year 2024-25 onwards, designed to test the core knowledge, skills and behaviours expected of doctors new to medical practice in the UK. We also maintain, and publish, a list of approved universities with medical schools that can award a UK primary medical qualification (**PMQ**), which we would recognise as allowing a graduate to gain registration. We only approve medical schools following a period of extensive quality assurance in line with the standards set out in 'Promoting Excellence: standards for medical education and training' [GMC-00008].

7.15 In respect of postgraduate medical education, since 2010 we have approved curricula developed by royal colleges and faculties, and we maintain a list of approved postgraduate programmes and sites. These curricula must meet the requirements we set out in 'Excellence by design: standards for postgraduate curricula' [GMC-00009] and align with our 'Generic professional capabilities framework of shared generic and specialty specific outcomes' (The GPC Framework) [GMC-00010].

Quality assurance and monitoring

7.16 The GMC only became responsible for postgraduate medical education and training in 2010. From that date, the GMC was responsible for quality assuring NHS Education for Scotland (NES), which was responsible for the quality management of all health boards across Scotland, including NHS Tayside.

7.17 We undertake quality assurance activities to check our standards are met, and that appropriate action is taken where they are not so that our standards of quality and safety

are met. Medical schools and postgraduate training organisations are subject to the same quality assurance process to ensure our standards are met. Postgraduate quality assurance covers postgraduate deaneries and their local offices, and local education providers (such as NHS boards) to ensure doctors in training are supported to meet relevant postgraduate curricula and training requirements. Our quality activities are risk based, which means we look at the evidence we gather, including data from our annual National Training Survey (**NTS**), and annual self-assessment questionnaires medical schools and Postgraduate Training Organisations (**PTOs**) are required to submit, and decide which areas are likely to be of concern. We provide feedback to organisations on areas of good practice and can take action if they are not meeting our standards, for example through our enhanced monitoring process. A PTO is a body responsible for designing, managing and assuring postgraduate medical training programmes. Its functions include allocating trainees to programmes, supporting training environments, monitoring education quality, and coordinating improvement plans. They operate at a national or regional education level rather than delivering training directly.

- 7.18 When a low level or emerging concern becomes one that we need to closely monitor, we discuss it with the relevant PTO and, depending on the risk rating, may request that they add this to our quality reporting system for us to monitor. When we monitor a concern via our quality reporting system, we ask the PTO to give us timely updates on the progress of the concern. We then assess this update and either accept it and ask for a further update later, or request a further discussion about escalating the concern. In Scotland, the PTO is NHS Education for Scotland.
- 7.19 When a concern poses a serious risk to patient or training safety, it is classed as high level and escalated to enhanced monitoring. Under this process, the NHS board must produce an improvement plan, which the PTO monitors through regular updates, with our oversight to ensure all requirements are met. We may join local visits to investigate issues or review progress, and we publish details of enhanced monitoring cases and share them with other healthcare regulators. Where medical students are placed in the department, we also inform their medical schools of the enhanced monitoring status.
- 7.20 We work with all organisations concerned, the health board and postgraduate training organisations to address the concern and develop a sustainable solution. Sometimes we need to work with other regulators responsible for service improvement and transformation in the health sector. We regularly review the risk level for each enhanced monitoring case which is informed by the data, intelligence and insights we have internally and information

from the deaneries and local education and training boards. We monitor the risk level and adjust our response accordingly.

Our Registration function

7.21 The registration framework described below largely came into effect from October 2007. Prior to this, the principal forms of registration were full registration and limited registration, rather than provisional and full registration as currently applies. Limited registration was introduced in 1979 under sections 22 to 24 of the Medical Act 1983 and enabled overseas qualified doctors whose primary medical qualifications were accepted by the GMC to work in approved training or equivalent posts within the UK, subject to conditions.

7.22 In order to grant limited registration, the GMC had to be satisfied that the doctor held an acceptable primary medical qualification, had acquired the necessary post-qualification experience, possessed the required knowledge and skill, had sufficient knowledge of English, was of good character, and had been selected for suitable employment. During the relevant period, applicants for limited registration were assessed through documentary evidence, declarations and, where required, the Professional and Linguistic Assessments Board (“PLAB”) test. Limited registration could only be granted for employment approved by the GMC and where appropriate supervision arrangements were in place. In practice, this generally related to recognised NHS training grade posts or equivalent employment. The GMC relied primarily on approvals and inspections undertaken by other competent bodies, including the Royal Colleges, rather than directly inspecting posts itself.

7.23 Limited registration was ordinarily granted for a maximum aggregate period of five years, subject to certain transitional exceptions preserved under earlier legislation. Doctors granted limited registration received a certificate recording the scope and duration of their registration and the employment for which it had been granted.

7.24 Specialist registration was introduced in 1997. Prior to this, doctors’ specialist qualifications could be recognised on the medical register, but there was no separate specialist register. In Mr Eljamel’s case, his specialist qualification was recognised by the GMC in 1996 and he was subsequently transferred onto the specialist register when it was established in 1997.

7.25 We maintain the register of medical practitioners who are eligible to practise in the UK.

To practise medicine in the UK a doctor must be both registered with the GMC and hold a licence to practise granted by us. Our medical register sets out who is qualified to work as a doctor in the UK, their registration status (for example, whether they hold a current licence to practise and any restrictions on their practice, such as fitness to practise action), their designated body and Responsible Officer (**RO**) as well as whether they are on the GP or specialist register and in what specialty. It also displays their registration history. An online version of the register is available in a simple, easy read and accessible format.

7.26 Registration with a licence to practise is the legal status that allows doctors to exercise the rights and privileges associated with practising as a doctor in the UK. Doctors wishing to practise in the UK are required to make an application for registration with a licence to practise, and as part of this they must satisfy us that they meet several key criteria:

- a) Hold an acceptable primary medical qualification (**PMQ**) that meets our criteria;
- b) Possess the knowledge, skills and experience for practice in the UK;
- c) Fitness to practise is not impaired;
- d) Have indemnity and insurance in place before they begin practising; and
- e) Have the necessary knowledge of English to practise safely in the UK.

7.27 The licence to practise was introduced in November 2009. It is not possible to practise medicine in the UK without a licence, but it is possible to hold registration without a licence. Doctors who hold registration only remain in good standing with us but are not allowed to exercise any of the legal privileges of a fully registered medical practitioner, such as prescribing, signing death certificates or working as a doctor in the NHS.

7.28 There are four main types of registration:

- a) Provisional Registration (**PR**) is a time-limited form of registration for doctors who hold a primary medical qualification (**PMQ**) but cannot demonstrate the experience standard for full registration. This is most commonly because they have not yet completed Foundation Year 1 (**FY1**), which is the first year of postgraduate training following graduation from medical school. Doctors with PR are only able to work in approved FY1 training posts;

- b) Full Registration (**FR**) is for doctors who have demonstrated the standards for registration. They hold a PMQ and have successfully completed FY1 or an internship but may not have completed a postgraduate specialty or general practice training programme;
- c) Full and Specialist Registration (**FRSR**) is for doctors who have demonstrated the standards to practise as a consultant in the UK usually through successful completion of a postgraduate specialist training programme. The standard for obtaining FRSR is set out in the Postgraduate Medical Education and Training Order of Council 2010 [GMC00201].
- d) Full and General Practitioner Registration (**FRGP**) is for doctors who have demonstrated the standards to practise as a GP in the UK usually through successful completion of a postgraduate GP training programme. The PMET Order also sets out the standards for obtaining FRGP.

7.29 Doctors who apply for registration have different routes to FR defined in the Act depending on where they obtained their medical qualification. Graduates from UK medical schools usually gain PR having graduated medical school with a UK **PMQ** and FR after completing **FY1**. International medical graduates (**IMGs**) must demonstrate an acceptable qualification, English proficiency, an equivalent experience or internship and equivalent knowledge and skills (typically through the Professional and Linguistic Assessments Board test) before obtaining FR. If they are unable to demonstrate an equivalent experience/internship standard, then they may be granted **PR** which will restrict them to FY1 posts only.

7.30 For **FRSR** or **FRGP**, there are different routes depending on the doctor's country of specialist or GP qualification. Given that Mr Eljamel practised as a consultant neurosurgeon after qualifying overseas from the University of Al Fateh in Libya in 1982, we have focused on the routes for obtaining FRSR. However, as mentioned above, it should be noted that the routes to FRSR have changed since he obtained it in 1995:

- a) As per our 'Guidance for assessing entry onto the Specialist and GP Registers' [GMC-00011], UK specialist qualified doctors obtain FRSR by completing a postgraduate specialty training programme and achieving all the higher learning outcomes set in the relevant curriculum. On successful completion of training, they are awarded a Certificate of Completion of Training (CCT), which acts as evidence that they have met the required standards to practise as a consultant;

- b) Non-UK specialist qualified doctors obtain FRSR through holding an equivalent specialist qualification or by demonstrating the required standards through the Portfolio pathway (formerly known as the Certificate of Eligibility for Specialist Registration route, or 'CESR'). For the Portfolio pathway (CESR), applicants must submit a significant bundle of evidence demonstrating that they meet the standards of education, knowledge, skills and experience to practise as a consultant in the UK including the higher-level outcomes in the relevant UK specialist curriculum, set by the relevant royal college or faculty. Once submitted, the application is subject to clinical evaluation either through the relevant royal college or faculty or by GMC associates from the relevant specialty. GMC associates are experienced clinicians we appoint to provide expert advice and support in regulatory, assessment and quality assurance processes. The royal college or faculty or GMC associates will make a recommendation, following which we will decide whether to grant FRSR.

Our Standards function

- 7.31 The professional standards framework described below developed over the relevant period (1995–2015). Prior to 1995, the GMC's guidance to doctors was primarily contained in Professional Conduct and Discipline: Fitness to Practise, commonly referred to as the "Blue Book". This guidance focused principally on describing forms of misconduct that could give rise to disciplinary proceedings. The Inquiry has been provided with a copy of the final edition of the "Blue Book" (May 1993 – October 1995) [GMC-00147].
- 7.32 The publication of the first edition of Good medical practice ("GMP") in 1995 represented a significant change in approach. Rather than focusing primarily on misconduct and disciplinary matters, GMP set out a positive statement of the principles, values and standards of good medical practice which patients are entitled to expect of their doctors. The Inquiry has been provided with a copy of the 1995 edition of GMP [GMC-00148].
- 7.33 During the relevant period, GMP was revised and updated on a number of occasions, including in 1998, 2001, 2006 and 2013. Over time, the GMC's processes for developing professional standards evolved to include greater engagement and consultation with stakeholders, including patients, professional groups and external organisations. From 1998 onwards, the GMC also developed a broader range of supplementary ethical guidance to support GMP, including guidance on consent, confidentiality and raising concerns [GMC-00148 - GMC-00153].

7.34 Throughout the relevant period, the GMC's professional standards and ethical guidance were intended to provide high-level principles and a framework for professional judgement, rather than a prescriptive or mechanistic code. Doctors were expected to apply the standards using their professional judgement, taking account of the circumstances of the patient, the clinical context and the requirements of their area of practice. There may therefore have been circumstances in which a doctor could appropriately justify departing from or not fully meeting a particular standard in the guidance.

7.35 Our professional standards cover the principles, values and standards of professional behaviour expected of all doctors, PAs and AAs registered with us. We work with a range of people, including doctors, patients, professional and patient groups representing their interests, as well as other stakeholders, to develop and agree these standards. These standards are set out in our core guidance 'Good medical practice' (**GMP**) [GMC-00013], which is supported by a range of more detailed guidance on areas such as consent, confidentiality, raising concerns about patient safety, and leadership and management. Together they form the professional standards we expect all our registrants to follow.

7.36 Our standards provide a framework for ethical decision-making in a wide range of situations and, as such, are necessarily high level. They do not constitute a rule book, and not all principles will apply in all situations. Doctors, PAs and AAs must use their professional judgement to apply the standards to their day-to-day practice, and use their knowledge, skills and experience to follow them in that context.

7.37 Our professional standards are consistent with UK law; however they do not amount to legal advice. GMP makes clear that doctors, PAs and AAs must follow the law, our guidance on professional standards, and other regulations relevant to their work. Were the law to change anywhere in the UK, we would review and update our professional standards accordingly.

7.38 Our professional standards are also distinct from clinical guidance, which is produced by a wide range of other bodies, including the royal colleges. GMP sets out that doctors, PAs and AAs must recognise and work within the limits of their competence and keep up to date with relevant guidelines and developments that affect their work.

