Tuesday, 8 September 2026

(10.06 am)

THE CHAIR: Thank you. Please be seated.

Well, may I begin by welcoming you all to the first of the Eljamel Inquiry's evidential hearings.

Many of you are attending in person today at the hearing suite here in Edinburgh. Others are joining remotely and watching via the live feed.

But whatever your interest and from wherever you are observing, you are all very welcome.

Many of you will also have attended one or other of the public meetings which were organised in October 2024 as part of the consultation held in connection with the setting of the Inquiry's Terms of Reference.

On those occasions, I addressed myself directly to the former patients of Mr Eljamel, and I said that I was very conscious of the length of time you had already waited for answers to your questions, and I recognised that you may have felt frustrated and worn down by the time it had taken to get to that point.

Given the circumstances in which the present hearings were postponed in the spring, I can only think that that frustration will have grown. Indeed it will likely be shared by others who have a different but nonetheless significant interest in the Inquiry's work.

Mr Dawson will shortly be providing me, and you, with an update of where broadly our investigations stand and report on our plans going forward. He may also touch on the circumstances which led to the postponement of the hearings originally scheduled for April of this year. And let me be clear, what happened was deeply disappointing, as was the extent to which having to address the issue in advance of the decision to postpone was time-consuming and extremely disruptive to the Inquiry team's focus, a point that has been made forcefully in the recent past.

I should nevertheless record my appreciation of the recent efforts that were made to address this, by means of a legal solution, the technical fire safety concerns that had arisen to the point where I can now be satisfied that these hearings can properly and safely take place. The solution device may come with practical and financial consequences for the Inquiry but these will be for me to deal with. What matters is that the hearing suite is now available for its intended use with the result that we are in a position to commence with the evidence in section 1 of the Inquiry's evidential plan today.

It is indeed a watershed moment for all those who have suffered or continue to suffer as a result of

medical treatment they received and their experiences subsequently. They deserve special mention on what will doubtless be a day of very mixed emotions indeed.

It is also a moment of profound significance for all those who have long campaigned for and promoted the necessity for this public inquiry. Im personally recommitting myself today to its very important work, I will do all I can to meet the expectations that so many have invested in it.

As has been said before and will likely be reiterated this set of hearings involves to a significant extent, although by no means exclusively, an exercise in context-setting for the later and more involved sections of the Inquiry's evidential plan.

The evidence you will hear over the next four or so weeks may well lead to the exploration of further lines of investigation or the revisiting of issues that have arisen which may merit more detailed examination. Witnesses may in due course be recalled to give evidence in later sections if our investigations justify that course of action. We go, as I have said before, where the evidence takes us.

But even allowing for the introductory nature of the hearings you should understand they are themselves the product of a considerable body of preparatory work

involving the drafting and completion of detailed and lengthy statements and expert reports and the recovery, production and preparation for disclosure of many documents.

It is therefore right that I should also record my appreciation not only of the hard work of the Inquiry team, which has been considerable, but also the efforts already committed by core participants and their representatives to the evidence-gathering process, the consideration of disclosed materials, and more recently the exercise of contributing with suggestions to the evidence proposals for individual witnesses.

Contributing in this way is of the essence of the privileges and responsibilities of being and acting for core participants in a public inquiry. I have said before but it merits repetition, the Inquiry team and I rely on your positive engagement to help us to fulfil the challenging mission set for us by the Terms of Reference. We all have an interest in the successful pursuit of an investigation underpinned, if I may say so, by a spirit of dignity, courtesy and respect and which meets the justifiable expectations of former patients, members of the medical profession then and now, and the wider public who rely on the provision of safe, reliable, patient-centred and accessible

healthcare.

If these objectives are to be achieved, and I'm sure they will be, I will necessarily continue to rely on your help and support as well as your encouragement.

On a separate but related point I anticipate that during his address Mr Dawson will remind you of an important paragraph in the Inquiry's protocol on its approach to evidence and written statements which concerns the provision of evidence by individuals and organisations to the Inquiry. In particular I expect he will take the opportunity to issue a further call for evidence as we move towards more detailed systemic investigations which will follow the hearing of the evidence in Section 1 and evidence of the patient group in Section 2.

Can I simply ask anyone watching these proceedings or reading about them to pay close heed to that call. I strongly encourage anyone to get in touch with the Inquiry team if they feel that they have information, views or recollections to share with us. You may be assured that any such approaches will be greatly appreciated and valued.

In a statement I issued to coincide with the commencement of these hearings I expressed the hope that those with an interest in our work would find their

content interesting and informative in providing evidential context for what will follow in later sections of the Inquiry plan. In saying that, I also recognise the risk that some aspects of the evidence may be difficult, even traumatic for some to listen to.

I make no assumptions as to what that evidence might be, but wish to stress that the risk is well appreciated and that steps have been put in place in an effort to address it as best we can, consistent with the trauma-informed approach which we have sought to adopt in our work.

I therefore wish to assure you that support and assistance is available through the Inquiry secretariat and through the professional services of the Spark charity, representatives of whom will be available at the hearing suite each day or remotely for those watching online. They are all on hand to offer help and support if you need it.

With those introductory remarks I now intend to invite Mr Dawson, senior counsel to the Inquiry to address the hearing with his update and overview of the stage we have reached in our investigations with a view to commencing the evidence of the first witness in the Inquiry, Liz Smith CBE, immediately after we break for lunch today.

Mr Dawson.

Opening statement by MR DAWSON

MR DAWSON: Thank you, sir. I am Jamie Dawson KC, senior counsel to the Inquiry. I appear at these evidential hearings alongside my learned junior Mr Ross Crawford. I'm also accompanied by other members of the Inquiry legal team as well as members of the Inquiry secretariat team who have played and continue to play a dedicated role in the delivery of these Inquiry Section 1 hearings.

Sir, the Inquiry has reached a significant milestone today in that this is the first day on which oral evidence will be heard by this Inquiry. For many, indeed many who join us today, this day has been a long time coming. The subject matter of this Inquiry is relatively historic, focused as it is on the systems surrounding the practice of Mr Sam Eljamel, a consultant neurosurgeon who worked in the Tayside area, in particular at Dundee Royal Infirmary and at Ninewells Hospital, a prominent teaching hospital in that city, as a consultant neurosurgeon from 1995 until his suspension on 10 September 2013, resignation from his post at Ninewells on 31 May 2014 and the subsequent voluntary erasure of his name from the General Medical Council's medical register.

