

Table 2. Patient Journeys

	Operation date	Issue	1st event	2nd Event	3rd event	4th event	5th event	6th event	7th event	Apology	Notes
pt A	24/01/2007	Wrong site	Complaint (10/6/2014)	Complaint response (24/06/2014)	Legal Action (06/03/2017)	Legal action settled (2020/2021)				No record	No formal review of case found
pt C	18/07/2011	Wrong site	Complaint (05/12/2012)	DATIX (04/01/2013)	SCEA meeting (12/03/13)	Complaint response (20/03/2013)	SCEA complete (13/05/2013)	Legal claim initiated (06/08/2013)	Legal action settled (2014/2015)	Yes (20/03/2013)	
pt D	28/07/2011	Wrong site	Complaint (25/9/2013)	DATIX (26/09/2013)	Complaint response (24/01/2014)	Legal Action (11/7/2014)	Legal action settled (2016/2017))			Yes (24/01/2014)	No formal review of case found
pt E	29/04/2013	Wrong site	DATIX (12/07/2013)	LIR (12/8/2013)	SCEA commissioned Aug 2013	SCEA meeting (3/3/2014)	SCEA report (02/06/2014)			Unsure	No complaint/legal action
pt F	29/07/2013	Intraoperative complication	DATIX (09/08/2013)	Complaint (03/03/2014)	Complaint response (11/06/2014)	Legal action (24/04/2015)	Legal action settled (2017/2018)			Yes (11/05/2014)	No formal review of case found
pt B	08/08/2013	Failure to remove tumour	Complaint (24/04/2014)	Complaint response (22/04/2014)	Legal action (04/02/2015)	Legal action settled (2016/2017)				Yes (22/04/2014)	No formal review of case found

Patient A

Patient A had a transthoracic discectomy at the level of T5/6 on 24/01/2007. They were kept under review following surgery until September 2007. In this time there were reviews of the patient's care by multiple Consultants. The patient complained on 10th June 2014 and this was responded to on 24th June 2014. This followed a re-examination of his case by the Clinical Lead of Neurosurgery as part of a review of 150 high risk cases. There have been numerous contacts with the complaints team and a legal claim was raised by the individual on 6th March 2017 which was settled in 2020/21. There is no documented evidence of a formal investigation conducted under the adverse events policy and no evidence of an apology from NHS Tayside at the time that the complaint was received. Subsequently, patient A has received an apology from the Chief Executive and the Chair of NHS Tayside in 2022 and a subsequent detailed review of their surgical procedure by the Executive Medical Director which they received in March 2023.

Patient C

The first Significant Clinical Event Analysis (SCEA) relating to Professor Eljamel's practice referred to an operation performed on patient C, themselves a medical practitioner. Surgery to decompress a spinal stenosis at the level of L4/5 was performed on 18th July 2011. The patient and patient C's GP made several enquiries to clarify what surgical procedure was performed. Eventually a repeat scan indicated that Professor Eljamel had performed surgery at the level of L3. On review of the scans it became apparent that patient C had an extra lumbar vertebra. This was not reported by radiologist on initial scan and led to miscounting during surgery and, as a consequence, surgery was performed on the wrong lumbar vertebra. Patient C complained on 5th December 2012. The views of patient C were included in the SCEA that followed their complaint. The SCEA review was held on 12th March 2013, an apology was provided on 20th

March 2013 and the final SCEA report was issued on 13th May 2013, 6 months after the complaint. A legal claim was initiated on 6th August 2013 and settled in 2014/15. The Medical Director contacted the patient on 20th June 2013 regarding the outcomes of the SCEA, and their intention to conduct a more thorough review (this refers to the RCS Invited Review).

Patient D

Professor Eljamel supervised a neurosurgical trainee performing a discectomy on Patient D on 28th July 2011 following a referral from the pain clinic. The consultant who made the referral subsequently arranged a repeat scan due to ongoing symptoms and this suggested that the surgery had been performed at the wrong level. This was brought to the attention of the then Clinical Lead, who reviewed the patient and raised his concern with the General Manager and Clinical Director of their specialty. The patient registered their complaint on 25th September 2013, the same day as the review by the Clinical Lead. The issue was logged as an incident on 26th September 2013. Following this, a clinical review was performed of the patient's care by another neurosurgical consultant, but there is no evidence of a formal adverse event review which should have been triggered in line with the Adverse Events policy. Patient D commenced legal proceedings on 11th July 2014 and the case was settled in 2016/17.

Patient E

Patient E was operated on by Professor Eljamel for an intramedullary lesion on 29th April 2013. X-ray marking was used to guide the level of surgery and a radiological procedure was undertaken during the procedure. However, the spinal tumour was not successfully removed because surgery was performed at the wrong level. This was logged as a “never event” on 12th July 2013 and the SCEA was commissioned following a local incident review that took place on 12th August 2013. The SCEA took place some 7 months later on 3rd March 2014. The report from the SCEA was finalised on 2nd June 2014, 14 months after initial surgery and 11 months after the issue was logged as a “never event”. It is mentioned in the SCEA report that patient E had communicated his concerns but this has not been formally logged as a complaint at any time.

Patient F

Patient F was operated on by Professor Eljamel on 29th July 2013 and during the operation the tip of a surgical instrument broke off in the T7/8 disc space. This was recognised but a fingertip search using a microscope and an X-ray during the operation were unable to locate it. This was recorded as a minor incident on the Datix system on 9th August 2013. There is no record of a formal review of this complication. Patient F complained on 3rd March 2014 and received an apology from the General Manager on 11th June 2014. There is no record of communication with patient F until after the complaint. A legal claim commenced on 24th April 2015 and was settled in 2017/18.

Patient B

Patient B was operated on by Professor Eljamel on 8th August 2013 for “excision of a right orbital lesion ?meningioma”. Patient reports that Professor Eljamel advised them that 99% of the tumour had been removed. Histology reports in August 2013 and September 2013 showed that the tissue removed was a Lacrimal gland. Patient B was advised in October 2013 that there