7.39 GMP covers areas that include:

- a) making the care of patients the first concern;

- b) providing a good standard of practice and care, and working within competence;
- c) working in partnership with patients and supporting them to make informed decisions about their care;
- d) treating colleagues with respect and helping to create an environment that is compassionate, supportive and fair;
- e) acting with honesty and integrity and being open if things go wrong; and
- f) protecting and promoting the health of patients and the public.

7.40 As mentioned at paragraph 7.11, UK doctors must hold a licence to practise, along with the suitable type of registration for the work that they do (such as specialist registration as a neurosurgeon). It is not possible to practise medicine without a licence, but it is possible to hold registration without a licence. Whether a doctor holds registration only or a licence to practise too, they are required to follow our professional standards.

7.41 The professional standards set out in GMP and the more detailed guidance describe good practice. In instances of departure from our professional standards, we may take fitness to practise action. I have explored this in further detail in paragraphs 7.24 to 7.40.

Our Fitness to Practise functions

This section sets out our fitness to practice functions as they currently operate. The fitness to practice processes in place during the relevant time period are set out later in this document, 20.3 onwards.

Raising a concern

7.42 Anyone can raise a concern with the GMC. Those raising concerns might include patients or their families, employers, doctors or other healthcare professionals. Common sources of information include patient complaints, referrals from **ROs**, employers, media reporting, and notifications from the police and other bodies acting in a public capacity. We provide a range of channels and support to help anyone who raises a concern to understand how to disclose information so we can consider whether action needs to be taken.

7.43 We receive high numbers of enquiries from patients and the public that do not meet legal fitness to practise thresholds and / or are not issues the GMC can address. Often

these concerns do not raise questions about a doctor's fitness to practise and should be more appropriately dealt with locally by the doctor's employer or contracting body. Alternatively, they may raise questions that are not issues we can address but can be considered by one of the many other organisations responsible for the health, wellbeing and safety of patients in the UK – including the Scottish Public Services Ombudsman.

When and how we investigate concerns about doctors

7.44 We have a legal duty under the Act to protect the public. The Act splits public protection into three distinct parts. Section 1(1B) of the Act says that we must act in a way that:

- a) protects, promotes and maintains the health, safety and wellbeing of the public;
- b) promotes and maintains public confidence in the profession; and
- c) promotes and maintains proper professional standards and conduct for members of the profession.

7.45 When a concern is raised with us about a doctor, we are legally required to assess if that individual poses any current and ongoing risk to one or more of the three parts of public protection. This is set out in our guidance, 'Decision on whether regulatory action is required (doctors)' [GMC-00014].

7.46 To summarise, when assessing whether a doctor poses any current and ongoing risk to public protection, we will consider:

- a) The seriousness of the information received about the doctor's behaviour, performance and / or the impact of a health condition on their ability to practise safely and effectively;
- b) Any relevant context known about the doctor and / or their working environment; and
- c) How the doctor has responded to the concern, including looking at evidence of insight and remediation.

7.47 We will only investigate a concern relating to a doctor if it falls under one of the following grounds for taking regulatory action (under section 35C(2) of the Act):

- a) misconduct (examples include but are not limited to sexual assault; violence; improper sexual or emotional relationships; serious clinical concerns; knowingly practising

without a licence; unlawful discrimination; dishonesty; and gross negligence or recklessness_;

- b) deficient professional performance (this could consist of acts and / or omissions and includes failing to act appropriately or being unable to provide care to the standard expected);
- c) a criminal conviction or caution in the British Isles (or elsewhere for an offence which would be a criminal offence if committed in England or Wales);
- d) adverse physical or mental health;
- e) not having the necessary knowledge of English; or
- f) a determination (essentially, a decision) by a regulatory body either in the UK or overseas to the effect that fitness to practise as a member of the profession is impaired.

7.48 An investigation can only be opened where information received about a doctor falls under at least one of these grounds and raises a question about whether the doctor poses a current and ongoing risk to one or more of the three parts of public protection i.e. raises a question as to whether the doctor's fitness to practise is impaired. If the concern does not meet the threshold for investigation, we may consider that the complaint should be disclosed to the doctor and the doctor's **RO** to be reflected on as part of their workplace annual appraisal, called the 'Notify RO process'. This enables the doctor to reflect on the concern raised as part of their personal development.

7.49 Decision-makers will make decisions in line with 'Deciding whether to open an investigation (doctors)' to decide whether to open an investigation [GMC-00015]. Investigations are disclosed to the doctor, the doctor's RO and any other employers or contracting bodies. The nature of the concerns will determine what investigatory steps need to be undertaken. Most commonly these involve obtaining:

- a) expert report(s);
- b) witness statement(s); and
- c) any other documentary evidence that may be available (e.g. information from police files, health assessments, or local investigation reports).

7.50 At the conclusion of most investigations, draft allegations are sent to the doctor. Doctors are given 28 days to respond with any comments or supporting evidence that they would like us to be aware of, after which two case examiners will make a decision, applying the guidance 'Deciding the outcome of an investigation' [GMC-00016]. Case examiners are our fitness to practise statutory decision makers. They comprise both medical and non-

medical members in various fields and their primary role is to make a decision at the end of a fitness to practise investigation. They can also assist with the investigations process and make recommendations on the progression of a case. At the end of an investigation the two case examiners determining the outcome of the case must decide unanimously based on the evidence according to the relevant burden of proof, taking into account our statutory objective to protect the public. The case examiners must decide whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree requiring restrictive action. This is known as the realistic prospect test.

7.51 If the case examiners decide that the realistic prospect test is not met, they may decide that it is appropriate to issue the doctor with a warning. The purpose of issuing a warning is to provide a formal response to indicate that the doctor's behaviour or performance represents a significant departure from the professional standards and should not be repeated.

7.52 The case examiners may conclude that there is a realistic prospect of establishing that the doctor's fitness to practise is impaired. This means that, if established, the facts would demonstrate that the doctor poses a current and ongoing risk to public protection requiring restrictive action in response. In these instances, the case examiners will consider proposing undertakings or refer the case to a Medical Practitioners Tribunal (**MPT**) hearing. Undertakings restrict a doctor's ability to practise and/or require them to do something. The purpose of putting in place undertakings is to provide a doctor with time to address concerns and demonstrate they are fit to practise on an unrestricted basis, while ensuring that the current and ongoing risk they pose to public protection is adequately managed. Undertakings can only be agreed where the realistic prospect test is met, and the case examiners are satisfied that undertakings would protect the public and there is no possibility of erasure should the matter proceed to an MPT hearing.

7.53 Where the case examiners consider that the realistic prospect test is met and it is not appropriate to agree undertakings with the doctor, they must refer the doctor's case to the Medical Practitioners Tribunal Service (**MPTS**) to arrange for it to be considered by an MPT hearing. The MPTS was created in shadow form in June 2011 to increase separation between the GMC's adjudication and investigatory functions, and to promote greater confidence in the independence of the tribunals conducting fitness to practise hearings. It was established as a statutory committee of the GMC in 2015, to further enhance this separation. Its committee has the responsibility for producing an annual performance report to Parliament.

- 7.54 Where the case examiners refer a case to an MPT hearing, further evidence may need to be gathered prior to the hearing. This may include factual and documentary evidence, witness or expert evidence, and evidence of the doctor's past regulatory history.
- 7.55 At any stage, we may seek an interim order to restrict a doctor's practice while a GMC investigation is ongoing, for example by imposing conditions or a suspension. Interim orders are determined by Interim Order Tribunals (**IOTs**), also run by the MPTS. IOTs do not make any findings of fact. The test for imposing an interim order is whether it is necessary for the protection of the public or is otherwise desirable in the interests of the public and / or in the interests of the doctor (for example, where continuing to practise could worsen a doctor's health, such as in instances of acute psychiatric illness). Our 'Guidance for MPTS Tribunals - Section 2: IOT hearings' [GMC-00017] sets out further guidance on how IOTs make decisions.
- 7.56 The MPT will decide what action, if any, is needed to protect the public. If a doctor's fitness to practise is found to be impaired, a sanction of conditions, suspension or erasure from the register may be imposed. Where the doctor's fitness to practise is found not to be impaired, a warning may be imposed. Our guidance document 'Guidance for MPTS Tribunals - Section 3: MPT hearings' [GMC-00017] sets out further guidance on how MPTs make decisions.
- 7.57 We may become aware of information during an investigation which indicates that there may be concerns about the systems and environment in which doctors work and healthcare is delivered, suggesting a wider failing within an organisation. Serious systems concerns are likely to affect patient safety and wellbeing, and it is important that we share information appropriately so action can be considered by the relevant organisation. Our fitness to practise teams can share information which suggests there may be concerns about the systems within a healthcare provider with relevant organisations.
- 7.58 A doctor may seek removal from the medical register at any time, through a process known as voluntary erasure (**VE**). While VE is ordinarily a registration decision, if a VE application is made during an ongoing fitness to practise investigation, the decision will be made by two case examiners, unless the case has been referred to an MPT and the hearing has begun, in which case the MPT will consider the VE application. Further detail is set out in the current 'Guidance on making decisions on voluntary erasure applications and advising on administrative erasure' [GMC-00018]. We provide further information

about the voluntary erasure process that was in place during the Inquiry's timeline of interest as part of our response to Part E.

8 In particular, what was the role of the GMC's Employment Liaison Adviser or equivalent position over the relevant period? What individual or individuals held that position over the relevant period?

8.1 In 2012, we set up a team of **ELAs** to facilitate more effective working between the GMC and healthcare providers, predominately in connection with fitness to practise and revalidation (we describe revalidation in paragraphs 11.1 to 11.3) but also to enhance the effectiveness of local handling of concerns. At the time of their introduction, ELAs were introduced to support effective revalidation and appropriate referral to the GMC by acting as a bridge between the GMC and employers, helping to identify performance concerns early, advise on those concerns, and ensure consistent application of revalidation and fitness to practise processes. This aligned with our ambition beginning in the 2010s to move regulation upstream and ensure that regulatory intervention was proportionate.

8.2 The ELA role has broadened over time. They continue to work in partnership with employers to improve patient safety and ensure high standards of medical practice through providing advice on GMC thresholds and revalidation recommendations. They also provide insights into fairness when considering fitness to practise referrals and encourage system improvements by advising on robust local investigation of concerns, performance management, and clinical governance.

8.3 One of the primary roles of an ELA is to provide **ROs** with advice on whether the thresholds for referral of concerns to the GMC are met. Our ELAs work closely with ROs to support effective local handling and referral to the GMC in appropriate cases. They maintain relationships with ROs through regular meetings and respond to ad-hoc requests for support. The frequency of these meetings depends on a range of factors including, but not limited to, the level of experience of the RO, and the presence of any concerns or unusual fitness to practise or patient safety issues. ROs will discuss with their ELA emerging concerns about doctors. These discussions provide the RO with an opportunity to discuss patient safety issues, local problems and local management, and thresholds for referral to the GMC.

8.4 Willie Paxton held the role of ELA for Scotland, covering NHS Tayside, over the relevant period. He was the first Scottish ELA, starting in 2013.

9 Please set out the role and significance of the GMC's medical register generally but also with particular reference to the relevant period.

9.1 We have set out above at paragraphs 7.11 to 7.16 an overview of the role and significance of the medical register, both generally and in relation to the different types of registration that a doctor may hold with us.

9.2 Since its establishment in 1858, the purpose of the medical register has always been to distinguish qualified, legally registered doctors from unqualified practitioners, assuring patients, employers and members of the public of the qualifications and expertise of medical practitioners they may be being treated by or working with. Registration with the GMC has always been the only way that doctors may legally practise in the UK and carry out the variety of roles and responsibilities that are conferred by this legal status (such as prescribing medication or signing death certificates).

9.3 The accessibility of the register has evolved over time to reflect technological advances. Historically, a physical version of the register was printed and issued annually. The Act was amended in 2002 to allow the GMC to publish an online version of the register in place of the printed annual register, and the online register was introduced in 2006. Its introduction has allowed us to maintain a publicly available version of the register in real time, reflecting changes in doctor's registration status as they happen. This has driven increased transparency and accessibility.

10 What rights and responsibilities flow from entries which can be made on the GMC's medical register with regard to the medical practice of an individual medical practitioner (a) in the UK and (b) beyond the UK?