Many who have been harmed as a result of treatment received over that period or as a result of the way that the state has responded to their treatment in the subsequent years have fought for a long time to reach today. It is right that we recognise their efforts and their sacrifice as well as those of their loved ones in reaching this point.

The evidential hearings of any public inquiry like this one represent a significant milestone in their progress. Sir, this is a public inquiry. Inquiries like this are inevitably fought for by members of the public. They concern matters of public interest, in our case the most revered of our public services, our National Health Service, the fundamental principle and purpose of which is to promote and protect public health and safety. They are commissioned by public servants for the benefit of the public. Often, as here, they are commissioned because of a reasonable apprehension that previous efforts to address or deal with an issue of public importance have been inadequately focused on the interests of those members of the public whom some service or agency was designed to protect and serve.

Far too often in my experience of them to do these processes look like lawyers speaking to lawyers. We are lawyers and I am afraid we cannot help that fact. We

are used to speaking to one another in language that we understand and are used to or even at times in Latin but that does not mean that an important public process like this which is designed for the benefit of the public, and which has been committed by you, sir, to being patient-centred, that we cannot do better.

Thus, this address is unashamedly aimed at the public whose interest we serve and the patients for whom you have deliberately placed at the centre of what we do.

I take a keen, deliberate and direct interest, sir, in correspondence received by this Inquiry from members of the public be they former patients of Mr Eljamel or others with a direct involvement in or interest in our work. This correspondence often expresses disappointment and apprehension about the past which manifests itself as an apprehension about the Inquiry process and what it will be able to achieve. In particular in light of external forces which place impediments in our path.

However, this correspondence also shows hope. It shows faith in you and in the Inquiry team, albeit at times not in others which must never be assumed or taken for granted that this Inquiry can work and fulfil its not immodest aims. That correspondence often shows

selflessness, a keen interest in the wider public good, and expresses itself in particular and clearly well thought through terms. It shows the courtesy and respect for your process which you have offered and expected from others. It embodies, sir, a commitment from those who take the time to get in touch, that this Inquiry can be a force for good and that it can be an Inquiry which takes place properly in public with the participation of the public and ultimately for the benefit of the public.

I taken encouragement from that and from the possibilities that such a collaborative attitude has the potential to bring.

Sir, it would not be uncommon in statutory public inquiries or this one for the opening days of an evidential hearings like these to be focused on hearing opening statements from, or on behalf of, the Inquiry's core participants. Instead, as those who have been following the progress of this Inquiry are well aware, the procedure which we have adopted took a different course. You, sir, heard opening statements from the Inquiry's core participants at a hearing specifically designed for that purpose in November 2025. That course was taken both so that proposals and aspirations of our core participants could be ventilated

at an early stage allowing the Inquiry to take account of what was said at that time in its planning. But also so that at this hearing the focus could be on oral evidence from the outset.

As a result, we will hear from our first oral witness this afternoon. In light of your desire, sir, to get to the oral evidence at these hearings as soon as possible, and in light of the opportunity afforded to them to make extensive submissions and written and oral statements at the Inquiry's three previous hearings, core participants have not been called upon to produce written submissions in advance of the hearings today, nor have they received a written Counsel to the Inquiry note as they did at previous hearings. They will, however, have an important part to play over the next four weeks and indeed have been part of our preparations for these hearings before today to which I will return in due course.

Though the focus today and the weeks to follow is and must be on oral evidence, it is incumbent upon me to provide some important context to the proceedings which are about to commence for those who have an interest in our work. It is important for those who have been with us since the start that they be provided both with an update on what has been happening since we last held

a public hearing in May this year and also that they receive a clear indication as to the structure and intentions for these hearings as well as an explanation as to where they sit and what will happen after these four weeks are finished.

In addition, it is likely that there are others who have had or who have acquired an interest in our work who are taking a keener interest as we have now reached the evidential stage, including representatives of the media who are welcome and an important part of our public function. They too deserve an explanation of what is passed, what we plan for these hearings and where we intend to go next. Therefore, sir, we have set aside some time this morning to enable me to make this opening submission in the hope that it will fulfil those important purposes. I intend to address the following matters this morning which are designed to help explain the intentions for these Section 1 hearings as well as to provide an update on progress in the Inquiry and our planning more generally.

Therefore my submission will be split into the following parts.

One, representation. Who is here today and their role in the proceedings. Two, the delay in the holding of these hearings and developments in connection with

our hearings venue here at Waverley Gate in Edinburgh. Three, the scope of the Section 1 and the Inquiry's evidential plan and the witnesses who are due to give evidence at these hearings. Four, the procedural plan for these hearings. Five, Section 2 progress and the plans for the next set of evidential hearings in December 2026. Six, planning beyond December 2026. Seven, other important developments in the Inquiry's progress. And eight, conclusions and next steps.

To turn then, sir, to representation. Who is here today and their role in the proceedings.

It is very important to observe, sir, that these proceedings are being transmitted to those who cannot or do not wish to be here today via a feed available YouTube. A video of the proceedings will be available after the hearing for those who wish to watch it back. A transcript of the proceedings for each day will be uploaded to the Inquiry's website as soon as the end of each day's proceedings finish and it can be reasonably achieved in the light for the need for it to be accurate. The availability of this feed and the regular publication of transcripts of the proceedings are derived from your statutory responsibility, sir, to take such steps as you consider reasonable to allow public access to our proceedings but are also important parts

of your additional commitment, sir, to making our work including but not limited to what goes on at our public hearings available to as wide an audience as possible in the knowledge that there are individuals who take an interest in our work and who cannot be here due to physical disability, geographical distance or due to the fact that attending would be too difficult for them for some other reason. Such individuals include but are not limited to members of the patient core participant body upon whose active engagement in our work we do and will continue to rely.

This hearing, as I said, sir, is taking place at a hearing room in our hearing suite at Waverley Gate premises in central Edinburgh. When not available to us, the space is used for the hearings of the Scottish Covid-19 Inquiry, another public inquiry set up by the Scottish Ministers. Within the hearing room today my colleagues within the secretariat have, as at previous hearings, managed to configure the seating arrangements as they are currently so that every patient who applied, along with at least one supporter if they wanted one, as well as all representatives of our core participants who wished to be here, have been offered a seat. This has been done to accommodate everyone who applied, in particular the former patients of Mr Eljamel and their

supporters, who are all most welcome here today.

