Witness Name: Karen Titchener
Statement No: PSC-00001
Dated: 13.07.2026

ELJAMEL INQUIRY WRITTEN STATEMENT OF KAREN TITCHENER

I, Karen Titchener, will state as follows:-

Part A - Your roles, qualifications and background

1. Please set out your roles and qualifications.

1.1 I am the Patient Safety Commissioner for Scotland. I commenced in the full time post on 1 September 2025. I am a Registered General Nurse and Advanced Nurse Practitioner but do not currently work as a nurse. I have provided a copy of my Curriculum Vitae (CV) [PSC-00004].

2. Please explain your professional/ occupational background, in particular focussing on roles and the responsibilities which you hold or have held which are relevant to matters covered in the Inquiry's Terms of Reference. If you wish, you may exhibit a CV with your statement.

2.1 I have 40 years' experience working within healthcare systems in the United Kingdom and internationally.

2.2 My professional background has focused on the development, implementation and operational management of complex care services, particularly Hospital at Home models, which provide acute and specialist care to patients in their own homes as an alternative to hospital admission.

2.3 I have held senior leadership roles responsible for the design, delivery and governance of these services. This has included responsibility for:

- Clinical service development and implementation;
- Patient safety and quality assurance;
- Operational management of multidisciplinary teams;
- Oversight of patient pathways and care delivery models; and
- Monitoring outcomes and driving service improvement

2.4 I held senior roles within NHS services and international healthcare organisations, where I led large-scale Hospital at Home programmes. One such programme in London involved managing a service with over 85 staff and approximately 3,000 patient admissions annually.

2.5 My work has consistently involved ensuring that care is delivered safely outside traditional hospital settings, including identifying and mitigating risks, developing protocols, and improving patient outcomes.

2.6 I have also contributed to the wider healthcare system through research, publication, and professional collaboration. This includes peer-reviewed publications and involvement in professional organisations such as the UK Hospital at Home Society.

2.7 While my professional experience is centred on service delivery, patient safety, and system improvement, my involvement in matters relating to Mr Eljamel has been very limited to date as explained later in this document.

Part B - The role of the Patient Safety Commissioner for Scotland

3. Please explain the role of the Patient Safety Commissioner for Scotland, including but not limited to:

(a) The statutory basis and remit of the role, including its aims and objectives;
(b) The background to and reason for the role coming into existence;
(c) The process by which you came to occupy the role;
(d) The responsibilities and powers associated with the role;
(e) How the role is funded and operationally supported;

(f) To whom you report or are answerable in your roles as Patient Safety Commissioner for Scotland; and
(g) The operational systems which have been allocated to you or adopted by you in the role to seek to promote your aims and objectives.

(a) The statutory basis and remit of the role, including its aims and objectives;

3.1 The role of the Patient Safety Commissioner for Scotland (“the Commissioner”) is established by the Patient Safety Commissioner Act 2023 (“the PSC Act 2023”).

3.2 The Commissioner is an independent Parliamentary office holder, whose primary aim is to promote and improve patient safety across healthcare in Scotland and ensure that the views of patients and the public are central to this work. Patient safety, as established by the *Patient Safety Commissioner for Scotland Act 2023 (the Act)*, is grounded in the concept of health care which is defined as the prevention, diagnosis or treatment of illness, and extended to include forensic medical examinations. The Act does not define "patient safety" as a standalone term, and I believe that is intentional as it allows the role to respond to where safety risk presents itself, rather than being confined by a rigid definition.

3.3 In practice, I understand patient safety to mean protecting patients from avoidable harm arising from, or because of, the systems and processes through which health care is delivered. That is wider than clinical error alone. It includes how care is organised, how risk is identified and communicated, how institutions review adverse events and learn when things go wrong and critically, whether that learning translates into genuine change in practice, rather than remaining a paper exercise. It also encompasses whether the structures that surround care governance, oversight, workforce, and environment are truly fit to keep patients safe.

3.4 On the specific question of care, experience and satisfaction, I would draw a practical distinction:

3.5 **Patient care** being the clinical and organisational quality of what is delivered which falls within my remit where it carries safety implications. A system that routinely fails to assess a patient's risk before a clinical decision is made is a patient safety issue, not simply a care quality concern.

3.6 **Patient experience** is directly relevant to my remit where it signals underlying safety risk. When patients consistently report not being listened to, not being informed of risks, or

feeling unable to raise concerns, that is not merely a satisfaction issue it is evidence of a system that may not be safe. The Act explicitly requires me to promote the importance of the patient voice in relation to safety, which means experience is a legitimate and important source of evidence for my work.

3.7 **Patient satisfaction** in the narrower sense, for example, whether someone found a ward comfortable or a clinician approachable sits outside my primary focus. My statutory purpose is systemic safety improvement.

3.8 The remit of the role covers all healthcare providers in Scotland including NHS bodies, NHS- contracted providers such as GPs, dentists, and independent/private providers. The role applies to all aspects of healthcare safety.

The aims and objectives of the role are:

- To improve patient safety system-wide;
- Promote the importance of the patient and public views in safety matters;
- Identify patterns and systemic risks across healthcare; and
- Ensure better coordination of responses to safety concerns

b) The background to and reason for the role coming into existence;

3.9 The role was created in response to the Independent Medicines and Medical Devices Safety Review (Cumberlege Review, 2020) [PSC-00007]. That review found:

- Patients' concerns were often ignored or dismissed; and
- This led to avoidable harm and systemic failures

3.10 Scotland committed by way of the Programme for Government 2020 [PSC-00010] to establishing a national patient advocate**.** Therefore, the role was created to strengthen the patient voice and provide independent scrutiny of safety addressing system-wide failures rather than isolated incidences.

c) The process by which you came to occupy the role;

3.11 The position was advertised for the third time in February 2025. I applied for the position and was interviewed on 24 March 2025. I was nominated by the Scottish Parliament on 9 May 2025.