10.1 As the GMC is a UK regulator, and the medical register reflects entitlement to practise medicine as a doctor in the UK, being registered and holding a UK licence to practise does not grant formal legal status in relation to practising medicine in any other country. Doctors working overseas must comply with the legal and regulatory frameworks of the country they intend to practise in. Where a doctor who is registered with us plans to practise overseas, they may request we send a certificate of good standing (CGS) to another medical regulator or regulatory authority. This will show the doctor's registration and licence status; registration history; identifying information (such as their GMC number); whether their registration has been restricted, suspended or revoked; and any

relevant information about their fitness to practise (such as any historical fitness to practise sanctions).

11 Please explain (including details of any changes):

- a) What, if any, validation and revalidation standards and processes existed over the relevant period for doctors to maintain their licence to practise;**
- b) What appraisal standards and systems relating to validation or revalidation of doctors were in place over the relevant period; and**
- c) The GMC's self-reporting requirements on medical professionals in place over the relevant period; and**
- d) The GMC's reporting requirements on medical professional relating to the practice of other medical professionals in place over the relevant period:**

11.1 Revalidation for doctors was introduced in December 2012 and every licensed doctor who practises medicine must revalidate as a condition of maintaining their licence. Revalidation requires doctors to demonstrate that they are up-to-date and fit to practise. It supports doctors to develop their practice, drives improvements in clinical governance and helps give their patients confidence in their skills and knowledge. The GMC is responsible for setting out the UK wide framework for revalidation and approving revalidation recommendations about individual doctors from **ROs**.

11.2 In general, doctors revalidate through a process of collecting required supporting information about their practice which they discuss at annual appraisals. Usually, every five years the outputs of these appraisals and other local clinical governance information, are reviewed by their RO who makes a revalidation recommendation to the GMC, and we make a decision. ROs have a statutory responsibility for clinical governance systems within their organisations including responding to concerns and investigations, complaints management and local appraisal.

11.3 The GMC's 'Protocol for making revalidation recommendations' provides guidance for ROs [GMC-00012]. This guidance sets out information sharing principles and recognises that the consistent sharing of information about doctors supports patient safety as well as the doctors involved. It also promotes public confidence in the medical profession. The information sharing principles in the guidance emphasise that patient safety is paramount when deciding whether to share information about doctors. Individuals with governance

responsibility for doctors working in any setting have a duty to share information of note about a doctor with that doctor's RO.

Part C – Involvement of the GMC with the professional practice of Mr Eljamel

12 How might concerns regarding Mr Eljamel's professional practice have been brought to the attention of the GMC?

12.1 Paragraphs 7.24 to 7.40 set out an overview of the way in which concerns may currently be brought to the GMC's attention. I have set out below at question 19, in the context of Mr Eljamel's fitness to practise history, how concerns could have been, and were, raised during the relevant period.

13 Was any report made to the GMC by Mr Eljamel or others (including but not limited to NHS Tayside or other surgeons) of any adverse events occurring in or issues related to the care of his patients? If so, please set out details. What role could the GMC have played in handling or advising on any such adverse events or issues?

13.1 We received sixteen complaints or referrals about Mr Eljamel's fitness to practise in total, as detailed in the table set out at GMC-00032. Our first interaction with NHS Tayside in respect of Mr Eljamel's fitness to practise occurred on 10 December 2013 during a meeting between Willie Paxton, the Employer Liaison Advisor (**ELA**) for Scotland during the relevant period, and Andrew Russell, Responsible Officer (**RO**) for NHS Tayside. As set out in the ELA meeting notes [GMC-00024], Dr Russell notified us of a significant event analysis he had chaired following wrong level surgery carried out by a neurosurgeon at NHS Tayside, and the fact that he had commissioned the Royal College of Surgeons (**RCS**) to review his performance by looking at 14 of his cases.

13.2 NHS Tayside then made a formal referral to the GMC regarding Mr Eljamel's professional practice on 29 January 2014, following the conclusion of the RCS's external review. Their referral included a copy of the RCS report and supporting documentation for us to consider as part of our initial triage process. NHS Tayside's referral form and supporting evidence (including the RCS report) is set out at GMC-00037.

13.3 Following receipt of this referral, we opened a fitness to practise investigation into Mr Eljamel and referred him to the Medical Practitioners Tribunal Service (**MPTS**) for an

Interim Orders Tribunal (**IOT**) to consider whether an interim order was necessary for the protection of members of the public or otherwise in the public interest. The IOT can impose an interim order that either temporarily suspends a doctor from practising or attach conditions to limit a doctor's practice. The GMC sought the imposition of conditions given the range of issues raised in the RCS's external review report and Mr Eljamel's apparent inability to sustain changes in his practice. An IOT considered the concerns raised about Mr Eljamel and imposed interim conditions on his practice. [GMC-00201 – GMC-00205].

13.4 As part of the investigation and in line with our processes, we disclosed the fact of the fitness to practise investigation to his current and recent employers. As Mr Eljamel had previously held practising privileges at BMI Fernbrae, we wrote to BMI Healthcare [GMC-00211] to notify them of the current investigation and seek any information they held about the concerns raised or any other complaints or concerns in relation to Mr Eljamel. Initially BMI confirmed there were no fitness to practise [GMC-00212] concerns about him. Subsequently in November 2014 BMI Fernbrae contacted us to disclose a patient complaint [GMC-00206] and enclosed an external review report they had obtained from a specialist adviser, set out at Exhibit GMC-00055. NHS Tayside confirmed that the patient [GMC-00213] complaint had already been referred to the GMC as part of their initial referral on an anonymous basis.

13.5 In respect of the GMC's role in handling or advising on adverse events or issues, our remit is set out in legislation and we take action in accordance with the provisions, criteria and thresholds set out in the law. We do so through the **ELA**, who advises on whether these would meet the threshold for referral to the GMC. Once we receive a referral, our role is to consider whether regulatory thresholds have been met for us to start an investigation, gather relevant information (including through employer disclosure processes) where appropriate, and take regulatory action where necessary, such as to protect the public.

14 Please set out the identify of key individuals within the GMC who had engagement with Mr Eljamel and the nature and timing of that engagement.

14.1 The GMC's direct engagement with those registered with us is limited to formal interactions in the course of our regulatory activities. Examples of direct interactions include (but are not limited to):

- a) Liaison throughout registration processes, such as when a doctor applies for full or specialist registration, when we are asked to grant or maintain their licence to practise, to confirm they have successfully been revalidated, and in circumstances when they apply for **VE**;
- b) Interactions as part of fitness to practise processes, for example to notify a doctor that a concern has been received, to request information or evidence, or to notify them of a decision or outcome (during the fitness to practise processes we may also interact via third parties, such as legal representatives and / or defence bodies. The General Medical Council (Fitness to Practise) Rules 2004 (as amended) set out details about when and how we may interact directly with a doctor during fitness to practise proceedings); and
- c) Responding to individual enquiries, for example to clarify ethical or professional standards or to deal with administrative or procedural queries.

14.2. GMC staff interacted with Mr Eljamel at various points during his professional practice - during registration processes, including in dealing with his VE applications, and in the course of each fitness to practise concern against him being considered and, where deemed necessary, investigated. Our records do not show any other direct engagement with Mr Eljamel.

14.3 The names of key individuals within the GMC who had engagement with Mr Eljamel and the nature and timing of that engagement is set out at GMC-00217.

15 Please set out a broad chronology of the involvement of the GMC with or their knowledge of the professional practice of Mr Eljamel, including:

- a) The nature and timing of any intimation to them of matters relating to the professional practice of Mr Eljamel or any other matter falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues (see question 13 below);**
- b) The nature and timing of any meetings attending by or correspondence involving any representatives of the GMC relating to the professional practice of Mr Eljamel or any other matters falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues;**
- c) The process leading to any appointment of Mr Eljamel to any roles within NHS Tayside covered by ToR 1;**

- d) **Mr Eljamel's clinical supervision, suspension or resignation from NHS Tayside (ToRs 8 to 10);**
- e) **Any of the investigations relating to Mr Eljamel or systems relating to his professional practice in NHS Tayside covered by ToR 12 (see question 14 below);**
- f) **The document management systems within NHS Tayside relating to the professional practice of Mr Eljamel over the relevant period or subsequently (as covered by ToR 14); or**
- g) **Any actions or decisions taken by or involving the GMC relating to the professional practice of Mr Eljamel or any other matter falling within the ambit of the Inquiry's Terms of Reference or provisional List of Issues, including the reasons for any such action or decisions.**

In setting out the chronology requested under the question above, please identify any key individuals within the GMC involved in any of the listed matters and the nature of their involvement.

15.1 In relation to Mr Eljamel, we exercised our statutory functions as soon as we were made aware of concerns relating to his professional practice. This included liaising with his **RO** as appropriate via our Scotland **ELA**, investigating fitness to practise concerns that met statutory thresholds, and taking regulatory action to protect the public. The actions we took are detailed throughout this statement, in particular in the chronology table included as Appendix 1 [GMC-00032] and in response to questions in Part D below]

To what extent could the GMC have become involved in matters relating to the professional practice of Mr Eljamel? What actions could the GMC have taken in terms of their legal and regulatory responsibilities?

16.1 The GMC has a defined regulatory remit under the Act. This sets out our overarching objective which is the protection of the public. The pursuit of this objective includes protecting, promoting and maintaining the health, safety and wellbeing of the public, promoting and maintaining public confidence in the medical profession and promoting and maintaining proper professional standards and conduct for members of that profession. The Anaesthesia Associates and Physician Associates Order 2024 has also introduced that overarching objective in relation to Physician Associates (PAs) and Anaesthesia Associates (AAs). (As set out at paragraph 7.3 we did not start regulating PAs and AAs until December 2024, and my evidence therefore focuses on the regulation of doctors.)

16.2 Our regulatory responsibilities do not extend to supervising doctors' day-to-day professional practice, which is the responsibility of employers, although we take a broad interest through the lens of clinical governance, supported by appraisal and our requirements for revalidation. In line with our statutory remit, we have a formal role when we receive information raising a concern about a doctor's fitness to practise. When such information is received, it is our role to assess whether a doctor poses any current and ongoing risk to public protection and if so, whether to take regulatory action.

16.3 When an employer comes to us with a concern that has been raised locally, we may provide advice through our **ELAs** to them and **ROs** on local handling, safeguarding considerations, and, where appropriate, escalation to relevant third parties. We expect employers to raise issues with us in a timely way given the risk to patient safety of any delays.

16.4 We may also share information with other system regulators and improvement bodies in line with established memoranda of understanding.

17 In particular, what a) reports were made to the GMC (by Mr Eljamel or others) and b) steps were taken by the GMC of Mr Eljamel relating to the following:

- a) Mr Eljamel's technical surgical skills;**
- b) Mr Eljamel's patient care, including communication with patients; or**
- c) Mr Eljamel's workload management, including his commitment to private practice.**

17.1 I have set out at Appendix 1 [GMC-00032] a chronology of our involvement in Mr Eljamel's professional practice, cross-referencing to relevant exhibits. This covers the breadth of our different regulatory activities, including our outreach, education, registration and fitness to practise functions. I have also dealt with question 17 within that column.

17.2 For completeness I have included the GMC's interactions relating to Mr Eljamel's registration and fitness to practise. Further information about these aspects of Mr Eljamel's professional practice is provided in part D and E.

18 What knowledge did the GMC have of and what steps did the GMC take connected to:

- a) The nature of matters being looked into as part of any of the investigations listed under ToR 12;**
- b) The process by which any such investigations were undertaken;**
- c) The outcome of any of those investigations; or**
- d) The steps being taken to take action resulting from the findings of those investigations.**

18.1 Discussed in question 17.

Part D – complaints and concerns

19 To what extent, on what grounds and by whom could complaints or concerns about the professional practice of a consultant neurosurgeon, such as Mr Eljamel, have been raised with the GMC over the relevant period or subsequently? In particular:

- a) What action or censure was the GMC empowered to take with regard to such issues?**
- b) Were any such systems of raising complaints or concerns available to members of the public, including patients?**
- c) What whistleblowing opportunities / mechanisms did the GMC provide for other surgeons regarding the performance or conduct of neurosurgical consultants, like Mr Eljamel?**

19.1 The GMC's statutory role and duties in respect of handling concerns about a doctor's fitness to practise remain largely unchanged between the concerns being raised by NHS Tayside in January 2014 and now.

19.2 While our processes have evolved over time, sources of complaints and concerns have remained consistent (as set out in paragraph 7.40). The main difference is changes brought about by the introduction of the ELAs. After their introduction in 2013, ROs were able to seek advice from ELAs about whether concerns met GMC thresholds prior to making a referral. Their introduction has helped ROs understand when concerns need to be managed locally and where they need to be referred to us. It has also helped us reduce the disproportionality we have historically seen of doctors with particular protected characteristics being more likely to be referred. We have invested in growing our outreach

capacity to make sure we are able to have better and more timely conversations with ROs about potential referrals.