Their presence either in person or online is of fundamental importance to the work of this Inquiry and consistent with the public commitments you have made, sir, to putting them at the centre of our work.

By way of reminder, those wishing to take a formal role in the Inquiry were invited to become core participants within the meaning of Rule 4 of the Inquiries (Scotland) Rules 2007. Those applications for core participant status were considered by you, sir, as chair of the Inquiry in accordance with Rule 4 of the 2007 Rules.

All of our core participants are legally represented at these hearings and they are the following.

139 former patients of Mr Eljamel and 21 representatives of former patients represented by Levy & McRae solicitors a total 160 patient core participants as individuals.

These patient core participants are represented by my learned friends Ms Joanna Cherry KC and Mr Euan Scott.

NHS Tayside are represented by a solicitor from the NHS Central Legal Office and by my learned friends Ms Una Doherty and Cat MacQueen. Healthcare Improvement Scotland and Public Services Delivery Scotland are

represented at these hearings by another solicitor from the Central Legal Office and my learned friend Mr Shane Dundas.

The latter body is the successor of the previously designated core participant NHS Education for Scotland which has, this year, become part of a new body Public Services Delivery Scotland, as a result of an administrative rearrangement of the NHS which has resulted in the dissolution of the previous body and the redesignation of the new one as an organisational core participant in this Inquiry.

It is also worth clarifying, sir, that these two bodies are separately represented from NHS Tayside.

The Scottish Ministers are represented at these hearings by solicitors from Messrs Harper Macleod and my learned friends Laura Thomson KC and David Blair. As at previous hearings of the Inquiry they represent the Scottish Ministers in their capacity as core participants in and material providers to the Inquiry only as opposed to the sponsors of the Inquiry in which capacity they were represented at the last hearings we held in May but in which capacity they are not represented today.

The University of Dundee is represented at these hearings by solicitors from CMS and my learned friend

Emma Toner KC. The Royal College of Surgeons of Edinburgh are legally represented at these hearings by Brodies solicitors from which firm Mr Marshall appears as their representative at these hearings.

For clarity, sir, some may recall that at previous hearings of the Inquiry you invited Professor Stephen Wigmore, chair of the Independent Clinical Review or ICR, to be a represented and extended to him the same rights of reply and participation in those procedural hearings as others for the objective of seeking to allow them to contribute to the efficient work of those hearings and ultimately of the Inquiry.

As the Inquiry moves into its evidential phase, it has not been considered appropriate for the ICR to continue to be represented as they have no role in the leading of the evidence which we will hear, unlike our core participants. Though I do have something to say in due course by way of update about the ICR and its work as part of this submission.

Indeed as we move to our evidential phase the participation of the ICR and its representatives may become in the capacity of witnesses providing evidence as opposed to contributors to our structural plans. Sir, we will also be joined at these hearings on occasion at least by legal representatives of witnesses

who are not from core participant groups or not themselves core participants in this Inquiry. As presently advised, Mr James of Circle Healthcare, the witnesses who will give evidence from the GMC, Dr Gillies of NHS Lothian and Professor Smith of the Royal College of Surgeons of England are legally represented or have some form of legal support being provided to them in connection with their evidence. Those representatives will usually sit at the front row of the hearing suite while their witnesses are giving evidence.

I will say more, sir, in due course about the practical features of the important role which our core participants and their legal representatives can play at this hearing. I would say, sir, that the opportunities for participation in the hearings, unlike in some other public inquiries, are neither small nor illusory. They are considerable and of considerable value to our work both at these oral hearings and beyond.

All of our core participants have committed to cooperation with the Inquiry in the fulfilment of its stated aims. In their written opening statement to this Inquiry, NHS Tayside said that it very much views this Inquiry as an opportunity for an independent assessment of what went wrong and why. It welcomes recommendations

from this Inquiry as to further changes which should be made, the Inquiry's conclusions will be of great importance to NHS Tayside as the safety, well-being and trust of patients is at the heart of its work. As a learning organisation it wants to hear from patients and families, those best placed to advise and share their experiences as to how it can consistently improve and build confidence in the services it delivers.

NHS Tayside went on to say it is fully committed to assisting the Inquiry and will work collaboratively with the Inquiry team. It welcomes the Inquiry's trauma-informed approach, to which I will return, and is keen to ensure that this is adhered to. NHS Tayside recognises that its systems and processes are a significant focus of the Inquiry's investigations and it will closely review relevant materials and will listen carefully to the evidence to understand the perspectives of those directly affected, all with an openness and willingness to get things right for patients.

In their opening written statement to the Inquiry the Scottish Ministers said that they welcome the opportunity to participate in this Inquiry and to assist the Inquiry in its work. They said that the Scottish

Ministers recognise that legitimate questions and concerns exist regarding their responsibilities to secure the effective provision of national health services in Scotland and in particular oversight of NHS Tayside and the handling of complaints about Mr Eljamel.

They welcome, they said, both the scrutiny and the opportunity for learning that this Inquiry will bring. They say that the Scottish Ministers wish to ensure that the Inquiry of their commitment to learning lessons and to taking positive steps to improve the experience of all who receive treatment and care within the NHS. They said that patient safety is their priority.

They also added that the Scottish Ministers are grateful for the opportunity to contribute to the Inquiry's work in particular by making the opening statement which they were invited to make in November. They reiterated their willingness to work collaboratively with the Inquiry and to assist the Inquiry in fulfilling its Terms of Reference.

In their written opening statement to the Inquiry, Healthcare Improvement Scotland said that HIS looks forward to working with and assisting the Inquiry in fulfilling its Terms of Reference. They said that that organisation will share any knowledge and experience

that it has in relation to the Inquiry's areas of investigation and they renewed their commitment to supporting the Inquiry with its work in any way that they could.

In their written opening statement to the Inquiry, NHS Education for Scotland, now as I've said part of Public Services Delivery Scotland, said that NES looks forward to working with and assisting the Inquiry in fulfilling its Terms of Reference, that it will share any relevant knowledge and experience that it has in relation to the Inquiry's areas of investigation and NES also renewed its commitment to supporting the Inquiry with its work in any way that it can.