3.12 The role is formally appointed by His Majesty, the King. It is an eight-year fixed term independent of the Scottish Government and NHS Scotland.

d) The responsibilities and powers associated with the role;

3.13 The Commissioner's responsibilities include:

- Promoting patient safety across the healthcare system;
- Amplifying the views and experiences of patients and the public; and
- Identifying systemic patient safety concerns

3.14 The Commissioner has powers to:

- Initiate investigations into patient safety concerns;
- Require information from healthcare providers and individuals;
- Publish reports on findings;
- Make recommendations for improvement; and
- Require organisations to respond to recommendations**.** The powers the Commissioner has to achieve this is outlined in the Act which states at sections 10 and 11:

10 Investigation report

(1) Having concluded a formal investigation under section 8 section 8, the Commissioner must—

(a) prepare a report on the investigation, and

(b) lay a copy of it before the Scottish Parliament.

(2) The report must state -

(a) the Commissioner's findings in relation to the issue investigated and the reasons for them, and

(b) the Commissioner's recommendations in light of those findings.

(3) The Commissioner must give a copy of the report to any person to whom a recommendation in the report is addressed.

(4) The Commissioner may address a recommendation to a person in a report on a formal investigation whether or not—

(a)the person was identified in the investigation's terms of reference as a person to whom the Commissioner expected to address a recommendation,

(b)the Commissioner took steps to bring the investigation's terms of reference to the person's attention in accordance with section 8(2)(b).

11 Requirement to respond to report

(1) A person is subject to a requirement to respond to a recommendation in a report under section 10 if—

(a) the report states—

(i) that the recommendation is addressed to the person, and

(ii) the period within which the person's response to the recommendation is required, and

(b) the Commissioner gives the person a copy of the report.

(2) A person complies with a requirement to respond to a recommendation by giving the Commissioner a written response to it before the end of the period within which the report states that the person's response is required.

(3) A written response to a recommendation is a document setting out—

(a) what the person responding has done, or proposes to do, to give effect to the recommendation, and

(b) if the person does not intend to do anything to give effect to the recommendation (wholly or partly), the person's reasons for that.

(4) The Commissioner may, in whatever manner the Commissioner considers appropriate—

(a) make publicly available (in full or in part) a person's written response to a recommendation,

(b) publicise a person's failure to comply with a requirement to respond to a recommendation.

3.15 The role is focused on system-level learning and prevention of future harm, rather than resolution of individual cases.

e) How the role is funded and operationally supported;

3.16. The Office of the Patient Safety Commissioner ("the Office") is funded through public funds via the Scottish Parliament as a Parliamentary officeholder. It's annual budget of 2027-2028 is £532,527. This will support a small team of investigators and our corporate services (Executive Director of Investigations, a Policy and Investigative Manager and, a Corporate Services and Operations Manager). We have now filled all these positions as of 1 July 2026.

3.17 The Office is supported by an advisory group made up of 50% professionals and 50% patients/public. These members are selected by me and then approved by the Scottish Parliamentary Corporate Body (SPCB). There are currently six members of the advisory group. We had our first meeting of this group on 16 March 2026.

f) To whom you report or are answerable in your roles as Patient Safety Commissioner for Scotland;

3.18 I am accountable to the Scottish Parliament, and I am required to submit annual reports to the Scottish Parliament and produce a strategic plan.

3.19 The role is independent of both the Scottish Government and NHS Scotland, ensuring impartiality in carrying out its function. The importance of independence is not simply a personal preference it is a founding principle written into the architecture of the legislation itself.

3.20 The Patient Safety Commissioner for Scotland is established by the Act as a public office providing scrutiny of care that is independent of both government and the health service. That dual independence from the Scottish Government and from NHS bodies is deliberate and essential. It means that when the Commissioner investigates a systemic safety concern, gathers information, or makes recommendations, those actions cannot be directed, withheld, or shaped by the very organisations whose practices may be under scrutiny.

3.21 Responses to the public consultation that preceded the Act strongly supported an independent role with powers backed by legislation. The reason is straightforward: without independence from government or the NHS there may be an issue with gaining the trust of patients and the public as someone who could influence change in the right direction [PSC-00007].

3.22 The need for independence also flows directly from the role's origin. The Cumberlege Review found that patients had repeatedly raised legitimate safety concerns that were not heard or acted upon by the organisations responsible for their care. An office that sits within, or is answerable to, those same organisations cannot credibly fulfil the function of amplifying patient voices and holding systems to account. Independence is the condition that makes the role trustworthy to the public it serves.