19.3 Historically, concerns raised to the GMC by whistleblowers, such as other doctors, healthcare professionals, or staff, were treated as referrals or complaints within the usual fitness to practise processes. We applied the same assessment and investigation thresholds to such concerns as to other complaints.

19.4 In response to increasing interest in how we handled cases involving individuals who regarded themselves as whistleblowers raising concerns in the public interest, we commissioned an external review in September 2015 led by Sir Anthony Hooper QC. This coincided with a wider review, the Freedom to Speak Up Review led by Sir Robert Francis QC, being undertaken for the Department of Health and Social Care (**DHSC**) into whistleblowers in the NHS in England. Sir Anthony made eight recommendations as a result of his review for the GMC [GMC-00207], resulting in action being taken to enhance the information required from referring organisations about whether a doctor had raised safety concerns, ensure relevant context was obtained in referrals, develop training for investigators on whistleblowing issues, consider internal procedural adjustments, and explore confidential mechanisms for healthcare professionals to raise concerns.

19.5 Separately, in 2015 the UK Government consulted on introducing mandatory annual reporting of public interest disclosure statistics by 'prescribed persons'. This ultimately led to the Prescribed Persons (Reports on Disclosures of Information) Regulations 2017, which required certain bodies, including the GMC, to publish annual whistleblowing disclosure reports from April 2017 onwards. For the purposes of the legislation, 'prescribed persons' are bodies identified in the legislation as appropriate recipients of whistleblowing disclosures, who have a statutory duty to handle and report on those disclosures.

20 Were any such complaints or concerns raised? If so,

- a) By whom?**
- b) When?**
- c) What was the nature of the complaint or concern?**
- d) What process or investigation took place?**
- e) What was the outcome / how were the complaints or concerns resolved?**

20.1 The table at Appendix 1 [GMC-00032] sets out requested information about the sixteen complaints we received about Mr Eljamel, between 2001 and 2023. Within that table, I have exhibited documentation relating to the complaints we received and decisions we made about each.

20.2 Set out below is a summary of the applicable guidance and processes at the time that the complaints set out in the table at Appendix 1 [GMC-00032] were made, mapped to the complaint(s) that they applied to. Given the passage of time, we have been unable to locate the guidance in place governing how we dealt with the 2001 complaint.

Triage guidance

20.3 During triage, a fitness to practise decision maker will carry out an assessment of the complaint to decide whether it raises an allegation of a doctor's impaired fitness to practise (in relation to health, performance or conduct) and, if it does, how the GMC should investigate it.

20.4 The 'Triage Manual' sets out a general overview of fitness to practise and the underpinning legal framework, generic business and systems processes and the approach to dealing with complaints. I have exhibited the 'Triage Manual' with the different versions applicable at the time of relevant complaints, as follows:

- a) 'Triage Manual' ([GMC-00082], in force from December 2013). Section 3.7 (pages 36 to 51) sets out the process for triaging an enquiry, including considering whether the complaint raised allegations of impairment, and how to investigate if so. When undertaking a triage, we would follow a number of steps, including, for the reasons set out in the Manual, reviewing complaint, complainant and doctor information. We would also consider factors such as whether the five-year rule was engaged and whether we needed to share information with any other organisations (at this time, the Rules stated that an allegation arising from events that happened more than five years ago should not proceed, unless the rule was waived due to exceptional circumstances and it being in the public interest to pursue it). Section 3.8 of the Manual) [GMC-00082_51-60] sets out potential triage outcomes, including closure of the enquiry; promoting the enquiry to a full fitness to practise investigation; promoting an enquiry that did not, in itself, raise fitness to practise questions, but may require action if forming part of a wider pattern of concerns about a doctor's practice; or referral where considered necessary to another organisation where issues did not relate to fitness to practise. This version

of the 'Triage Manual' [GMC-00082] was in force at the time of the second complaint detailed in table at Appendix 1 [GMC-00032] being considered.

- b) 'Triage Manual' [GMC-00082], in force December 2013 to April 2014). This largely set out the same information as described above, with minor amendments to reflect information security updates. This version was in force at the time of the third and fourth complaints detailed in the table at Appendix 1 [GMC-00032].
- c) 'Triage Manual' [GMC-00084], in force April 2014 to July 2015). This also largely set out the same information as described above, with additional amendments to reflect the introduction of the new head of impairment relating to knowledge of the English language. This version was in force at the time of the fifth to the thirteenth complaints set out in the table at Appendix 1 [GMC-00032].

20.5 The remainder of Mr Eljamel's complaints were made after he had relinquished his registration.. For completeness, I have also set out in exhibits the 'Triage Manual' in force in August 2020 [GMC-00085], June 2023 [GMC-00086] and July 2023 [GMC-00087]. As set out in guidance, where we receive a complaint about a person who is not a doctor (including doctors who are no longer registered), we will record this but close these complaints as we cannot take regulatory action against someone who is not, or who is no longer, on the medical register.

Guidance on decisions at the end of a fitness to practise investigation

20.6 At the end of an investigation, a decision will be made by two case examiners (**CEs**), one medical and one lay. Where they do not agree, the matter would be decided by the Investigation Committee.

20.7 The relevant guidance in place at the time of the complaints being considered is set out below and outlines the approach to decision making and relevant outcomes, as follows:

20.8 'Making decisions on cases at the end of a fitness to practise investigation – guidance for the Investigation Committee and case examiners' [(GMC-00088] in force April 2013 to June 2014). Paragraph 14 of the guidance sets out the test to be considered. This is that the Investigation Committee or CE must have in mind the GMC's duty to act in the public interest which includes the protection of patients and maintaining public confidence in the profession, in considering whether there is a realistic prospect of establishing that a doctor's fitness to practise is impaired to a degree justifying action on registration. This

version of the guidance was in force at the time of the fourth complaint set out in the table at Appendix 1 [GMC-00032].

20.9 'Making decisions on cases at the end of the investigation stage – guidance for the Investigation Committee and case examiners' [GMC-00089] in force June 2014 to July 2015). This set out the same test for consideration as outlined above. This applied to the seventh and twelfth complaints set out in the table at Appendix 1 [GMC-00032].

Part E – the removal of Mr Eljamel's name from the GMC medical register

21 Please set out details of Mr Eljamel's registration with the GMC, including but not limited to:

- a) The timing and details of entries relating to his registration / practising privileges; and**
- b) The basis for and reasoning behind any such entries being made.**

21.1 Details of Mr Eljamel's GMC registration are as follows:

21.2 We determined that Mr Eljamel met our requirements for limited registration, and he was granted this on 1 August 1986 under section 22 of the original form of the Medical Act 1983, [GMC-00090]. Limited registration, which was abolished in 2009, allowed trainee doctors to practise in specified posts under restrictions and supervision, and was often time limited. Mr Eljamel was not required to sit the Professional and Linguistic Assessments Board test to demonstrate his knowledge and skills under section 22(1) of the Act, which international medical graduates were, and still are, ordinarily required to complete to demonstrate they have sufficient knowledge and English language skills required to meet requirements for GMC registration. This was due to the fact he was sponsored for limited registration by the Royal College of Physicians and Surgeons of Glasgow and was therefore granted an exemption under section 23(5) of the Act. Mr Eljamel completed four periods of limited registration under supervision of an appropriate consultant between 1 August 1986 and 20 February 1990. Documentation relating to his limited registration is set out at GMC-00030_1-6. The document 'Guidance on limited registration', [GMC-00091], was in place at the time.

21.3 Mr Eljamel was granted full registration on 20 February 1990, and his application and related correspondence are set out at GMC-00030_7-11. In the same way that full registration operates now (as set out in paragraphs 7.11 to 7.16), full registration entitled a doctor to practise in the UK without supervision or restriction, having met our

requirements for qualification and training. The decision to grant full registration was made based on the factors considered on the decision form [GMC-00030_7] (including having been qualified for at least four years and having at least 12 months' substantive registrar experience in the NHS). The decision was also in line with requirements at the time for moving from limited to full registration, which are set out in the first two paragraphs of the 1989 Committee minutes [GMC-00092]. The 1990 consultation paper [GMC-00093] provides further information about the requirements for full registration.

21.4 Mr Eljamel was recognised as a consultant neurosurgeon on 12 January 1996. GMC-00030_19-34 sets out the correspondence that relates to his application to be recognised as a consultant in neurosurgery. At this time, we did not hold a separate Specialist Register. The Specialist Register was created in 1996 and came into effect on 1 January 1997, as detailed in the Specialist Register implementation memo [GMC-00094]. Doctors wishing to be recognised as part of a particular specialty were required to seek an additional letter next to their name on the main medical register to confirm their particular specialty and demonstrate that they had completed the necessary level of UK specialist training. They would then be eligible to seek a substantive consultant post. The additional '(S)' indicator, which Mr Eljamel received, signified a surgical specialty. As set out in the implementation memo [GMC-00094] when the Specialist Register was created, doctors with a 'T(S)' indicator were automatically transferred to it.

21.5 GMC-00030_19-35 sets out the correspondence we hold in relation to Mr Eljamel's application to receive the 'T(S)' indicator in 1994. At the time, the indicator would only be added to a doctor's record if the GMC received a sealed list from relevant training bodies within the UK notifying us that they had issued the doctor with a Certificate of Accreditation confirming completion of specialist training. The relevant training bodies included faculties and royal colleges.

21.6 In Mr Eljamel's case, he had practised for some time in Ireland and, while there, completed the Fellowship of the Royal Colleges of Surgeons (**FRCS**) in Surgical Neurology with the Intercollegiate Board in Surgical Neurology in September 1992, and received a mark of distinction from the University of Liverpool in December 1992. He also undertook higher surgical training in Neurological Surgery in November 1993, which had been successfully recognised by the Joint Committee on Higher Surgical Training (the JCHST - a committee of the RCS, Association of Professors of Surgery, and the Specialist Surgery Association in Great Britain and Ireland) as evidence of him having satisfactorily completed his higher surgical training. The Inquiry may wish to consider approaching the Medical Council in Ireland for further information.

- 21.7 After completing these qualifications, Mr Eljamel contacted the GMC to provide evidence of his additional training and ask that he receive the 'T(S)' indicator against his name on the medical register. We were unable to add the 'T(S)' indicator to his record as we had not received the JCHST's sealed list [GMC-00030_28]
- 21.8 We received correspondence from the Irish Surgical Postgraduate Training Committee at the RCS in Ireland in October 1994. [page 29 of GMC-00030]. This confirmed that they had certified on 12 May 1994 that Mr Eljamel had completed the training required in surgery in general and neurosurgery specialty to the satisfaction of the Council and the JCHST. This led to correspondence between the GMC and the JCHST in late 1994 [page 31 of GMC-00030] about the arrangements between them in respect of doctors they felt were eligible for the 'T(S)' indicator, but who had completed the training in Ireland (and, therefore, outside of the UK). We wrote to the JCHST on 21 March 1995 to seek the sealed list demonstrating that several doctors, including Mr Eljamel, would be eligible for the 'T(S)' indicator [GMC-00030_34].
- 21.9 We do not hold further correspondence following this exchange including a copy of the sealed list including Mr Eljamel's name from the JCHST nor any documentation from the RCS of England, but we know he was awarded the 'T(S)' indicator in January 1996 in line with processes in place at the time. We have since verified his **PMQ** and his specialist qualifications to ensure that he was entitled to full and specialist registration on the basis of legitimate qualifications.
- 21.10 Mr Eljamel was also granted a licence to practise on 16 November 2009. This was the date that the General Medical Council (Licence to Practise) Regulations 2009 ('the Licence to Practise Regulations'[GMC-00095] came into effect and licences to practise were introduced. From this date, doctors registered with the GMC were required to hold a licence to practise as well as registration in order to practise in the UK. Transitional arrangements set out in the Licence to Practise Regulations enabled doctors on the medical register when the licensing regime came into force automatically to be granted a licence to practise, unless they specifically asked the Registrar not to receive one in advance.
- 21.11 Mr Eljamel's registration applications were decided in accordance with the guidance in place at the time. Due to the passage of time, we have not been able to locate specific guidance documents that cover all aspects of Mr Eljamel's registration history. We have, however, been able to identify some documents that cover how these processes worked at the time, as follows and as detailed above:
- 21.12 'Guidance on limited registration' [GMC-00091] – covering limited registration.