In their written opening statement to the Inquiry, the Royal College of Surgeons of Edinburgh said that the Royal College will seek to assist the Inquiry in any other way the Inquiry considers appropriate.

And in their written opening statement to the Inquiry, the University of Dundee stated that the university would wish to make clear that it welcomes this Inquiry and recognises immediately its importance and undertakes to co-operate fully with the Inquiry in its investigation of the issues noted and more generally. They added that finally, if the Inquiry should find in due course that there may be any lessons

to be learned on the part of the university in relation to any of the Inquiry's Terms of Reference both the Inquiry and the public should be in no doubt that comprehensive steps will be taken by the university to address those matters which have been identified.

And in their written opening statement to the Inquiry the patient core participant group said that this Inquiry has been a long time coming and hard-fought for, a matter which I've already recognised. They said that the group are fully intent on supporting the Inquiry so that it may fulfil its remit.

The Inquiry, sir, very much welcomes these commitments made by these various different bodies or groups and values the contribution which the Inquiry can expect as a result of them having been made and made so publicly.

In that regard may I say a few words about our organisational core participants. It is too often the case in public inquiries in my view, sir, that organisational core participants see themselves as occupying a defensive role. With respect, may I suggest that that is not an appropriate way in which to view the designation of organisational core participants even if their designation has been based, in part at least, on the possibility that they may face criticism in the

Inquiry's work. When you selected our core participants for this Inquiry, sir, you exercised your wide discretion bearing in mind a number of features. You considered the applications you received in light of your obligation to run the Inquiry as thoroughly and as effectively as possible, bearing in mind the Inquiry's wide-ranging Terms of Reference and the need for Inquiry processes to be rigorous and fair. As is set out in the Inquiry's core participant protocol, you assessed carefully whether applicants could assist the Inquiry in its work and whether their designation would actively contribute to the efficient and thorough operation of the Inquiry. That is the touchstone by which you determined their applications and the benchmark for our expectation that they will participate actively in what we do.

As we committed to doing, core participants in this Inquiry have been accorded rights, roles and responsibilities which exceed the rights they derive automatically from the law to ensure that they have every opportunity to participate actively in our work. Bodies which have received such status have the responsibility of and experience of important features of our remit: patient care and safety; the organisation, funding and operation of hospital-based surgical care;

the performance of surgery and the setting of the surgical standards; medical and surgical education and training; and the betterment of those important services.

In line with the Inquiry's commitment to cooperation and the commitments which have quite properly been made by these organisations, I would remind them of the background to their involvement, the importance of their active participation, the commitments they have made and the opportunity which this Inquiry affords for the betterment of the care of those who receive surgical treatment or care in Scotland.

I look forward to continuing to work with them in the achievement our mutual aims and aspirations for this process.

Sir, to move on then to a matter which you have mentioned in your opening address, namely the delays in the holding of these hearings and developments in connection with the hearings venue in which we find ourselves in Waverley Gate in Edinburgh.

Sir, before I turn to the objective of and plans for these hearings as well as the plans beyond them which I will in due course, I must, I feel, take some time to seek to explain developments with regard to the safety of this building, an issue which necessitated the

postponement of our Section 1 evidential hearings which were originally due to take place in April and May of this year and which was the main focus of the procedural hearing you held on 14 May.

I require to do so for the reasons you held the hearing at that time in the interests of transparency and openness with all those in attendance and who take interest in our work.

It is an important feature of the Inquiry's approach to its hearings and indeed its work more generally that people should feel safe when they engage with our work. That is why, sir, when safety issues beyond your control came to light earlier this year they were not taken lightly, they were interrogated and investigated, action was taken as a result.

As many of those who are in attendance today will recall you held a procedural hearing on 14 May this year, part the purpose of which was to seek further clarification from the Scottish Government as to what steps were being taken by it, in its capacity as the tenant of this building which has accorded the Inquiry permission to use it, to address fire safety concerns which had arisen. At that time I set out a detailed history of what had happened to that point, when the issue had arisen and what the Inquiry knew about it, as

well as what steps had been taken by that point by us and to our knowledge to seek to resolve the issue.

That history as a matter of public record was fairly not disputed by the Scottish Government at the hearing and need not be rehearsed here. Needless to say, the Inquiry's position at that time was characterised by a dissatisfaction with the fact that the issue had arisen in the first place as well as with the limited and poorly explained efforts to resolve them on the part of the Scottish Government and the amount of time and effort which had to be spent by the Inquiry team in seeking to see that it was resolved. Counsel who appeared on behalf of the Scottish Government at the hearing in May made clear that fire safety issues had arisen which would necessitate certain works being undertaken on what was called a shaft wall which forms part of these premises. Relatively few details could be provided at that time as to what those works would entail but it was intimated that plans were being progressed to have the works undertaken so as to facilitate the Inquiry in progressing with its planned public hearings which, by that stage, you had committed, sir, would be hearings at which public attendance would be possible, in light of the public nature of this process and the importance of physical attendance which

had been conveyed by you in particular on behalf of patient core participants by various means.

The Inquiry received a further letter from the Scottish Government on 27 May of this year which set out more detail of the shaft wall works which were proposed. It was stated that a meeting had taken place the day before the procedural hearing on 13 May between the government and the property's landlord and that the outcome was as follows.

At that meeting the landlord confirmed that in order to ensure compliance with the required fire safety standards, a shaft wall was required along the whole of the corridor serving both Inquiry spaces which serves as fire escape route. The City of Edinburgh Council has indicated that a full corridor shaft wall remedy would be acceptable and meet the standards required to secure the necessary building warrant sign-off. The landlord has indicated that they are willing to undertake the required works on behalf of the Scottish Government subject to agreement from the Scottish Ministers on the funding arrangements. The landlord is currently engaged with contractors to explore the practical delivery of a solution.

It was also pointed out that at a subsequent meeting which took place on 26 May to ensure the landlord and

contractors remained committed to the urgency of the completion of the works and that, to quote, "Other options are also being looked at by the landlord on which we will update you as early as we can".

In that correspondence it was concluded that while progress is being made, it is not yet possible to confirm a resolution date due to the ongoing design and options work outlined above.