3.23 The Act builds independence into the role through several distinct structural provisions:

1. Parliamentary appointment and accountability. The Patient Safety Commissioner is a parliamentary commissioner, appointed by His Majesty the King on the nomination of the Parliament and accountable to the Parliament. The Commissioner does not report to Scottish Ministers. Accountability runs to Parliament, not to the executive.
2. No general obligation to comply with directions. The Commissioner is not an agent of the Crown and there is no general obligation to comply with directions. The Commissioner is therefore independent and is not subject to the general control of the Parliament, the Government, or the Scottish Parliamentary Corporate Body. The SPCB has only those specific administrative functions explicitly set out in the Act. It cannot direct the Commissioner's substantive work.
3. Protection against conflicts of interest in appointment. The SPCB may determine the terms and conditions of the Commissioner's appointment, including prohibiting the Commissioner from holding any other office, employment or appointment — or requiring that the Commissioner first obtain the approval of the SPCB before holding any other office, employment or appointment. This is to avoid an appointment being seen to compromise the independence of the Commissioner.
4. Post-tenure restrictions. The Act also places restrictions on what a former Commissioner may do after leaving office, preventing them from taking up employment with organisations that have been investigated again, a structural protection against the perception or reality of compromised independence.
5. Defamation protection. Section 18 of the Act provides the Commissioner with protection from actions of defamation in connection with the exercise of functions. This means the Commissioner can publish findings, name organisations, and report publicly on systemic failures without the chilling effect of litigation risk, a practical safeguard for operational independence.
6. Financial independence. The Commissioner's budget is provided through the SPCB rather than through a government department, separating funding from ministerial control. The accounts are audited by the Auditor General for Scotland.
7. Own-initiative powers**.** The Commissioner can initiate a formal investigation, gather information, and publish recommendations without requiring the consent or agreement of any government minister or NHS body. The decision to investigate is entirely the Commissioner's own.

3.24 Taken together, these provisions mean that independence is not simply a matter of culture or intention it is a set of structural protections that the Scottish Parliament deliberately built into the Act. That architecture reflects the clear view of Parliament, expressed through the legislation itself, that effective patient safety oversight requires an officeholder who is,

and is seen to be, free from the control of the organisations and systems they are there to scrutinise.

g) The operational systems which have been allocated to you or adopted by you in the role to seek to promote your aims and objectives.

3.25 As directed by the PSC Act 2023 we have produced Key Principles for the Patient Safety Commissioner Scotland Office and a Patient Safety Charter [PSC-00005 and PSC-00006]. These were discussed at the first advisory group and were approved by the Scottish Parliament Corporate Body on 24th April 2026.

3.26 In carrying out the role, I have adopted a number of approaches to promote patient safety, including:

- Engagement with patients, families and carers to understand their experiences;
- Identification of themes and patterns in patient safety concerns;
- Engagement with stakeholders across the healthcare system; and
- Development of priorities and areas for review

3.27 These approaches are designed to support the identification of systemic issues and to promote learning and improvement across the healthcare system. The Act does not require me to wait for a pattern to be formally established before I can act. My functions include gathering and analysing information, publishing reports, and initiating formal investigations and I can exercise all of those on my own initiative. Individual patient experiences are not simply anecdote. They are data. When a patient tells me that their concerns were not listened to, that a risk was not communicated to them, or that something went wrong and no one explained why, that is a signal. When I hear the same signal repeatedly across different patients, different settings, different NHS boards it becomes a pattern. And patterns of that kind are exactly what my role exists to investigate and act upon.

3.28 The Act requires me to promote the importance of patient and public voices in relation to safety. That is not a passive function. It means actively seeking out experiences including from those whose voices are least likely to reach formal complaint systems: people in rural communities, those with mental health conditions, those who feel they will not be believed, or those who simply do not know where to turn.

3.29 I work alongside Healthcare Improvement Scotland, the Scottish Public Services Ombudsman, NHS boards, and others. Where their work surfaces concerns that may have a

systemic dimension, that informs my own assessment. Equally, where I identify a concern that falls within another body's remit, I refer it accordingly. The role is designed to sit across the system not to duplicate what others do, but to identify what falls through the gaps between them.

3.30 The threshold I apply is whether what I am hearing reflects a failure of systems, processes, governance, or culture rather than an isolated individual incident. A single adverse event may be a tragedy. The same type of event recurring across different settings, or a review process that consistently fails to identify root causes or change practice, is a systemic failure. That is where my remit begins.

3.31 I would add one further point. The patients who contact me do not always frame their experience in systemic terms they are describing what happened to them, and that is entirely right. Part of my role is to hold their individual account with care and respect, while also asking the wider question it raises. Those two things are not in tension. The individual experience is often the most powerful evidence that a system has failed, and it is my responsibility to make that connection visible.

3.32 The Office now has a dedicated website which provides public access to key information, including the Commissioner’s principles and routes for engagement with the Office. The Office also accepts enquiries via email. In addition to this, I am on LinkedIn and we hold sessions via local advocacy groups in communities which gives individuals the opportunity to speak to me in person.

3.33 I am currently developing the Office’s operating framework, including approaches to data collection, analysis and the conduct of investigations in accordance with the Commissioner’s statutory powers.

3.34 In addition, I am progressing collaborative working arrangements with relevant organisations, including regulators, NHS bodies, ombudsman services and other oversight bodies such as Healthcare Improvement Scotland and the Scottish Government.

4. In particular, with regard to matters covered in the Inquiry’s Terms of Reference:

> **(a) what role does the Patient Safety Commissioner for Scotland have with regard to the promotion of patient safety within the following bodies; and**
> **(b) what overlap in responsibilities is there between the relative responsibilities of the**

the Patient Safety Commissioner for Scotland and the following bodies:

1) Health boards in Scotland;
2) Healthcare Improvement Scotland;
3) NHS Education for Scotland;
4) Regulatory bodies such as the General Medical Council;
5) Private providers of hospital medical care;
6) Royal Colleges, such as the Royal College of Surgeons or the Royal College of Surgeons of Edinburgh;
7) The Health and Safety Executive;
8) Universities; and
9) The Scottish Government.