21.13 The 1989 Committee minutes [GMC-00092] and the 1990 consultation paper [GMC-00093] – providing further information about the requirements for full registration.

21.14 The Specialist Register implementation memo [GMC-00094] – providing further information about specialist registration routes.

22 Please set out the sequence of events whereby Mr Eljamel's name came to be removed from the medical register in 2015. In particular:

- a) **What application was made, when and by whom?**
- b) **What procedure was used?**
- c) **What information was provided?**
- d) **What process was followed?**
- e) **How was the matter determined and when?**

Voluntary Erasure (VE) procedure

22.1 A doctor may seek removal from the medical register at any time through the VE process.

22.2 The process for submitting a VE application, and the procedures for dealing with such applications, have been set out in the Voluntary Erasure and Restoration following Voluntary Erasure Regulations 2004 (**'the VE Regulations'**) since they came into force on 1 November 2004 (they have been amended several times since their introduction, in 2009, 2014 and 2015).. These allow doctors to apply for removal from the medical register at their own request and allow this application to be granted by the Registrations VE, Restoration and Licence (**VERL**) team if there are no ongoing fitness to practise allegations, investigations or proceedings. Where there are ongoing fitness to practise concerns, the application instead needs to be considered by Case Examiner (**CE**)s, as fitness to practise decision makers. They are then responsible for deciding whether to grant or refuse the VE application.

22.3 Internal operational guidance builds upon the VE Regulations to set out procedures for dealing with a VE application. At the time of Mr Eljamel's VE applications, the following relevant guidance was in place:

22.4 'Voluntary erasure procedure' guidance used by the VERL team, with different relevant versions dated 4 February 2014 [GMC-00096], 9 March 2015 ([GMC-00097], and 15 April 2015 [GMC-00098];

22.5 'Evidence' guidance in place at the time the VERL team considered Mr Eljamel's two applications [GMC-00099] and

22.6 'Operational guidance for dealing with Voluntary Erasure applications' used by the Fitness to Practise Investigations team, with different relevant versions dated 22 February 2012 [GMC-00100] and 19 June 2015 [GMC-00101].

22.7 'Guidance on making decisions on voluntary erasure applications' used by Case Examiner (CE)s, dated April 2014 [GMC-00102] and January 2015 [GMC-00103]. This update was not materially different to its predecessor; changes related to the format of the document and so the publication date in the body of the January 2015 version remains April 2014.

22.8 Procedural requirements included:

22.8.1 A requirement for a formal application to be lodged in writing for the attention of the Registrar – the function of considering these applications was delegated to the VERL team on my authority as the Registrar;

22.8.2 Initial consideration by the relevant decision maker, who could grant the application administratively in circumstances where there were no ongoing fitness to practise concerns, and no other reasons why granting a VE would be contrary to the public interest;

22.8.3 Referral for fitness to practise consideration where the doctor concerned was subject to an open fitness to practise investigation, or where other public interest concerns arose;

22.8.4 Fitness to practise decision makers to consider the VE application in light of the GMC's statutory duty to protect the public, and other considerations set out in guidance; and

22.8.5 The doctor to provide a statement to cover three months of work from the organisation(s) where they had most recently provided medical services, typically in a 'Provision of medical services statement'. This statement was (and remains) our means of checking whether there were any known fitness to practise issues that we needed to be aware of and take into account in our decision about whether to grant VE.

Mr Eljamel's Voluntary Erasure (VE) applications

22.9 Mr Eljamel applied for VE twice:

22.10 His first application was lodged on 27 March 2014, which we refused on 18 June 2014.

A copy of his application (including solicitors' correspondence) is set out at GMC-00047 and the decision at GMC-00050.

22.11 His second application was lodged on 9 June 2015. It was considered by **CEs** in light of the ongoing fitness to practise investigation and was granted on 4 August 2015. A copy of his application (dated 07 June 2015) is set out at Exhibit GMC-00040 and the decision at GMC-00041.

22.12 Mr Eljamel lodged his first VE application in two ways – via his online application submitted on 27 March 2014, which was received by our Registration and Revalidation (**VERL**) team, and through solicitors' correspondence of the same date that enclosed a copy of his application, which was received by our Fitness to Practise Investigations team. This led to Mr Eljamel being notified of an initial opinion by a CE and then later informed of a separate formal decision by the CEs in accordance with the procedure. The initial notification resulted from the Fitness to Practise Investigations team asking a CE to offer an opinion on the VE application on 2 April 2014. The CE indicated the following day that it was most likely the VE would not be granted or considered a viable option at that time [GMC-00104_44]. Mr Eljamel and his solicitors were informed of this on 11 April 2014 [GMC-00104_46-46]. The normal procedure for considering a VE application was then followed, with the VERL team submitting the VE application to Fitness to Practise colleagues for a formal decision by CEs [GMC-00104_48-57]. The CEs considered the application and formally refused it on 18 June 2014 [GMC-00050].

22.13 The VE guidance [GMC-00102] that applied at the time of Mr Eljamel's first VE application advised that decision makers should not generally consider an application for VE until the fitness to practise investigation into the doctor concerned has concluded and all relevant evidence has been gathered. It also provided that they must be satisfied that it is right in all the circumstances to agree to VE (and not to proceed with the investigation) before any application was granted. The specific factors to consider were:

22.14 the public interest – which incorporates: (i) protection of patients and the public generally from doctors whose fitness to practise is impaired; (ii) maintenance and promotion of public confidence in the medical profession; and (iii) maintenance and promotion of public confidence in the GMC's performance of its statutory functions.

22.15 the doctor's health and likelihood of return to practice - which includes the following factors: (i) the doctor's health; (ii) the likelihood of the doctor seeking restoration to the register; (iii) the length of time since the doctor last practised; (iv) the genuineness of the doctor's desire to cease to be registered; and (v) any evidence that the doctor has no intention to practise in the UK or elsewhere in the future.

22.16 An updated version of the VE guidance came into effect on 15 January 2015, [GMC-00103]. This update was not materially different to its predecessor; changes related to the format of the document and so the publication date in the body of the January 2015 version remains April 2014. The relevant factors and considerations set out at paragraphs 22.13.1 and 22.13.2 above remained in this next iteration of the guidance, and were the factors considered when Case Examiner (**CE**)s made a decision on Mr Eljamel's second VE application.

23 In particular, what information or representations were a) requested and b) submitted by i) Tayside Health Board or ii) any other body in connection with the removal of Mr Eljamel's name from the GMC's medical register.

23.1 Mr Eljamel submitted a statement from his employer [page 57 of GMC-00104], NHS Tayside when he first applied for **VE** in 2014? Mr Eljamel did not submit an additional statement from his employer, when he reapplied for VE in 2015 [GMC-00040]. The **VERL** team who accepted his application noted the absence of the employer form. Although there is no further detail about this in the VERL team's decision [GMC-00041], we already had information from his employer at that time [page 57 of GMC-00104], as Fitness to Practise Investigation colleagues were, in parallel with the VE decision, in liaison with NHS Tayside's **RO** on a regular basis, as part of investigating the fitness to practise concern they had raised.

23.2 By the time the second VE application was considered in 2015, in accordance with our investigation process, we had obtained an expert report [GMC-00208]. Those allegations against Mr Eljamel that the expert considered met our threshold of being seriously below the standard expected related to failure to perform per-operative x-rays and communication failures with patients and GPs including issues with consent. In their VE decision, the **CEs** noted that, in relation to failures to perform per-operative x-rays, Mr Eljamel had corrected his practice in 2012 prior to his retirement. Evidence that Mr Eljamel had addressed issues relating to him having not used intraoperative imaging correctly included the following:

- a) the RCS external review report [GMC-00037], which included an account from Mr Eljamel stating that he now used intraoperative imaging to ensure procedures were done correctly; and
- b) testimonials provided to the IOT [GMC-00209] at the time of interim conditions being imposed, which confirmed that Mr Eljamel had been doing radiological confirmation intraoperatively for the past 18 months.

23.3 The CEs also noted [GMC-00041_8-9] that the expert's concerns about consent and some of the concerns about communication were not supported by evidence.

23.4 In terms of risks arising from Mr Eljamel's clinical performance, the key factors in the guidance relevant to the VE decision were the protection of patients, which would be delivered by Mr Eljamel's removal from the medical register, and how likely, or unlikely, it was that Mr Eljamel would return to practice in the future. The VE decision was granted on the basis that, when the information available at that time was finely balanced by the two CEs, they considered it unlikely Mr Eljamel would seek to return to the register in order to continue to practise medicine. This was based on the fact that he had been retired for some time, was undertaking significant caring responsibilities for his wife CAT A CAT A and had stated that he had no intention to return to the medical profession. I have commented further on the VE decision in question 31.

24 What was the normal process by which representations in connection with an application for a name to be removed from the medical register would normally be followed around that time? From whom would such representations normally be sought?

24.1 As set out in the various VE guidance documents [GMC-00096 – GMC-00103]], we require doctors to submit their VE application form with an additional statement completed by their recent employer(s).

25 What was the purpose of a) the employing Health Board / Trust or b) any other body being asked to make such representations in a situation where a registered medical professional entry on the GMC medical register was being considered?

25.1 The VE guidance in place [GMC-00100] at the time of both of Mr Eljamel's VE applications provided for CEs to consider representations from employer(s) as part of the evidence before them, guidance dated April 2014 [GMC-00102] and January 2015 [GMC-00103].

This update was not materially different to its predecessor; changes related to the format of the document and so the publication date in the body of the January 2015 version remains April 2014. If there was evidence that a doctor intended to practise in the UK again, or elsewhere in the future, this would be taken into account by CEs in the course of weighing up relevant factors. If CEs believed that a doctor intended to practise again, in the UK or elsewhere, it would not be appropriate to grant VE in the interest of ensuring the protection of patients everywhere. In Mr Eljamel's case, there was no evidence of his intention to return to practise in any capacity at the time of his VE application being considered and granted.

26 Had submissions or representations been made by the employing Health Board / Trust what difference could that have made to a) the process which the GMC would have followed and b) the likely determination of the application, including the impact which that determination could have had on the practitioner's ability to continue to practise in other countries?

26.1 We may take regulatory action in respect of a doctor registered in the UK, whether through fitness to practise sanctions, or VE, but it is always for other countries' authorities to make decisions about registration and practice. They will determine what level of consideration to give to information we share with them about a doctor's registration.

Part F – documents

27 Please set out the broad locations of where documents thought to be relevant to the requests made in this Rule 8 request were stored, including hard copy or electronic systems, and the identity of the party who or which controls or administers such systems.

27.1 The entirety of our records and systems within the scope of the Rule 8 request and Section 21 notice are controlled and administered by the GMC. Documents considered potentially relevant to the Rule 8 request c were held across several electronic and hard copy systems. The way the relevant documentation was stored depended on the date and nature of the documents.

27.2 In responding to the Rule 8 request and Section 21 notice, we carried out reasonable and proportionate searches to identify documents falling within each of the relevant search

categories. Search activity was undertaken across the locations and systems we identified as the most likely repositories for documents relevant to the search categories.

27.3 Hard copy records (such as the registration documents and 2001 fitness to practise complaint documentation) are stored off-site, catalogued and managed via a GMC-administered system called Transearch. The registration and fitness to practise documentation that predate our case management system, Siebel, are held in hard copy, catalogued at box level and organised by doctors' surname.

27.4 Electronic complaint records and correspondence are accessed and controlled within Siebel. All Siebel documents are then electronically stored within our Electronic Document Management System (EDRMS), Livelink. Administrative documents, such as policies and procedures, are stored and accessed within our EDRMS. Both Siebel and Livelink systems were introduced in 2006.

28 As far as the searches for documents undertaken by the GMC as per the request made in Appendix C below are concerns, as regards of the categories of documents which has been requested:

- a) Please indicate what searches for documents have been undertaken for each category, including where such searches were undertaken and why these searches were thought to be comprehensive as regards the document sought in each category, including details of search terms used on electronic systems of document storage;**
- b) If there are significant classes of documents which were thought to have existed as some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of the GMC, please identify what these are;**
- c) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of the GMC, please identify broadly what has happened to them (including whether they have been lost or destroyed and, if so, when and why); and**

d) If there are significant classes of documents which were thought to have existed at some point relevant to a search category which no longer exist or are no longer held by, on behalf of or under the control of the GMC and the GMC is aware of these being held by or on behalf of another party, please indicate the nature of these documents and by whom the GMC believes them to be held.