On 11 June the Inquiry was provided with a copy of a note intimated by the Scottish Government which explained that another solution to the ongoing fire safety issue may have arisen despite the previous apparent requirement for and commitment to the building works which the Scottish Government had intimated would take place. The proposed solution involved a new lease being entered into between the Scottish Government and the landlord which would include the corridor within the area leased to the Scottish Ministers and combine the two current leases held by the Scottish Government over this hearing suite and the neighbouring office used by the Inquiry into one overall lease to the Scottish Ministers.

This, the Inquiry was told, would align the arrangements for the occupation of this floor of the building with the leased areas on the upper floors of

the building. It was suggested without further explanation that this conveyancing solution would allow the construction which had taken place to configure this floor as it is to comply with the technical safety standards required without the need for further works to be undertaken at all.

It was intimated that agreement in principle on this proposed solution had been secured between the council and the landlord supported by their technical advisors.

On 17 June the Inquiry responded to this proposal with a number of further queries about the proposed new arrangement. In any event, work proceeded with the implementation of a new lease which was considered by the Scottish Government to be necessary based on the assurance provided to them by the landlord which included the assurance that the council will be content with this new arrangement. A project plan was issued to the Inquiry with steps setting out when the new solution could be delivered against various milestones.

By 16 July an update was received by the Inquiry that the initial steps undertaken in terms of the project plan involving intimation of a new draft lease arrangement and a commitment from the sponsoring Minister of the Inquiry to enter into such a lease meant that a retrospective building warrant had been granted

by the council in connection with the previous building works which had been undertaken to configure the property as it is. Further intimations were received by the Inquiry when key aspects of the project plan were met including the signature of the new lease.

On 5 August the Scottish Government confirmed that use of the hearing suite could resume as a building warrant had been received from Edinburgh City Council and missives had been exchanged relating to the new lease over the premises. On 17 August after further reassurances about progress received by the Inquiry from the government including in relation to the issuing of a completion certificate by the council relating to the building works and progress towards the finalisation of a new lease. As a result the Inquiry was able to publish the following on its website that day. The Scottish Government as tenants of the premises has informed the Inquiry that:

"It has now been confirmed that the lease arrangement has beenfinalised and the required retrospective building warrant is now in effect. The hearing suite therefore fully complies with the appropriate building regulations which set the necessary safety standards."

Based on this update, the Inquiry intends to hold

full in-person hearings as-planned in September at the hearing suite in Waverley Gate.

Sir, an important part of the Inquiry's commitments to safety, as part of its trauma-informed strategy and more widely, involves clarity about why it is that those who are here today with us should feel that they are now safe. That is particularly difficult to set out when the Scottish Government has not taken any action, as they explained in May that they were required to do, to undertake or instruct any works on this property at all. That may seem unusual, and reasonably so, in the face of detailed explanations provided to you, sir, on behalf of the Scottish Government in May about the nature of the remedial works which would be necessary for the property to be made safe at that time.

Those who are in attendance should feel safe and should feel that the Inquiry has done everything it can to make sure that they do. The secretary to the Inquiry has spent a considerable amount of time over many, many months trying to resolve the safety issue as, to a lesser extent, have all members of the Inquiry senior team.

The Inquiry is now as satisfied as it can be that the fire safety issue has been resolved. The Inquiry secretariat staff are on hand to address any concerns or

queries which those who are here with us today have in that regard or indeed any other. Many of those with a keen interest in our work have told us that in the past they have not felt safe and moreover that when they had expressed that that is how they feel they have not been listened to or their sensation of insecurity has not been treated with dignity and respect. Our commitment to safety is not just to assert that people are safe but to do what we can to make them feel that way. Their safety is not a matter to be taken lightly or for granted, it is a matter to be secured by us for them and for us to show them that we have secured it.

Throughout this process the need to keep people informed of details which could be shared has been at the forefront of the Inquiry's approach. Aspects of the detailed negotiations to do with the property could not be shared because of their commercial sensitivity. However, the need for openness and transparency has been appreciated and actioned by the Inquiry as best it could at all times. Moreover, the needs of those who participate in our process to remain adequately informed about what is going on has been impressed upon the Scottish Government by the Inquiry team at all stages of the process and it continues to be.

These principles need not only to be adhered to by

our staff, which they are, but by those such as the Scottish Government on whose support and services the Inquiry continues to require to rely. It is our hope, sir, that shortcomings in that regard on the Scottish Government's part will not be repeated and that the need not only for speed and efficiency in their support of the Inquiry but also for the ability to share details of what is going on with our core participants and the wider public will be appropriately factored into our dealings with them in future. That is what those core participants reasonably expect and it is what you and your team are committed to delivering.

Sir, can I now move to the scope of Section 1 of the Inquiry's evidential plan and the witnesses who are due to give evidence at these hearings.

Before turning to the ambit of the evidence which we intend to cover at these hearings, sir, may I take some time to remind those listening about our approach to the gathering of evidence at this Inquiry as well as the purpose of evidential hearings such as these.

It is the process which has been adopted by this Inquiry and authorised by you, sir, that evidence does not require to be spoken to at oral hearings to be amongst the evidence which you can consider in the determination of your findings in your ultimate report

or reports. That final report or those final reports are the ultimate aim of your process, the written record of what you have found, what you have found went wrong, who was responsible and what you think can reasonably be recommended for such adverse outcomes as you have found to have taken place at a broad level to be avoided in the future.

Evidence contained in documents, including for example in ICR applicant statements and other witness statements provided to the Inquiry, will be deemed by the Inquiry to be evidence in the Inquiry which you as the Chair can consider in making findings and recommendations in the fulfilment of your Terms of Reference.

Such evidence will be able to be relied upon without the need for it to be spoken to in oral evidence in hearings or otherwise adduced formally. You have determined that such formality would be inconsistent with the inquisitorial nature of this process and likely to involve unnecessary cost.

Thus, evidential hearings are not an end in themselves but a part, though an important part, of the journey to the report or reports which are the ultimate aim of everything we do. Paragraph 5 of the Inquiry's Public Hearings Protocol provides as follows.

The public hearings of the Inquiry serve a number of important purposes including (a) in accordance with the Inquiry's obligations under Section 18 of the 2005 Act to permit attendance by core participants, members of the public including reporters, at the Inquiry and to see and hear a simultaneous transmission of the Inquiry's proceedings subject to any restriction notice or order made under Section 19.