4.1 The Patient Safety Commissioner for Scotland is established under the Patient Safety Commissioner for Scotland Act 2023**.** The role is to advocate for systemic improvement in the safety of health care in Scotland and to promote the importance of views of patients and other members of the public in relation to the safety of health care. The role is therefore distinct from that of providers, regulators, educators and government: it is primarily a system-facing, independent, patient-focused role concerned with identifying safety issues, promoting learning and making recommendations, rather than delivering services, employing staff, regulating professions or setting government policy.

4.2 In relation to each of the bodies listed below, my role is not to direct or manage their operations. Rather, it is to consider, from the perspective of patient safety and the patient voice, whether issues arise within or across those systems, and where appropriate to highlight concerns, engage with relevant organisations and promote improvement. Any overlap is therefore generally at the level of patient safety interest and system learning**,** rather than duplication of operational, statutory or regulatory functions.

1) Health Boards in Scotland

4.3 Health Boards are responsible for the delivery, governance and quality of NHS services in their areas. My role does not overlap with their operational responsibility for providing care, employing staff, managing complaints or running clinical governance systems. The overlap lies in a shared concern with patient safety: Health Boards are responsible for delivering safe care, while my role is to promote systemic improvement and ensure that patient perspectives are heard and reflected in learning and recommendations. Scottish

Government guidance on clinical and care governance makes clear that local governance arrangements sit with NHS bodies, not with the Commissioner [PSC-00009].

2) Healthcare Improvement Scotland

4.4 Healthcare Improvement Scotland has an established role in quality improvement. It also regulates independent healthcare services in Scotland through inspection arrangements. My role does not duplicate HIS's inspection, improvement-support or regulatory functions. The overlap is that both roles are concerned with safer care and improvement; however, my role is independent and patient-centred, with a particular emphasis on identifying systemic issues and amplifying patient voices across the healthcare system.

3) NHS Education for Scotland (now Public Services Delivery Scotland)

4.5 NHS Education for Scotland's role is educational and developmental: it supports education, training and workforce development within NHS Scotland. My role does not extend to designing curricula, approving training programmes or managing workforce education. The overlap is limited to the fact that education, culture and training are all relevant to patient safety. Where patient experience suggests that training, supervision or safety culture are relevant systemic issues, those may be matters I would highlight, but responsibility for education itself rests elsewhere.

4) Regulatory bodies such as the General Medical Council

4.6 Bodies such as the GMC regulate individual professionals, set standards, oversee education and training, maintain registers and investigate serious concerns about fitness to practise. My role does not overlap with those regulatory and disciplinary powers. The overlap lies only in the broad objective of protecting patients and promoting safe care. If patient safety issues emerge which are relevant to professional standards or regulation, those may be matters on which I engage or comment at a systemic level, but I do not determine individual fitness to practise or impose sanctions.

5) Private providers of hospital medical care

4.7 Private providers are responsible for the safety and governance of the care they provide. The Commissioner's remit extends across healthcare in Scotland, including non-NHS provision, but my role is not to manage or regulate those providers. The overlap is therefore again at the level of patient safety and system learning. Where patient concerns arise in relation to independent or private provision, those may fall within my wider remit to identify

and promote improvements in patient safety, while operational and regulatory responsibility remains with the provider and the relevant regulators.

6) Royal Colleges, such as the Royal College of Surgeons or the Royal College of Surgeons of Edinburgh

4.8 Royal Colleges are professional bodies concerned with standards, education, training, examinations and professional leadership. My role does not overlap with their professional or educational functions. The overlap is indirect: both the Commissioner and the Royal Colleges have an interest in safe practice and high standards, but they approach that from different positions. My role is independent and patient-safety focused; theirs is professional and educational.

7) The Health and Safety Executive

4.9 HSE is the national independent regulator for workplace health and safety, including in publicly and privately owned health and social care settings in Great Britain. Health and safety is a reserved matter and HSE's jurisdiction extends to Scotland. HSE explains that, where other regulators have patient or service-user safety within their remit and powers to secure improvement or justice, it will not generally investigate; its focus is on workplace and non-clinical risks. In Scotland, there is an additional distinction: where HSE does investigate and identifies potential offences, it reports to the Crown Office and Procurator Fiscal Service, which decides whether to institute criminal proceedings, HSE does not prosecute directly in Scotland. My role does not overlap with HSE's enforcement powers. The overlap is limited to a shared concern with safe systems, but our remits are materially different [PSC-00008].

8) Universities

4.10 Universities are relevant insofar as they contribute to education, research and, in some contexts, clinical training. My role does not overlap with their academic governance, employment, teaching or research governance functions. Any overlap would be indirect and arise only where matters relating to education, training, research culture or patient safety learning come into focus as wider systemic issues.

9) The Scottish Government

4.11 The Scottish Government is responsible for health policy, legislation, national frameworks and the overall structure and funding context within which NHS Scotland operates. The Commissioner is independent of the Scottish Government. My role does not

overlap with the Scottish Government's policy-making or executive functions, although there may be interaction where I make recommendations, raise systemic concerns or identify areas in which policy, guidance or national frameworks may require further consideration in the interests of patient safety. The Scottish Government does not direct or guide the role of patient safety commissioner and cannot advise the commissioner on areas they think they role should focus on. Although I may have discussions with them around concerns if I wanted anything to change, I would direct that to the Cabinet Secretary for Health.

4.12 In summary, the principal distinction is that the Patient Safety Commissioner for Scotland is not a provider, employer, inspector, educator, professional regulator or government department. The Commissioner's role is to bring an independent, patient-centred focus to patient safety across the system, to identify themes and risks, and to promote improvement. Any overlap with the bodies listed above is therefore limited and complementary, rather than constituting duplication of their statutory or operational responsibilities.