28.1 In terms of our search methodology, searches were undertaken across electronic systems, email accounts, websites, and hard copy records to identify material relevant to the Rule 8 request. Our approach combined structured folder reviews, keyword searches where functionality permitted, and manual review of hard copy files. Detailed search terms are set out at GMC-00105.

28.2 Searches of electronic records held on Siebel and Livelink were conducted by reviewing folders and sub-folders associated with the relevant subject matter, including team, project, and case-related directories. Where system functionality allowed, we undertook keyword searches to help us identify potentially relevant material.

28.3 We also undertook searches of Outlook work email accounts covering the relevant period, by applying keyword searches and reviewing relevant folders, including inboxes, sent items, and archived folders. Email searches were carried out using the Microsoft Purview programme.

28.4 As set out at paragraph 27.3, hard copy records that predate our Siebel registration records and fitness to practise complaint files are catalogued at box level by doctors' surnames and stored off-site. We conducted searches by querying the records management system using the doctor's name and GMC number to identify relevant boxes for review. Identified records were retrieved and manually reviewed.

28.5 To gather complaints, decisions and registration documentation that is held on electronic systems, we reviewed Mr Eljamel's record in Siebel to identify complaints, decisions, and relevant registration information. We also reviewed **ELA** meeting minutes and associated documentation.

28.6 In respect of registration and revalidation guidance documents, we conducted searches for relevant guidance documents and webpages published on the GMC website and within Livelink. Some of the requested material had already been digitised and was

available within our archive knowledge library. Keyword searches were therefore not required for these documents.

28.7 Additional searches of hard copy material were required, as sub-Committee minutes and papers have not yet been fully digitised. Processes and procedures relating to limited and full registration between 1971 and 1993 were identified through manual review of Overseas Committee sub-committee minutes. Relevant procedures, templates, and supporting documents were located and digitised for the Inquiry.

28.8 We also reviewed digitised indexes of GMC Council minutes held in our Records Hub, another EDRMS, for references to the Overseas Committee. Relevant reports were extracted to provide background on the Committee's function during the relevant period. Keyword searches were not required, as these records were already digitised and systematically organised.

28.9 To gather professional standards documents, archived professional standards webpages were searched on the GMC website.

28.10 Searches were conducted for education standards and fitness to practise guidance documents (including 'The Early Years' [GMC-00210] and 'Tomorrow's Doctor'[GMC-00110 - GMC-00112]) within Livelink and our Records Hub. These searches were cross-referenced against digitised Education Committee minutes to identify any reviews or updates to the guidance.

28.11 Where guidance was not available electronically, hard copy files were reviewed by searching Transearch for the named guidance or for indexed education standards files created around the time the guidance was developed.

28.12 In some cases, the Internet Archive's Wayback Machine was used to access archived versions of GMC webpages, or those of the Specialist Training Authority or Postgraduate Medical Education and Training Board (**PMETB**), where printed or published versions were not held.

28.13 At the time of responding to this Rule 8 request and Section 21 notice, we have not identified any significant classes of documents falling within the relevant search categories which are known to have existed but which are no longer held by, on behalf

of, or under the control of the GMC, other than as set out at where relevant in the statement (such as in relation to Mr Eljamel's specialist registration) and below.

28.14 We recognise that some documents which may previously have existed within the relevant search categories may no longer be held as a result of the GMC's retention schedule, 'Retention and disposal of personal data – GMC', [GMC-00106]. Staff are advised to save all material on Siebel and delete it from their Outlook inboxes. Although we do not have a timeframe within which we delete staff emails, we manage emails by limiting the size of staff email accounts, which ensures regular destruction of data from Outlook.

29 Please certify that the documents which have been produced in response to this Rule 8 request are, to the best of the GMC's knowledge and belief, all documents held by the GMC, on its behalf or under its control.

29.1 I certify that the documents produced in response to this Rule 8 request and Section 21 notice are, to the best of the GMC's knowledge and belief, all documents held by the GMC, on its behalf, or under its control which fall within the scope of the Rule 8 request and Section 21 notice.

Part G – Conclusions

30 Please state what the GMC considers the key challenges were, its understanding of the reasons for those challenges, what went well and what did not (either as was apparent at the time or in hindsight), and whether the GMC identified (at the time or subsequently) things that could or should have been done differently in the way that systems which existed to promote the best interests of the former patients of Mr Eljamel over the relevant period or subsequently.

30.1 This has been answered with question 31 below.

31 What lessons, if any, has the GMC learned from its / their involvement in the systems which existed to promote the best interests of the former patients of Mr Eljamel over the relevant period.

31.1 Firstly, I recognise the concerns that patients have raised about our decision to grant Mr Eljamel VE in August 2015; the extent of the potential harm caused by Mr Eljamel has

understandably prompted questions from, and on behalf of patients. We have asked ourselves what actions were, or could have been, taken that might have made a difference. This includes considering whether referring Mr Eljamel through to a fitness to practise hearing before the MPT would have been a more appropriate step for the GMC rather than granting his application for VE.

31.2 We have reflected on the decisions we made, recognising the clear public interest there is now in Mr Eljamel's practice, whilst also making sure our decisions are kept within the GMC's remit. In this regard the GMC's role is not to punish doctors for their past behaviour but instead to consider the future risk a doctor may pose, and take such steps as are necessary to protect the public.

31.3 In allowing Mr Eljamel's name to be erased from the register on a voluntary basis, this objective was achieved. Granting the VE application provided certainty that Mr Eljamel could not practise medicine or treat patients in the UK. Referring the complaints against Mr Eljamel to a fitness to practise hearing would not have provided certainty as to the outcome. An order that Mr Eljamel's name should be erased from the register could only have been imposed at a hearing if the GMC had proved our case, the MPT considered Mr Eljamel's fitness to practise remained impaired, and the MPT decided that the only appropriate sanction to protect the public was an order for erasure. The MPT can only order erasure / removal of a doctor's name from the register if it is satisfied that no other orders, such as the imposition of conditions or a period of suspension, would be proportionate and reasonable, and erasure is the most severe sanction that can be imposed by the MPT.

31.4 As noted in GMC-00107, which sets out communications regarding the decision, a VE application requires **CEs** to weigh up a number of factors when determining a VE application, including evidence of a doctor's intention to return to practise, either in the UK or overseas. As noted at paragraph 25.1 the CEs who considered Mr Eljamel's application had no evidence before them of his intention to return to practise in any capacity, and granting VE therefore ensured that the public and patients were protected as a priority and with certainty.

31.5 It is possible for a doctor to apply to have their name restored to the register after an MPT order for erasure (although this cannot be made until five years elapsed from the order) or following an application for VE. In both situations a doctor will have to satisfy the GMC that they are fit to practise. If a doctor applies for restoration having been granted VE at

a time there were outstanding fitness to practise concerns against them, the most likely scenario is that we will refuse to restore their name to the register if those concerns are serious enough to suggest their fitness to practise is impaired.

31.6 Had Mr Eljamel applied for restoration he would have had to satisfy us that he was fit to practise, that he had remedied the fitness to practise concerns about his performance, and that he had kept up to date with medical practice. From what we know, it appears unlikely that the GMC would have granted his application.

31.7 The VE decision – and the high bar on any potential return to the UK register – served to achieve the objective of protecting future patients in the UK. However, I fully understand that patients, relatives and others may feel that this takes away the opportunity of the Tribunal process with a more public hearing of the concerns. Although the steps taken offered swift and certain public protection, it will always be true – and is true in this case – that we need to be able to explain these decisions clearly to provide reassurance to the patients about the rigour, and the consequences for a doctor, of the VE process.

31.8 I accept that our reasoning in Mr Eljamel's VE decision could have been clearer and better explained to provide this reassurance. If made today, we would likely expand our reasoning of the VE decision to make it clearer that there were no public interest reasons sufficient not to grant VE, given the matters evidenced during our investigation related to clinical performance and in those circumstances, VE would protect the public.

31.9 We have also reflected on the role of effective overseas notifications procedures in upholding the safety of patients everywhere, and considered how we might have done things differently. We recognise that there is wider interest in this, given the fact that, despite Mr Eljamel's retirement in 2014 and representations made during the VE process in 2015, he has reportedly gone on to practise in Libya.

31.10 While leaving the UK register prevents future practice in the UK, it does not directly affect a doctor's ability to practise in other countries, where responsibility for deciding if this is possible lies with that country's regulator. However, we inform relevant overseas regulators about fitness to practise action that might affect a doctor's ability to practise, such as when we have imposed an interim sanction. We do this by sending a monthly decisions circular which contains information about fitness to practise decisions made in the preceding month, as well as writing directly to regulators we consider to be relevant -

such as the regulator in a doctor's country of qualification. The decisions circular is only sent to overseas regulators who have agreed to receive it.

32 We have checked how this operated in Mr Eljamel's case, and know that we notified overseas regulators via our monthly decisions circular [GMC-00214 and GMC-00216] of his interim conditions when these were first imposed in 2014, and of his successful VE decision in 2015. Unfortunately, we no longer hold records of which regulators received our decisions circular at the time and cannot confirm that this included the Libyan regulator.

32.1 We also sought to directly contact relevant overseas regulators to notify them about the interim conditions and VE. Regrettably, at the time of sending out the notification of the interim conditions, we mistakenly wrote directly to the Saudi Arabia regulator rather than the Libyan regulator [GMC-00215]. This was due to human error; a search was made for 'Al Fateh', which returned results of a location in Saudi Arabia, rather than searching for 'the University of Al-Fateh (where Mr Eljamel qualified) which would have returned results in Libya. At the time of sending the VE decision notification, we believe we also failed to make direct contact with the Libyan regulator and missed an opportunity to correct our earlier mistake.

32.2 Following media reports in 2023 that Mr Eljamel was working in Libya, we reviewed our files and identified we had not made contact with authorities in Libya. We sought to correct these errors swiftly and shared information relating to his interim conditions and VE with the Libyan regulator directly by letter dated 11 May 2023 [GMC-00076].

32.3 It is regrettable that we did not directly notify the Libyan authorities immediately after key decisions relating to Mr Eljamel's registration and have since reorganised our processes. While the responsibility for issuing the decisions circular and overseas notifications sat across various teams within our Registrations and Revalidation function and the MPTS in 2014 and 2015, the two processes have now been streamlined. Since 2022, this function has sat within a single team, the International Liaison and Illegal Practice Team, which manages international regulatory information sharing, alongside other work in relation to investigations into illegal medical practice and registration fraud.

32.4 With the benefit of hindsight, and had the CEs been able to consider evidence that Mr Eljamel intended, or had gone on, to practise overseas, this would have been a factor

that would have weighed against the VE being granted. Had our CEs known this at the time that they were considering the VE application, it is therefore likely that VE would have been refused and instead his case would have been more likely to have gone ahead to an MPT for full consideration at a hearing with a desired sanction of erasure, if the GMC had proved Mr Eljamel remained impaired and a risk to future patients.

32.5 Whilst it will always be for an overseas regulator to decide the weight to place on regulatory action that has taken place outside of their jurisdiction, we recognise that an overseas regulator might perceive a fitness to practise sanction following a hearing as a stronger regulatory measure than VE and might therefore have reached different decisions about allowing him to practise. We acknowledge therefore that, had Mr Eljamel faced a hearing before MPT and received a sanction, this might have prompted another regulator to take action in a way that being notified of a VE would not – and so, although granting VE provided certainty of protection for UK patients, we appreciate that, its impact overseas might not have been so significant as a formal finding by MPT.

32.6 Later this year, we understand that the **DHSC** will be consulting on a new order to replace the Medical Act 1983 and update the legislative regime under which we must operate. Looking forward to the changes we anticipate will be achieved through this regulatory reform, it is possible that cases involving doctors (as well as PAs and AAs) under fitness to practise investigation may be resolved via a new accepted outcomes route rather than through a MPT hearing. If a doctor admits to the allegations and accepts that their fitness to practise is impaired, a case can be closed where the GMC and a doctor agree to an outcome that protects the public, including erasure. This could, in future, mean that in cases such as this the accepted outcomes route could be used where there is an open fitness to practise case and where a doctor seeks erasure where they have agreed to this outcome. The fitness to practise conclusions will remain on the doctor's record should they seek restoration to the register or seek to practise again overseas at a later date.

33 Please refer to anything else the GMC considers / consider may be of substantial interest to the Inquiry in relation to the systems which existed to promote the best interests of the former patients of Mr Eljamel over the relevant period. In addition, please identify any key areas / systems / practices which the GMC considers / consider worked well, and any key areas in which you / they consider there were issues, obstacles or missed opportunities.