At evidential hearings to enable evidence already gathered by the Inquiry in the form of written statements or other documentary evidence to be ventilated in public, explored, examined and their contents clarified or supplemented by the oral evidence heard as hearings, to challenge witnesses on the evidence already given by them to the Inquiry in the form of written statements, or based on material contained in documentary evidence recovered by the Inquiry, ultimately to assist the Inquiry in making findings in its report or reports, including where appropriate the identification of things which occurred falling within the ambit of the Inquiry's Terms of Reference and/or which fell below a reasonable standard which they did as well as who or what organisations were responsible. And finally to enable core participants via their legal representatives to submit questions for

consideration by Counsel to the Inquiry and to make applications, if necessary, under Rule 9 of the Inquiries (Scotland) Rules 2007 as set out in paragraphs 31 below.

Thus evidential hearings such as these ones have been designed to serve the purpose of the public ventilation of issues covered by the Inquiry's Terms of Reference, challenge of evidence received by the Inquiry, and the opportunity for our core participants to submit questions for consideration by the Inquiry as part of our investigative process. I will return to the precise processes which have been and will be adopted in particular to allow core participants to contribute proposed questions for witnesses but it is important to understand that the ability of core participants to contribute to these hearings is a very important feature of the hearings process.

In essence, sir, the Inquiry has the ability to ask questions and even to compel them to be answered at any time by issuing Rule 8 requests for witness statements and/or documents to be produced or Section 21 notices for those purposes where required. Though the questions which have been asked by us are, in this Inquiry, apparent to core participants and the wider public as we have asked respondents to repeat them in their ultimate

written statements, core participants do not contribute to the formation of Rule 8 requests or Section 21 notices other than in a general sense as a result of the broad suggestions as to the lines to follow which have been made by them, for example in their opening statements to the Inquiry.

Thus, the opportunity for core participants to propose questions which our systems are designed to promote and also take seriously represents a particularly important feature of these evidential hearings and subsequent ones in which matters will be examined with witnesses in more detail as we progress beyond our introductory evidential phase.

In too many public inquiries in my view the role of core participants is too passive. Not here, as far as we are concerned.

Sir, as was announced as early as the preliminary hearing last September and is set out in the Inquiry's Public Hearings Protocol which was published as long ago as 10 June 2025, Section 1 of our evidential plan and hence these hearings which are associated with it is unashamedly introductory in nature. It is inevitable that amongst our audience there will be those with a deep interest in the subject matter of this Inquiry, to whom some or possibly even much of the information we

will examine in this section is already apparent. However, this Inquiry is conducted in the public interest and it must not be assumed that everyone with a legitimate interest in our work has the same degree of understanding or insight into what we are investigating. Some who may have made certain assumptions about what has occurred may even be enlightened by the evidence which actually emerges. In any event, it is important that we start at the beginning in particular for those who may know less. Those who know less at this stage have no less of a right to understand what we have discovered and what we will discover. On one view they rely on the Inquiry even more to provide them with information about what has happened which is within our remit. The public ventilation of the evidence we have uncovered is an important part of our public function after all.

Even amongst our core participants groups it is already apparent, sir, that there is a varied level of understanding of what the professional practice of Mr Eljamel in the Tayside area entailed, what it caused and what issues it created. There is certainly a varied understanding of what was done or could have been done about those issues possibly even to have prevented them.

As all of these groups and the individuals within

them are equally important, we must treat all within them equally. To assume the knowledge of those who already know the most on the part of others who may, for whatever reason, know less would be to exclude those who have an equal right to be here and to be provided with a reasonable opportunity to learn from and participate in our process.

It is important that for our investigations to be focused and appropriately orientated we spend time at the beginning understanding the context in which the detailed investigations to come must be undertaken.

That is not to say, sir, that there may not be matters into which these hearings will enable to us delve more fully than others. It may be by the end of these hearings, or even by the end of evidential Section 1, that you, sir, will form the view that the evidence that we have heard means that certain matters which are important to your investigations could be deemed to have been proven to your satisfaction. That is not to say that you or we will close our minds to the possibility that the evidence may reveal new information which requires such matters to be looked at with fresh eyes. However, it is a feature of going where the evidence takes you that we anticipate that there will be matters which become clear or at last clearer within

this evidential section whereas there will inevitably be others where a much fuller investigation will be required.

That is particularly the case, sir, in this Inquiry where there is considerable uncertainty as to what questions can be answered by reference to contemporaneous documents. Indeed, it is part of the purpose of this section to try to understand what documents exist, what they contain and hence what level of controversy in relation to the issues you have undertaken to resolve remains. It is only by gaining an understanding of that context that it will be possible to formulate a plan as to where we go next and how deeply we need to look into certain areas for answers.

The result of this approach we hope will be to provide a proper and useful context in which our more detailed investigations can be undertaken in due course.

The matters related to which we will hear evidence have been published for some time in the Section 1 scope which is available on our website.

It is an important aim of this section of our evidential plan to try to ascertain an impression as to what documents are held within organisations as I have said which played or could have played a part in key events falling within our remit. This is an important

part of scene-setting for a two reasons. One is that Term of Reference 14 requires us to examine document management systems within NHS Tayside including the extent to which absence of documents undermine the effectiveness of previous investigations into the professional practice of Mr Eljamel and systems surrounding it, such as those listed in Term of Reference 12.

In addition an analysis of available documents is of evidential significance. Where documents exist they may tell us the answers we need. They may not have been previously available and provide illumination for those who have not had access to them before. They may confirm suspicions or answer burning questions. Equally, they may not tell the whole story. They may be partially useful or even not exist at all in connection with certain matters of significance to our mission.

Whatever the picture which emerges, this is a useful part of our preliminary foray into the evidence. Where questions are answered by existing recovered documents we are on the way to fulfilling our mission which is to resolve our list of issues. Where we remain in the dark we will find ways to seek evidence from other sources directly from other witnesses in our quest for the truth. Either way, we hope that we will able to form

a clear impression of what evidence there is and what we need to find by the end of the section. I will return to the contribution we anticipate core participants making to that process in due course.