5. The Inquiry understands that there were difficulties and some delay in finding an individual who was suitably qualified or willing to undertake the role of Patient Safety Commissioner for Scotland. Please set out your understanding of the reasons for this, with particular reference to how similar roles were constituted and filled in the rest of the United Kingdom.

5.1 I was not directly involved in the earlier stages of the recruitment process for the Patient Safety Commissioner for Scotland and therefore do not have detailed knowledge of the specific reasons for any delay. This was lead through the Presiding Officer.

5.2 However, my understanding is that the role is both new and unique within the Scottish context and requires a combination of skills and experience which may limit the pool of suitable candidates. I would direct the Inquiry to the Scottish Parliament if they need to understand how (if at all) the patient voice on systemic matters would have been advocated prior to my appointment.

5.3 The position requires:

- Significant experience in healthcare systems;
- An understanding of patient safety and clinical governance;
- The ability to operate independently at a national level; and
- Credibility with patients, professionals and organisations across the system.

5.4 In addition, as an independent Parliamentary appointment, the recruitment process is necessarily formal and rigorous, which may also contribute to the time required to complete the appointment.

5.5 I understand that similar roles elsewhere in the United Kingdom, such as the Patient Safety Commissioner for England, have also required individuals with a comparable breadth of experience and independence, and that these roles are relatively new and still evolving.

a) As a formal requirement

5.6 The Act does not impose a statutory duty to liaise with the Patient Safety Commissioner for England. The legislation's collaborative expectation is framed in general terms and the counterpart role is not specifically named.

(b) In practice

5.7 In practice the relationship is active and I consider it important. I made contact with Dr Henrietta Hughes OBE, the Patient Safety Commissioner for England, before I took up my appointment, and again on taking up the post. I sit on her advisory group and we meet regularly, with the aim of quarterly meetings going forward.

5.8 Many of the patient safety concerns that reach my office particularly those relating to medicines and medical devices have counterparts in England, and the Cumberlege Review that gave rise to both roles was itself a response to harms experienced across the UK. Where a safety issue requires action by a UK-wide body such as the MHRA, a strong working relationship is the mechanism through which we can identify such issues and coordinate an effective response. The absence of a statutory requirement does not diminish the importance of this liaison; it places the responsibility on both officeholders to maintain it by professional commitment. I attend many meetings in Westminster to do with UK cases such as PIP, pelvic mess, and sodium valproate.

5.9 More generally, roles of this nature, which combine independence, system-wide influence and a strong patient advocacy function, are relatively uncommon, and this may contribute to challenges in identifying individuals who both meet the requirements of the role and are willing to undertake it.

5.10 Beyond these general observations, I am not in a position to comment further on the specific circumstances of the recruitment process.

6. What bodies do you understand held the main responsibility for promoting patient safety in the field of neurosurgery over the relevant period?

6.1 I was not living or working in Scotland during the relevant period and therefore do not have direct knowledge of the systems in operation at that time.

6.2 My understanding, based on general knowledge of healthcare systems and governance structures, is that responsibility for promoting patient safety in neurosurgery was shared across a number of organisations at both local and national levels.

6.3 At a local level, NHS Boards were responsible for the delivery of neurosurgical services and therefore held primary responsibility for ensuring patient safety within those services. This included clinical governance, oversight of staff, and the implementation of safety and quality systems.

6.4 At a national level, bodies such as Healthcare Improvement Scotland had a role in supporting and scrutinising quality and patient safety across NHS Scotland, including through inspections, reviews and the development of standards.

6.5 Regulatory oversight of individual clinicians was the responsibility of professional regulators such as the General Medical Council, which maintains professional standards and takes action where concerns arise regarding a doctor’s fitness to practise.

6.6 Professional bodies, including the Royal College of Surgeons, also contributed to promoting standards of practice, training and professional guidance relevant to neurosurgery.

6.7 In addition, the Scottish Government had an overarching role in setting healthcare policy and priorities, including those relating to patient safety.

6.8 As noted above, this reflects my general understanding. I did not have direct involvement in neurosurgical services or oversight of these bodies in relation to Mr Eljamel.

7. In particular, please set out what role/ powers/ responsibilities you have in relation to the following areas, which are of interest to the Inquiry under its Terms of Reference, focussing, in particular, on your ability to promote the involvement or interests of patients in each area:

a) Issues related to the appointments of consultants to hospital positions within the NHS in Scotland, such as the various professional positions held by Mr Eljamel in the relevant period, including those set out in Term of Reference 1;

b) Issues relating to factors possibly affecting outcomes for NHS patients, as set out in the Inquiry's Term of Reference 2, including workload, consultant supervision/ training of junior colleagues, the involvement of senior clinicians in private practice, their commitment to research or his teaching commitments;

c) Clinical governance systems within NHS boards in Scotland, including whistleblowing systems and use of/ compliance with them;

d) Complaints and feedback systems within NHS boards in Scotland, including the handling and resolution of patient complaints;

e) The role of any other bodies who could have had a role to play in the promotion of patient safety in the NHS in Scotland, including but not limited to Healthcare Improvement Scotland, NHS Education for Scotland and the Scottish Government;

f) Information sharing/ honesty on the part of senior clinicians with patients, NHS Boards or regulatory bodies;

g) Systems relating to clinical suspension, supervision or resignation of senior hospital clinicians in the NHS in Scotland, as well as those relating to their voluntary removal from the GMC medical register;

h) Investigations into matters relating to the professional practice of senior hospital clinicians, such as those listed in the Inquiry's Term of Reference 12;

i) Information sharing/ honesty on the part of Scottish NHS boards with patients, regulatory bodies, the Scottish Government or the police; and

j) Document management systems within Scottish NHS boards including the accuracy, comprehensiveness or retention of key documents.