33.1 Our reflections are covered in question 31.

34 Please set out what, if anything, the GMC considers / consider can be done to improve systems which existed to promote the best interests of the former patients of Mr Eljamel over the relevant period for the benefit of future patients like the former patients of Mr Eljamel in which the GMC played a part / of which it has knowledge.

33.1 Our reflections are covered in question 31.

33.2 We recognise that the GMC's overarching statutory objective is to protect the public, which we appreciate is different to the Inquiry's interest in systems to promote the best interests of the former patients of Mr Eljamel. As a public body, our powers are limited by statute - we can only do that which statute permits us to do, and must do that which statute requires us to do - so we acknowledge that our remit might be more narrowly drawn than other bodies from whom the Inquiry is seeking input and evidence.

Appendix C: Request for documents to be produced to the Inquiry

35 All documents held by or on behalf of the GMC relating to any matters covered by the questions to be covered in your witness statement above, including but not limited to:

34.1 In addition to the documents we have exhibited throughout the statement where relevant to our responses, we have collated wider materials where relevant, in line with the request in Appendix C.

34.2 As part of the GMC's disclosure to the Inquiry we have provided relevant minutes from meetings between our Employee Liaison Adviser and the Responsible Officer at NHS Tayside. These can be found at GMC-00024 - GMC-00029 and GMC-00177 - GMC-00185. Redactions have been applied to these documents prior to their disclosure to the Inquiry. The information redacted pertains to the personal data (including fitness to practise information) of third party doctors who are not connected to the Inquiry. The information contained therein includes sensitive information and special category data such as health information, convictions, etc. This information is not relevant to the Inquiry's terms of reference and is highly sensitive. In light of this, and in line with our data protection obligations, these documents have been redacted prior to disclosure.

34.3 In addition, you will note GMC-00187 is an extract from an email. The email itself pertains to the fitness to practise information of a third party doctor and is not relevant to the Inquiry's terms of reference. In light of this and in line with our data protection obligations we extracted the relevant information and have disclosed this to the Inquiry. The extract provided is the only information therein which related to Mr Eljamel.

34.4 Following a further request from the inquiry, we've reviewed the contents of exhibit GMC-00187 again. The rest of the document, apart from the extract provided, contains notes of meetings between the GMC Employment Liaison Adviser and NHS Tayside. The notes relate to fitness to practise concerns about a number of other doctors, some of whom are named. The doctors named are not neurosurgeons and the concerns do not relate to neurosurgery. As the extract from the document says, Dr McLoughlin was the Clinical Director who agreed Tayside's plan for supervising Dr Eljamel. This must have been before Dr Eljamel was granted Voluntary Erasure from the medical register in 2015. The fitness to practise issues about other doctors which are contained in the rest of the document date from 2022-2025. We cannot see the relevance of this information to the inquiry's terms of reference and as the rest of the document contains personal data about named doctors, we cannot see a lawful ground that would allow us to disclose it the inquiry. The section 21 notice received from the inquiry does not cover such material.

34.5 Further, you will note within our monthly decisions circular (at GMC-00216) redactions have been applied to the column entitled 'dates of birth'. These redactions were applied prior to the GMC's disclosure to the Inquiry. The circular contains the personal data of third party doctors. At the time the circular was issued the information which appears in unredacted form (at the point of disclosure) would have been publicly available information and on this basis, it has been provided to the Inquiry. However, the dates of birth of the doctors featured in the circular would not have been publicly available. Given that this is personal data not relevant to the Inquiry's terms of reference and not publicly available, the GMC have redacted this prior to disclosure in line with our data protection obligations.

35 Concluding remarks

35.1 I want to thank the Inquiry for the opportunity to support its important work, recognising the harm that was caused to patients and the importance of their experiences being publicly acknowledged as part of the Inquiry. We would be happy to discuss any of the information contained within this statement and disclosure materials, and are fully

committed to constructively engaging on an ongoing basis, including providing further information that would assist.

35.2 We hope that the information that we have provided will assist the Inquiry in its efforts and contribute towards preventing similar tragic circumstances arising again in the future.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed:

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Dated: 02 June 2026

Appendix 1 – Chronology of GMC involvement in Mr Eljamel's professional practice

Complaint number	Date	Interaction and key individuals (where relevant)	Outcome of decision (where relevant)	Exhibit
1	1 August 1986	Mr Eljamel is granted limited registration.	N/A	Registration documents Pages 1 to 6, Exhibit GMC-00030
2	20 February 1990	Mr Eljamel is granted full registration.	N/A	Registration documents - Pages 7 to 11, Exhibit GMC-00030
3	29 July 1991	GMC issues a Certificate of Good Standing at Mr Eljamel's request, in response to him indicating his intention to move and practise in Ireland.	N/A	Registration documents - Pages 16 to 18, Exhibit GMC-0030

4	12 January 1996	Mr Eljamel is granted specialist registration.	N/A	Registration documents -
				Pages 19 – 34, Exhibit GMC-0030
5	5 March 2001 (27 February 2001)*	Patient complaint regarding delay between biopsy and appointment with Mr Eljamel, and advice to have a biopsy. A second opinion later indicated the biopsy was unnecessary which may have contributed to the patient's symptoms.	Closed in March 2001 to be dealt with through local NHS complaint resolution procedures, including signposting for support from Tayside Health Council (a now-defunct local health council which supported patients with concerns or complaints).	Complaint document - Exhibit GMC-00033 Decision – Exhibit GMC-00034
6	16 November 2009	Mr Eljamel is granted a licence to practise.	N/A	Registration documents - Page 35, Exhibit GMC-0030

- * For completeness, we have included the date of any complaints letters where a complaint was sent to us by post in brackets, as the date on which the complaint was opened is slightly later than the date of the correspondence. This accounts for the time it took for such correspondence to be delivered, the complaint recorded, and the case opened on internal case management systems.

7	July 2012	National Training Survey* (NTS) report for 2011 - 2012 is published which includes information about training experiences at Ninewells Hospital. Results for handover and educational supervision were below the interquartile range (IQR), meaning the typical range of scores seen across comparable posts or programmes.	N/A	NTS results - Exhibit GMC-00031
8	2 October 2013 (16 September 2013)	Patient complaint relating to multiple GPs and consultants at NHS Tayside in respect of various treatment received. No specific complaint regarding Mr Eljamel, but patient believed he had some indirect involvement.	Closed in October 2013 at triage on basis that we could not identify any fitness to practise issues in respect of Mr Eljamel within the complaint.	Complaint document - Exhibit GMC-00035 Triage decision - Exhibit GMC-00036

- * Since 2005, the GMC has run the annual National Training Survey (NTS) to collect confidential feedback from trainee doctors and their trainers across the UK. The aim of the NTS is to assess and improve the quality of postgraduate UK medical education and training. We normally run the NTS each Spring, leaving the survey open for six weeks. Results are typically published each July.

9	July 2013	NTS report for 2012 – 2013 published. This did not flag any significant concerns at Ninewells Hospital.	N/A	NTS results - Exhibit GMC-00031
10	10 December 2013	Meeting between Willie Paxton, Employer Liaison Advisor (ELA) for Scotland at the time and Andrew Russell, Responsible Officer (RO) for NHS Tayside. As part of the discussions relating to local issues, Dr Russell noted that he had chaired a significant event analysis following wrong level surgery carried out by a neurosurgeon at NHS Tayside (although Mr Eljamel is not specifically named) and had commissioned the external Royal College of Surgeons review into his performance. He noted issues relating to probity regarding consent from patients upon whom he was carrying out corrective procedures. He also noted that the neurosurgeon's practice had been restricted and that he would be	N/A	Meeting notes - Exhibit GMC-00024

		suspended from this date*. Dr Russell indicated that he would make a fitness to practise referral via Mr Paxton that week.		
11	29 Janu ary 2014 (20 December 2013)	NHS Tayside complaint stating Mr Eljamel had been suspended following RCS external review. Enclosed a copy of the review report and documentation considered by the review team. Detailed that the team had considered 14 patient records, four of which included wrong level procedures. Concerns had also been raised about lack of transparency raising probity concerns and behavioural issues. NHS Tayside confirmed they were in the process of reviewing Dr Eljamel's spinal surgery cases, having identified 150 patients in the cohort who they	Promoted to full investigation after triage decision that this met GMC thresholds for further investigation. Case examiner (CE) advice was obtained which identified that a performance assessment[†] was not appropriate due to a number of the concerns appearing to relate to behavioural rather than clinical issues. Mr Eljamel made his first application for VE in March 2014, which was refused in	Complaint document - Exhibit GMC-00037 Triage decision to promote – Exhibit GMC-00038 ELA email dated 28 January 2014 and NHS Tayside letter dated 17 February 2014 –

* It should be noted that the ELA notes are dated 10 December 2013, but that the ELA erroneously noted that the surgeon would be suspended as of 'today (10Nov2013)'.

† A performance assessment is an assessment of the standard of a doctor's professional performance. It provides us with an independent opinion regarding their fitness to practise, by looking at a broad sample of their day-to-day work, where possible. The purpose of the assessment is not to investigate specific allegations.

		believed to be high risk, with a view to deciding whether or not there were further wrong level surgeries which were yet to be identified. Following the ELA meeting on 10 December 2013, our ELA confirmed by email on 28 January 2014 that following review of the further 150 cases, there were no further fitness to practise issues arising from this.	August 2014. Please see further detail below. An expert report was then sought in relation to a representative sample constituting eight patients' cases. This concluded aspects of care in relation to five patients fell seriously below the required standard, one fell below standard (although not seriously below), and there were no concerns in respect of the other two. Allegations were ultimately put to the doctor on the basis of the expert report. Mr Eljamel provided a formal response to the allegations. As part of this response he indicated an intention to make a second	Exhibit GMC-00039 Second VE application - Exhibit GMC-00040 Second VE CE decision – Exhibit GMC-00041
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			voluntary erasure application, which he applied for	
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			on 6 June 2015 and was granted on 4 August. The complaint was closed once the VE application was granted, as Mr Eljamel was no longer registered.	
12	6 February 2014 (5 February 2014)	Patient complaint alleging Mr Eljamel falsified notes and correct records to protect his reputation.	Promoted to full investigation after triage decision that this met GMC thresholds for further investigation. As part of our investigation we sought an independent expert's view. The expert concluded that the standard of care provided was of an acceptable level. On this basis, CEs decided to close with no further action on 4 August 2014.	Complaint document – Exhibit GMC-00042 Triage decision – Exhibit GMC-00043 Decision to close – Exhibit GMC-00044

13	7 February 2014	GMC refers Mr Eljamel to an Interim Orders Tribunal (IOT*) to consider whether an interim order was required to protect the public or otherwise in the interests of the public or doctor.	N/A	CE decision to refer – Exhibit GMC-00045
14	26 February 2014	IOT considers whether to restrict Mr Eljamel's registration on an interim basis pending the conclusion of the NHS Tayside referral being investigated.	Interim conditions imposed for 18-month period. These included requirements around notification of professional appointments (both domestic and overseas) and disciplinary proceedings, and information sharing with his employer. The order expressly restricted him from working privately and from carrying out spinal surgery.	IOT decision - Exhibit GMC-00046

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- * It should be noted that the documentation refers to an Interim Orders Panel, which was the predecessor of the IOT. These made the same decisions about the necessity of an interim order regarding a doctor's registration.