Sir, in this section we will also hear independent expert evidence, instructed by the Inquiry itself, from three expert groups. I will discuss the remits of these groups and their proposed role in more detail in due course but in broad terms they will provide important independent expert context on surgical procedures, rules and systems, considerations of best practice and developments in their areas of expertise, all of which relate to key areas covered by the Inquiry's Terms of Reference.

It is inevitable I think, sir, that those with a keen interest in the subject matter of this Inquiry will be keen that we delve deeply into certain subjects of interest to them. That is an entirely natural instinct especially amongst those who have waited so long for answers to their ever more pressing and urgent questions.

Sir, I will return in a moment to the processes which will be followed to achieve participation from core participants in this section and the importance of that in these hearings. However, for present purposes

may I emphasise that systems have been put in place so questions from core participants which are deemed to go too far, too deeply into the details to be merited being addressed within the context of our present introductory ambitions will be retained for future use. It should not be thought that these hearings will be the last opportunity for witnesses to be examined, or issues which merit more detailed investigations to be undertaken.

An introductory section means just that. By the end of our Section 1 investigations, which I should say will stretch beyond these hearings, we will merely be at the end of the beginning. We will use what we have discovered here as a basis for what comes next.

Sir, I'd like to say something about patients. From the time of your public consultation on the Terms of Reference you committed, sir, to putting patients at the centre of our process. That is why you have taken steps to designate that 160 patients or patient representatives are core participants, why they have a full-time funding award for lawyers to assist their participation to support and advise them in their work and why you have sought their input on key aspects of this Inquiry, from the Terms of Reference to the list of issues, to letters of instruction for experts and our

procedural planning via the three procedural hearings including in their valuable written and oral opening statement.

It is a fact of these hearings that evidence will not be heard in this section from patients directly. This, in my submission, should not be taken into be any departure from or even dilution of your firm commitment this that is a patient-centred Inquiry. It most certainly is not. In fact the entirety of the oral hearings led in December which will now come from patients or their representatives, a matter to which I will return in due course. The importance that the patient voice be heard will in part, we anticipate, be satisfied by the oral evidence we will hear from Liz Smith CBE, a former MSP and long time campaigner on behalf of a considerable number of Eljamel patients. Written statements have also been obtained and disclosed to core participants from other political representatives who are able to relay an element of the communal patient experience as well as a result of their involvement in the campaign for this Inquiry, namely Willie Rennie MSP and Michael Marra MSP from different parts of the political spectrum and with different experiences of the patient voice and patients' experiences.

It is anticipated that Ms Smith's evidence will cover her long-standing acquaintance with the experience of Eljamel patients including but not limited to her experience of campaigning for this public inquiry as well as her more recent involvement in the Scottish parliament's public administration committee's investigation into the cost-effectiveness of public inquiries in Scotland which forms an interesting context to our own investigations under Term of Reference 12 of the Scottish Government's approach to the announcement of this public inquiry.

The Inquiry's forward-looking function and the importance of patient care in that aspect of our work means that patients are also represented to an extent in the evidence of the Patient Safety Commissioner, Karen Titchener, who it is anticipated will cover the remit and ambitions for that relatively new role, her experiences so far of issues in the achievement of good quality patient care in Scotland, some of which we anticipate will chime with the experience of the patients at the centre of this Inquiry, thus enabling it to become a focused environment in which wider patient safety and patient care considerations can be examined and possibly addressed.

It is hoped that that evidence will provide a useful

context in which the Inquiry's ambitions to making patient-centred recommendations can be fulfilled ultimately in Section 6 of our evidential plan which will be devoted to evidence relating to recommendations which may future in your final report.

Though patients will not give evidence at this hearing session, their voice will be heard through these witnesses and through the participation of the large patient core participant group in the proceedings in the next four weeks. These patient-focused witnesses will be heard near the start of these sessions, this afternoon and on Thursday morning, to ensure that the evidence which you hear, sir, will rightly be heard in a patient-orientated and centred context. I say "rightly" because patient care is legally required to be at the centre of the National Health Service in Scotland. So patients should be at the centre of an Inquiry whose remit concerns that institution.

Sir, could I say something about our approach to core participant organisational witnesses. You will hear evidence, sir, from witnesses who speak on behalf of a number of organisations with remits which are related to the subject matter of this Inquiry. In particular, you will hear from the following.

Mr Mark Egan of the Royal College of Surgeons of

Edinburgh, Mr Robbie Pearson of Healthcare Improvement Scotland, Ms Emma Watson of Public Services Delivery Scotland of which NHS Education for Scotland now forms a part. The evidence of these individuals relate to their role and remit and any connection they may have to Mr Eljamel or involvement they may have had in aspects of his professional practice to which this Inquiry directly relates.

As far as other organisations are concerned, sir, you will also hear evidence from representatives of other organisations which had, or could have had, roles to play in the matters with which this Inquiry is primarily concerned. These representatives are expected to be able to provide evidence to the Inquiry on the general functions/operation remits of their organisation but have also, as part of the Section 1 remit, been asked to provide evidence of more specific aspects of the Inquiry's remit in which their organisation did have a role. Such witnesses including Professor Frank Smith of the Royal College of Surgeons of England. As well as outlining that organisation's general role evidence is also anticipated on the RCS investigation into Mr Eljamel practice which took place in 2013 as referred to in Terms of Reference 12. Dr Tracy Gillies of NHS Lothian who will outline that organisation's general

role, but evidence is also anticipated from her on the investigation undertaken by her in 2018/19 also referred to in Terms of Reference 12. Mr Charles Massey and Mr Anthony Omo of the GMC. They have requested that evidence be given by both of these individuals though the GMC statement was provided by and is signed by Mr Massey alone. Mr Omo, we understand, has experience of the GMC's current fitness to practice rules and systems. As well as outlining the organisation's general role, evidence is anticipated on the broad nature of any involvement of the GMC in matters relating to the professional practice of Mr Eljamel which arises under Term of Reference 7 and Term of Reference 13, as well as information which they have about the voluntary removal of Mr Eljamel's name from the GMC's medical register, in particular focusing on the role of NHS Tayside in that process which is covered by Term of Reference 11.