7.1 As Patient Safety Commissioner for Scotland, my role is independent and focused on identifying and promoting improvements in patient safety at a systemic level. I do not hold

direct operational, managerial, or regulatory responsibility in relation to the areas listed below. My role does not include decision-making authority over NHS Boards, individual clinicians, or regulatory bodies.

a) Issues related to the appointments of consultants to hospital positions within the NHS in Scotland, such as the various professional positions held by Mr Eljamel in the relevant period, including those set out in Term of Reference 1;

7.2 I have no role in the appointment of consultants within NHS Scotland.

7.3 However, where patient concerns relate to the impact of such appointments on safety, my role is to ensure those concerns are heard and, where appropriate, to highlight systemic issues to relevant bodies.

b) Issues relating to factors possibly affecting outcomes for NHS patients, as set out in the Inquiry's Term of Reference 2, including workload, consultant supervision/ training of junior colleagues, the involvement of senior clinicians in private practice, their commitment to research or his teaching commitments;

7.4.I do not have oversight or control of workforce arrangements, supervision, or clinical workload.

7.5 My role is to consider whether patient experiences indicate systemic safety risks arising from such factors and to make recommendations where appropriate.

c) Clinical governance systems within NHS boards in Scotland, including whistleblowing systems and use of/ compliance with them;

7.6 I do not manage or oversee clinical governance or whistleblowing systems within NHS Boards.

7.7 I may consider whether such systems are functioning effectively from a patient safety perspective, particularly where concerns are raised by patients or families.

d) Complaints and feedback systems within NHS boards in Scotland, including the handling and resolution of patient complaints;

7.8 I do not investigate or determine individual patient complaints.

7.9 My role includes identifying themes or patterns arising from patient feedback and promoting improvements in how concerns are handled and learned from.

e) The role of any other bodies who could have had a role to play in the promotion of patient safety in the NHS in Scotland, including but not limited to Healthcare Improvement Scotland, NHS Education for Scotland and the Scottish Government;

7.10 I do not direct or oversee the work of other national bodies.

7.11 However, I may engage with organisations such as Healthcare Improvement Scotland and NHS Education for Scotland to highlight patient safety concerns and encourage system-wide learning.

f) Information sharing/ honesty on the part of senior clinicians with patients, NHS Boards or regulatory bodies;

7.12 I do not regulate individual clinicians or enforce duties of candour.

7.13 My role includes promoting transparency and ensuring that patient perspectives on communication and honesty are considered in system improvement.

g) Systems relating to clinical suspension, supervision or resignation of senior hospital clinicians in the NHS in Scotland, as well as those relating to their voluntary removal from the GMC medical register;

7.14 I have no role in decisions relating to suspension, supervision, or removal of clinicians from practice. These matters fall within the remit of employers and regulators such as the General Medical Council.

h) Investigations into matters relating to the professional practice of senior hospital clinicians, such as those listed in the Inquiry's Term of Reference 12;

7.15 I do not carry out investigations into individual clinicians' professional conduct. My role is focused on systemic patient safety issues rather than individual disciplinary matters.

i) Information sharing/ honesty on the part of Scottish NHS boards with patients, regulatory bodies, the Scottish Government or the police;

7.16 I do not oversee or regulate Scottish NHS Boards' information-sharing practices. However, I may consider whether failures in communication, as experienced by patients, indicate broader patient safety concerns.

j) Document management systems within Scottish NHS boards including the accuracy, comprehensiveness or retention of key documents.

7.17 I do not have responsibility for document management systems within Scottish NHS Boards. My role may include identifying whether poor record-keeping has impacted patient safety and highlighting this as a systemic issue.

8. What initiatives have been envisaged or adopted by you in your role as Patient Safety Commissioner for Scotland which are designed to try to investigate, understand and/or address any issues arising in the areas set out under question 7 above.

8.1 I was not in post as Patient Safety Commissioner for Scotland during the period in which Mr Eljamel was practising.

8.2 Since taking up the role, my focus has been on establishing the Office and developing approaches to identify and address systemic patient safety concerns. I have identified some systemic concerns during my first year in the Office. In relation to question 7, I have emerging concerns around:

> 7c) The robustness or lack of clinical governance systems alongside the involvement of the relevant staff and patients at the right time;
> 7d) A disconnect between complaints and feedback systems in connection to adverse event reviews and duty of candour. Concerns about the delays in response in all these areas and not always including what matters to patients in these processes;
> 7e). The national whistleblowing office and HIS responding to concerns are two points of contact for whistleblowing, however we do get clinicians reaching out to our office saying they are afraid to speak up at work, so for me there needs to be increased rigour around speak up culture in Scotland that would prevent another Eljamel case from happening again; and
> 7f) Information sharing/honesty - Concerns that there is a lack of national learning from adverse events and lack of a robust national reporting system with no thematic

analysis outputs. In addition, where adverse events are not routinely reported and therefore the relevant review does not take place.

8.3 My work has been focused on promoting system-wide learning and improvement rather than investigating individual historic cases.

8.4 I have not undertaken any specific initiatives directly relating to matters concerning Mr Eljamel.

8.5 The role of the Patient Safety Commissioner for Scotland, as set out in the Patient Safety Commissioner for Scotland Act 2023, is focused on identifying and promoting improvements in patient safety at a systemic level.