15	27 March 2014	Mr Eljamel makes first application for VE.	N/A	Application document - Exhibit GMC-00047
16	2 May 2014	Meeting between Willie Paxton, ELA for Scotland, and Andrew Russell, RO for NHS Tayside. Mr Paxton and Dr Russell discussed Mr Eljamel's open fitness to practise investigation, including the interim conditions that had been imposed for 18 months. They noted that Mr Eljamel had unsuccessfully applied for VE.	N/A	Meeting notes - Exhibit GMC-00025
17	13 June 2014 (6 June 2014)	Patient complaint made via patient's solicitors noting patient incapacitated following surgery performed by Mr Eljamel. Further information requested from solicitors initially this was not provided and as such the matter was closed on 22 July 2014 as there was insufficient information to make a decision. Further information was received from patient's solicitors on 23 July 2014 and again further information was sought to inform the GMC's decision. By way of letter dated 15	Closed at triage on 9 July 2014 as insufficient information to make a triage decision and patient confirmed they did not wish to take matters further.	Complaint document – Exhibit GMC-00048 Triage decision – Exhibit GMC-00049

18		September 2014 the patient confirmed they did not wish to take matters further.		
19	18 June 2014	GMC considers and refuses VE application.	N/A	CE decision - Exhibit GMC-00050
20	23 July 2014 (21 July 2014)	Patient complaint alleging worsening of symptoms following surgery carried out by Mr Eljamel.	Closed on 15 September 2014 at triage due to the allegations being more than five years old, and the five year rule not being waived in this instance. When considering the five-year rule, we determined that there were limited factors weighing in favour of waiver, but some significant factors against this*. The factors	Complaint document - Exhibit GMC-00051 Triage decision - GMC-00052

* At the relevant time, Rule 4(5) of the GMC (Fitness to Practise) Rules 2004 stated: 'No allegation shall proceed further if, at the time it is first made or first comes to the attention of the General Council, more than five years have elapsed since the most recent events giving rise to the allegation, unless the Registrar considers that it is in the public interest, in the exceptional circumstances of the case, for it to proceed'. This decision was made with regard to the following relevant factors: the extent of the lapse of time (beyond five years); the reason(s) for the lapse in time; the extent to which relevant evidence is no longer available due to the

lapse of time; the gravity of the allegation; the number of incidents alleged; the extent of any continuing unwarranted risk to the public and/or to public confidence in the medical profession

			against waiver included the gravity of the allegation (which was considered in the context of the spectrum of seriousness of the types of concerns the GMC may receive), the distance in time between the date of the allegation and the date the complaint came to our attention, and the extent of continuing unwarranted risk to the public / public confidence (bearing in mind the open fitness to practise investigation and the IOT order in place at the time restricting Mr Eljamel's practice).	
21	July 2014	NTS report for 2013 – 2014 is published. This did not flag any significant concerns at Ninewells. Overall satisfaction and workload scoring above the IQR.	N/A	NTS results - Exhibit GMC- 00031

posed by the practitioner; the extent to which the allegation has been ventilated before other public/adjudicatory bodies such as the police, the coroner, the criminal or civil courts, other regulatory bodies and the practitioner's employer; and whether the allegation

raises an important, new and/or developing point of practice, principle or law (as distinct from the gravity of the allegation itself) on which guidance from a Fitness to Practise Panel might be valuable.

22	19 August 2014	IOT reviews interim conditions.	Conditions are maintained.	IOT decision - Exhibit GMC- 00053
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23	1 October 2014	Meeting between Willie Paxton, ELA for Scotland, Andrew Russell, RO for NHS Tayside, and Alan Cook, Medical Director for NHS Tayside. Mr Eljamel's fitness to practise case was discussed, noting that the investigation remained ongoing and that an expert report had been sought. They noted that the interim conditions remained in force. They also noted that another complaint against Mr Eljamel had been closed following consideration by Case Examiners who decided that no further action was to be taken. Mr Paxton, Dr Russell and Dr Cook also touched upon the upcoming visit from the GMC Education team to carry out checks in relation to undermining / bullying. Dr Russell assured that he would raise any fitness to practise concerns with Mr Paxton.	N/A	Meeting notes - Exhibit GMC-00026
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24	30 October 2014	Education visit at Ninewells Hospital. This followed local intelligence and evidence from NHS England Scotland investigations, indicating the hospital was a site facing undermining / bullying issues. The GMC Education team met with senior management, trainees in General Surgery, clinical leads, consultants and the deanery team. The team required three changes to be made where standards were not being met, to ensure rotas provided sufficient cover to allow trainees to attend teaching sessions, that rotas had sufficient senior oversight, and that trainee doctors were able to record their working hours accurately. Two additional recommendations were made in line with best practice, in relation to facilitating general surgery specialty doctors to attend regional training, and exploring an endemic issue of bullying and undermining between Emergency Medicine staff and surgical trainee doctors.	N/A	Report - Exhibit GMC-00054
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25	13 November 2014	Patient complaint that Mr Eljamel did not inform them about the risks of having surgery, communicated poorly with them, and that the patient experienced poor outcomes and after-care. Also alleged that Mr Eljamel carried out unnecessary surgery.	Triage decision that the allegations raised met our thresholds for investigation. The decision noted that the allegations were very similar to those already under GMC investigation (and previously considered) suggesting that there was a pattern of behaviour. An expert report was obtained which concluded that the standard of care fell below but not seriously below the standard expected. In most instances, we can only take regulatory action where the standard of care is assessed to fall seriously below the standards expected. Closed by way of Case Examiner decision on 14 May 2015. In light of the expert's conclusions, the CEs determined it would not be possible	Complaint document - Exhibit GMC-00055 Triage decision - Exhibit GMC-00056 CE decision - Exhibit GMC-00057
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			to prove that Mr Eljamel's behaviour was sufficiently serious to	
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			warrant action being taken on his registration.	
26	20 January 2015	Mr Eljamel relinquishes licence to practise.	N/A	N/A
27	29 January 2015	IOT reviews interim conditions.	Conditions are maintained.	IOT decision - Exhibit GMC-00058
28	10 February 2015	Meeting between Willie Paxton, ELA for Scotland, Andrew Russell, RO at NHS Tayside, and Alan Cook, Medical Director at NHS Tayside. The Education visit was discussed, and Dr Russell and Dr Cook felt it was a constructive process. Mr Eljamel's open investigation was also discussed and it was noted that there were no updates. It was noted that the interim conditions remained in place.	N/A	Meeting notes - Exhibit GMC-00027

29	4 March 2015	Patient complaint that Mr Eljamel claimed to have successfully carried out major back surgery on the	Closed on 20 April 2015 at triage due to the allegations being more than five years old,	Complaint document - Exhibit GMC-00059
		patient, but that the patient discovered that no surgery had actually been performed.	and the five-year rule not being waived in this instance. When considering the five-year rule, we determined that there were limited factors weighing in favour of waiver, but some significant factors against this. The factors against waiver included the gravity of the allegation and the extent of continuing unwarranted risk to the public / public confidence (recognising that the interim conditions were likely to be sufficient to protect the public).	Triage decision - Exhibit GMC-00060

30	31 March 2015 (25 March 2015)	Patient complaint that Mr Eljamel made a mistake during surgery that left the patient disabled. The patient also raised issues in relation to aftercare.	Closed on 21 May 2015 at triage due to lack of information. We were unable to identify the practitioner to whom the concerns related.	Complaint document – Exhibit GMC-00061 Triage d sion – Exhibit GMC-00062
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31	1 April 2015 (31 March 2015)	Patient complaint that Mr Eljamel claimed to have performed a surgery which it was later confirmed had not happened.	Closed on 11 June 2015 at triage due to the allegations being more than five years old, and the five-year rule not being waived in this instance. When considering the five-year rule, we determined that there were limited factors weighing in favour of waiver, but some significant factors against this. The factors against waiver included the gravity of the allegation, and the extent of continuing unwarranted risk to the public / public confidence (recognising that the interim conditions were likely to be sufficient to protect the public).	Complaint Exhibit document - GMC- sion - 0063 GMC- Triage d Exhibit 00064
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	29 April 2015	Patient complaint regarding an operation performed on her spine. Patient alleged Mr Eljamel did not discuss various treatment options with her prior to the surgery. The operation was unsuccessful, and it	Closed on 5 June 2015 at triage due to the allegations being more than five years old, and the five-year rule not being waived in this instance.	Complaint document - Exhibit GMC-00065
32		was alleged following this Mr Eljamel was dismissive of the patient's concerns.	When considering the five-year rule, we determined that there were limited factors weighing in favour of waiver, but some significant factors against this. The factors against waiver included the gravity of the allegation, the lapse of time between the date of the allegation and the complaint being made, and the extent of continuing unwarranted risk to the public / public confidence (recognising that the interim conditions were likely to be sufficient to protect the public).	Triage decision - Exhibit GMC-00066

	8 May 2015 (23 April 2015)	During the course of investigating the NHS Tayside referral, we receive information from BMI Fernbrae regarding a further complaint. As this was received at a late stage in the investigation, this was referred internally for a separate triage decision. BMI Fernbrae Hospital provided information relating to a patient who Mr Eljamel carried out an L4/5 decompression operation on in April 2013. The information indicated that Mr Eljamel carried out the	Matter was promoted for investigation but subsequently closed following Mr Eljamel's second VE application being granted.	Complaint document (including internal referral from Investigations team to Triage team) - Exhibit GMC-00067
		operation at the incorrect level (L3/4). The patient subsequently had further surgery at the correct level which provided significant benefit.		Triage decision – Exhibit GMC-00068 Second VE CE decision - Exhibit GMC-00041

33	4 June 2015	The GMC sends routine follow-up correspondence while investigating the NHS Tayside referral, seeking confirmation from Mr Eljamel about his previous indication of intent to seek VE.	N/A	Correspondence - Exhibit GMC-00069
34	9 June 2015	Mr Eljamel makes second application for VE.	N/A	Exhibit GMC-00040
35	2 July 2015	Interim order is reviewed and conditions maintained.	N/A	Exhibit GMC-00070
36	3 July 2015	Meeting between Willie Paxton, ELA for Scotland, and Andrew Russell, RO for NHS Tayside. Issues regarding timeliness of responses to GMC enquiries relating to Mr Eljamel's fitness to practise investigation were discussed, including it being	N/A	Exhibit GMC-00028

		noted that investigation officers were experiencing significant delays in receiving responses to simple requests from Mr Eljamel and that this was impacting investigation processes. It was noted that NHS Tayside had limited capacity in respect of GMC investigation requests, for example for documentation. Mr Paxton touched upon an ongoing national discussion about how the GMC could better support ROs with information collation, and Dr Russell agreed that this would be helpful. Mr Eljamel's fitness to practise investigation was discussed and it was noted that there were no further updates. The interim conditions remained in place.		
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37	28 July 2015 (27 July 2015)	Patient complaint that Mr Eljamel operated at the wrong lumbar level, and that they had poor surgical outcomes. Also made an allegation about his postsurgery communication.	Closed on 11 August 2015 at triage following second VE application being granted as Mr Eljamel was no longer registered.	Complaint - Exhibit GMC-00071 Triage decision - Exhibit GMC-00072
38	July 2015	NTS report for 2014 – 2015 is published. This indicated that handover scores were below the IQR. All other areas were within the IQR.		NTS results - Exhibit GMC-00031
39	10 August 2015	GMC approves second VE application and Mr Eljamel is erased from the medical register.		Second VE CE decision - Exhibit GMC-00041

40	8 December 2015	Meeting between Willie Paxton, ELA for Scotland, and Andrew Russell, RO for NHS Tayside. Mr Eljamel's fitness to practise investigation was discussed and it was noted that this had been closed on 13 August 2015, following Mr Eljamel successfully seeking VE.		Meeting notes - Exhibit GMC-00029
41	2 November 2017	Education monitoring visit to NHS Tayside as part of the GMC's national review of undergraduate and postgraduate medical education and training in Scotland. NHS Tayside was selected through a riskbased process and its undergraduate, Foundation programme, core medical training, general surgery and paediatrics programmes were reviewed. A		Education monitoring report - Exhibit GMC-00073
		number of areas of good practice were identified, including good clinical supervision and supportive cultures in particular areas. Additional recommendations were made to bolster training practices in particular parts of the hospital.		

42	28 August 2020 (27 August 2020)	Patient complaint indicating that Mr Eljamel claimed to have operated on him and it later transpired that no operation had taken place. The patient also stated we should share concerns with the Health and Safety Executive in line with an agreed Memorandum of Understanding.	Closed at triage on 22 September 2020 as Mr Eljamel was no longer registered.	Complaint - Exhibit GMC-00074 Triage decision - Exhibit GMC-00075
43	11 May 2023	GMC writes to Libyan regulator to notify them of Mr Eljamel's fitness to practise history – including his interim conditions and successful VE	N/A	Letter to Libyan regulator - Exhibit GMC-00076
44	16 June 2023	Member of public complaint sharing details of a news report relating to Mr Eljamel practising in Libya.	Closed at triage on 30 June 2023 as Mr Eljamel was no longer registered.	Complaint document - Exhibit GMC-00077
				Triage decision - Exhibit GMC-00078

45	19 July 2023	Patient complaint alleging that, following surgery by Mr Eljamel, the patient became deaf, and developed tinnitus and balance issues (although unclear if these developed as a result of the surgery or not).	Closed at triage on 22 July 2023 as Mr Eljamel was no longer registered.	Complaint document – Exhibit GMC-00079 Triage decision - Exhibit GMC-00080
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