8.6 It does not include a function to investigate individual historic complaints or specific past cases.

8.7 Accordingly, my work has not involved investigation of matters relating to Mr Eljamel but has instead focused on broader patient safety issues and system improvement.

9. Can you set out any particular historic systems or issues of which you have become aware in your role which relate to the matters contained within the Inquiry's Terms of Reference, in particular over the relevant period.

9.1 I was not in post during the relevant period and therefore do not have direct knowledge of the systems in operation at that time.

9.2 My understanding of historic issues is based on general observations arising from my role and engagement with patients and stakeholders since my appointment.

9.3 I have not undertaken a detailed investigation into historic neurosurgical services or the specific circumstances relating to Mr Eljamel.

9.4 The statutory role of the Patient Safety Commissioner does not extend to investigating historic complaints or individual cases.

9.5 My understanding of historic issues is therefore limited to general observations arising from my role and engagement with patients and stakeholders, rather than detailed investigation of specific events.

Part C- your involvement in matters relating to the professional practice of Mr Eljamel

10. To the extent that you have been, please set out when, how and by whom you have been involved in matters related to the professional practice of Mr Eljamel or issues relating to it or their resolution.

10.1 I have had limited involvement in matters relating to the professional practice of Mr Eljamel or issues relating to it or resolution as I have only had two emails and two virtual meetings via Microsoft Teams with patients of Mr Eljamel.

10.2 I became aware of concerns relating to Mr Eljamel through:

- Two email communications; and
- Two virtual meetings via Microsoft Teams with patients who raised concerns about their care

10.3 I received an email from Jules Rose on 21st September 2025 on the enquiry email asking for a meeting to discuss work to ensure this can never again happen in Scotland (PSC-00002). I responded to her and a Microsoft Team meeting was arranged (PSC-00011).

10.4 I had a virtual meeting via Microsoft Teams with Jules Rose on 9 October 2025.

10.5 I received an email from the Patients' Action Group on 26 November 2025 asking for a meeting to discuss patient safety governance and the issues facing their members [PSC-00003].

10.6 I had a virtual meeting via Microsoft Teams with Z0056, Z0072 and R0042 R0042, all from the Patients' Action Group on 18 December 2025.

11. What have you understood to be the issues and concerns of patients/ their representatives with whom you have had contact?

In particular:

a) How and by whom have those concerns and issues been articulated to you?
b) How prevalent or widespread are/ were these concerns?
c) To what extent have you been able to assist with their resolution, in light of your role and responsibilities?

a) How and by whom have those concerns and issues been articulated to you?

11.1 My direct engagement with patients or their representatives in relation to Mr Eljamel has been limited to the two email communications and two virtual meetings via Microsoft Teams outlined above.

11.2 On 9 October 2025, I had a virtual meeting via Microsoft Teams with Jules Rose, during which she outlined her personal experience and expressed concerns regarding patient safety and the need to ensure that similar circumstances do not arise in the future.

11.3 Ms Rose also described her ongoing advocacy work in relation to patient safety and support for affected individuals. I cannot recall the details as we had intended to speak again but not until after the Inquiry. I will continue to be available to patients who wish to make contact. Once the Inquiry has reported, I will consider what systemic improvement work, if any, falls within my mandate in light of its findings and recommendations.

11.4 On 19 December 2025, I had a virtual meeting via Microsoft Teams with representatives of the Patients' Action Group, including Z0056 , Z0072 and R0042 . This was an introductory discussion, during which they sought to understand the role of my office and any potential involvement in relation to the Inquiry.

11.5 I did not take detailed notes of these conversations, as they were initial discussions. I do not hold any documents relating to these meetings, only the emails provided above. This was a very brief meeting; they wanted to tell me they had separated from the Jules Rose advocacy group as they had differing opinions, and we had intended to meet again, but again wanted to wait until after the Inquiry.

11.6 These interactions represent the extent of my direct contact with patients or their representatives in relation to Mr Eljamel.

b) How prevalent or widespread are/ were these concerns?

11.7 Based on my limited engagement, I am not in a position to comment on the prevalence or extent of these concerns.

11.8 My understanding of the wider scale of concerns is therefore limited and based on publicly available information rather than direct engagement in my role.

c) To what extent have you been able to assist with their resolution, in light of your role and responsibilities?

11.9 In light of my statutory role and the ongoing Public Inquiry, I have not taken steps to intervene in matters relating to Mr Eljamel.

11.10 I have been mindful that any action by my office could risk duplication of, or interference with, the work of the Inquiry. When patients contacted me, I engaged with them appropriately. I made a deliberate decision not to take any action that could risk interfering with or pre-empting an active public inquiry established under the Inquiries Act 2005. I continue to be available to patients who wish to make contact. Once the Inquiry has reported, I will consider what systemic improvement work, if any, falls within my mandate in light of its findings and recommendations.

11.11 I have indicated to those I have engaged with that I would be willing to consider how my office may support learning and improvement following the conclusion of the Inquiry.

Part D – documents

12.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.

12.1 I have no documentation apart from the supplied emails that are relevant to this inquiry.

13. As far as the searches for documents undertaken by you in response to this rule 8 request are concerned, as regards of the categories of documents which have 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 documents sought

in each category, including details of search terms used on electronic systems of document storage;

b) **If there are significant classes of relevant documents which were thought to have existed at some point which no longer exist or are no longer held by, on behalf of or under your control, please identify what these are;**

c) **If there are significant classes of relevant documents which were thought to have existed at some point which no longer exist or are no longer held by you, on your behalf of or under your control, 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 relevant documents which were thought to have existed at some point which no longer exist or are no longer held by you, on your behalf of or under your control and you are aware of these being held by or on behalf of another party, please indicate the nature of these documents and by whom you believe them to be held.**

13.1 I have no documentation apart from the supplied emails that are relevant to this inquiry.

14. Please certify that the documents which have been produced in response to this rule 8 request to the best of your knowledge and belief, all documents held by you, on your behalf or under your control.

14.1 I certify that all the documents which have been produced in response to this rule 8 request, are to the best of my knowledge and belief, all documents held by me, on my behalf or under my control.

<u>Part E – conclusions</u>

15. The Inquiry is keen to understand your views on issues which have affected or currently affect the promotion of patient safety in the NHS in Scotland, in order to assist it, in particular with its role in making appropriate investigations to inform any recommendations which the Chair may make in his report(s). Please set out any reflections or views you have formed in or in connection with your role as the Patient

Safety Commissioner for Scotland on issues which have historically affected or current affect the promotion of patient safety in Scotland's National Health Service, with particular regard to the areas covered by the Inquiry's Terms of Reference.

15.1 I was not in post as Patient Safety Commissioner for Scotland during the period in which Mr Eljamel was practising, and I have not been involved in the investigation of matters relating to his practice.

15.2 During my time in post, I have been aware that a Public Inquiry into these matters was underway. I have therefore been mindful not to take any action which might duplicate, interfere with, or distract from the work of the Inquiry.

15.3 My reflections are therefore based on my general experience in the role and engagement with patients, families and stakeholders, rather than any detailed investigation of the matters under consideration by the Inquiry.

15.4 From this work, I have observed that the promotion of patient safety is closely linked to:

- The extent to which patient voices are heard and acted upon;
- The effectiveness of systems for raising and responding to concerns; and
- The transparency of communication between healthcare providers and patients.

15.5 I have also observed that patients and families may experience difficulty in navigating systems when concerns arise, particularly where those concerns relate to serious harm.

15.6 These reflections are general in nature and are not specific to any individual clinician, organisation or specialty.

15.7 In my time in post, I have reflected on the importance of ensuring that systems are sufficiently robust to identify and respond to patient safety concerns at an early stage.

15.8 Ongoing attention to transparency, patient involvement and system learning is, in my view, essential in supporting confidence that such issues are unlikely to recur.

15.9 In my role, I have reflected on the importance of ensuring that systems for identifying and responding to patient safety concerns are sufficiently robust and effective.

15.10 In particular, I consider it essential that patient voices are heard, that concerns are acted upon at an early stage, and that learning is identified and applied consistently across the system.

15.11 Continued attention to these areas is important in supporting confidence in the safety and effectiveness of healthcare services.

16. In particular, the Inquiry would be interested in your understanding of and views on the current systems which exist within the NHS in Scotland (with particular regard but not limited to NHS Tayside) based on your experience in your current role(s), regarding the following, both historically and in the present day:

(a) The operation and effectiveness of whistleblowing systems within the NHS in Scotland, with particular regard to the practices of consultant surgeons; and
(b) Systems which exist for the investigation of things going wrong in the NHS in Scotland, with particular regard to the independence and effectiveness of investigations into the role of health boards in things going wrong/ affecting patient safety.

Please set out the basis and rationale for your evidence in this regard.

a) The operation and effectiveness of whistleblowing systems within the NHS in Scotland, with particular regard to the practices of consultant surgeons

16.1 I do not have direct oversight of whistleblowing systems within NHS Scotland.

16.2 Based on my understanding, NHS Boards have established formal whistleblowing processes intended to enable staff to raise concerns about patient safety.

16.3 From a patient safety perspective, the effectiveness of such systems depends on:

- Whether individuals feel able to raise concerns safely;
- Whether concerns are responded to appropriately and in a timely manner; and
- Whether learning is identified and acted upon.

16.4 In my role, through engagement with patients, families and stakeholders, I am aware of the importance of ensuring that concerns raised within healthcare systems are heard and acted upon effectively.

16.5 My observations are general in nature and are not based on detailed investigation of whistleblowing practices within any specific NHS Board or specialty.

16.6 In my role, I have been approached by some staff who have expressed concerns about whether they feel able to raise issues safely within their organisations.

16.7 This feedback highlights the importance of ensuring that whistleblowing systems are not only in place, but are perceived by staff as safe, accessible and effective.

16.8 From a patient safety perspective, it is important that individuals feel supported to raise concerns and that such concerns are addressed appropriately.

b) Systems which exist for the investigation of things going wrong in the NHS in Scotland, with particular regard to the independence and effectiveness of investigations into the role of health boards in things going wrong/ affecting patient safety.

16.9 I do not carry out investigations into individual incidents, nor do I oversee the investigation processes of NHS Boards.

16.10 My understanding is that NHS Boards have established processes for reviewing adverse events and investigating when things go wrong, with support in some cases from national bodies such as Healthcare Improvement Scotland.

16.11 From a patient safety perspective, effective investigation systems are those which:

- Are transparent and proportionate;
- Focus on learning and improvement; and
- Are perceived as sufficiently independent and fair by patients and families.

16.12 Through my engagement with patients and families, I am aware that perceptions of independence, transparency and communication are important factors in maintaining confidence in such systems.

16.13 In my view, continued attention to these areas is important in supporting confidence that concerns are appropriately examined and that learning is identified and applied.

16.14 My observations are general in nature and do not relate to any specific NHS Board, including NHS Tayside.

The contents of this statement have been provided in my capacity as the Patient Safety Commissioner for Scotland and are a true and accurate account to the best of my knowledge and belief.

Signed 

Date 15 July 2026