Professor Rory McCrimmon and Professor John Connell of the University of Dundee, two witnesses are being called from that organisation. As was the right of any organisational recipients of a Rule 8 request, the university elected to complete two statements as, in its view, this would be the best way of responding to the Inquiry's relate request Rule 8 request. One was

completed by each of the witnesses who were giving evidence during the course of these hearings. As well as outlining that organisation's general role, evidence is also anticipated to be heard on the roles which Mr Eljamel held within the university, his responsibilities in them, how he was appointed to them, the extent to which his teaching and other commitments with the university occupied his time and attention possibly with an effect on his clinical commitments covered by Term of Reference 2(d), any oversight function carried out by the university of Mr Eljamel's work possibly relevant to Term of Reference 6 as well as his research and his commitment to research activities covered by Term of Reference 2(e).

Mr Peter James of Circle Healthcare, the body ultimately responsible for the operation of Fernbrae Hospital in Dundee where Mr Eljamel undertook his private work, will also give evidence. I have already explained at previous hearings that the Inquiry interprets its Terms of Reference as not permitting a detailed systemic analysis of the systems which related to the neurosurgical service provided at Fernbrae which was in part delivered by Mr Eljamel. This is an Inquiry with a focus on the NHS. However, as well as outlining that organisation's general role,

evidence is also anticipated from Mr James on the nature and extent of Mr Eljamel's private work, the time commitments he had to it, as well as the practising privileges which he enjoined at Fernbrae, all of which are relevant to Term of Reference 2(a). In addition there will be an investigation of the issues, if any, which arose in the practice of Mr Eljamel at Fernbrae as well as the systems which were in place for any issues to be communicated to the NHS which is covered by Term of Reference 3(c).

Miss Caroline Lamb will give evidence on behalf of the Scottish Ministers. As well as outlining the Scottish Government's general responsibilities for the delivery of healthcare and in particular neurosurgical services in Scotland, it is anticipated that matters which will be covered by her will include the nature and extent of the Scottish Government's knowledge of and involvement in issues relating to the professional practice of Mr Eljamel, including but not limited to the investigations into him and the systems surrounding him conducted by others under Term of Reference 12. There will also be an opportunity to understand the remit, operation and main conclusions of the Scottish Government review of unresolved and outstanding concerns concerning Mr Eljamel in 2022 as well as the Scottish

Government's involvement in or knowledge of other reviews conducted by other bodies including those listed in Term of Reference 12.

It will also be intended to cover the broad picture with regard to the Scottish Government's approach to handling calls for a public inquiry into the Eljamel affair which Ms Cherry told us in her opening statement started in 2014, the Government's position on and in response to that, including the thought process of alternatives to a public inquiry being offered and the thinking behind the announcement of a public inquiry in September 2023.

It was submitted indeed in the patient group's written opening statement that this Inquiry is also about the way the patients and their loved ones have been treated simply for seeking answers and redress. The potential that the state response to traumatic medical treatment may be as serious as the treatment itself and its potential to compound the harm already suffered by patients is not lost on this Inquiry. It will be examined by the Inquiry in its examination of the Scottish Government at these hearings and in Section 5 of its evidential plan.

Sir, as far as NHS Tayside is concerned, as will no doubt have been expected by those who take an interest

in our work, a significant number of witnesses who will be called at these hearings will be employees or former employees of NHS Tayside. This is the result of two related matters.

First the bulk of the Inquiry's Terms of Reference relate in some way to the systems and actions or inaction of NHS Tayside. Their Rule 8 request was therefore by far the most comprehensive. Even though these hearings are introductory in nature, there are lots of matters relating to NHS Tayside which require to be introduced. Further, as a consequence of the wide range of subjects covered in the statement, NHS Tayside, as was their right, took the view that having a number of different individuals respond to the Inquiry's questions would be the best way for the organisation's evidence to be presented. Therefore different topics have been covered by a number of different individuals all of whom have important aspects of the NHS Tayside position to cover.

These witnesses will not be called in the order or at the time when the Inquiry would have liked not, I should say, as a result of any issues with the witness' availability, they have in fact been most accommodating in that regard, but due to the need to accommodate availability or other issues and due to how

numerous the NHS Tayside witnesses are. We will do what we can to make sure the evidence is presented in a way which maximises comprehension despite these unavoidable consequences of availability considerations.

Sir, as far as NHS Tayside is concerned the Inquiry will hear evidence from the chief executive, Nicky Connor. Her evidence will include an examination of the destruction of theatre logbooks which would have been relevant to the Inquiry's investigations, how that was allowed to occur, and the steps which have been taken in the aftermath of their destruction. It was made clear, sir, in the opening statement and associated submissions by Ms Cherry on behalf of the patient group that this was a matter of some considerable and some might say understandable concern on part of the patient group. As such, this matter will be addressed with Ms Connor in the first week of these hearings.

In addition, sir, it is an important part of providing evidential context to our work to do what lawyers might describe as narrowing the ambit of the dispute. What that means, sir, is trying to understand what it is from the outset that NHS Tayside, an organisation with which this Inquiry is principally concerned, accepts and does not accept. Again, it is intended to try to address those matters with

Nicky Connor and other witnesses.

In the second week of the hearings the Inquiry will hear from the Executive Nurse Director of NHS Tayside, Mr Simon Dunn. It is anticipated that his evidence will focus on the NHS Tayside complaints and feedback systems as well as the nature and extent of the complaints and feedback received from NHS Tayside relating to Mr Eljamel, investigations broadly undertaken as a result, the remaining documentation which was held relating to those and the steps taken by NHS Tayside as a result of these investigations, all of which are covered by the Inquiry's Terms of Reference 4 and 5. He also covers NHS Tayside's significant event management policy and adverse event management policy as well as any incidents relating to Mr Eljamel falling within those systems.

In week three the Inquiry will hear evidence from NHS Tayside's Director of People and Culture, Ms Elaine Watson. It is anticipated that her evidence will focus on the appointments of Mr Eljamel and information relating to how he was successful in gaining key positions he held including his appointment as a consultant in 1995, all of which are covered by Term of Reference 1. It will also cover the trajectory of his career in NHS Tayside, the main roles and

responsibilities he had and the terms on which he held them, including the rules relating to matters covered by Term of Reference 2 such as private work, workload, teaching and research commitments and the responsibilities of consultants towards junior staff, including the allocation of surgical responsibilities to them.

Her contribution also covers the rules within NHS Tayside relating to supervision, suspension, dismissal and removal of a medical professional's name from the GMC medical register as well as Mr Eljamel's clinical supervision, Term of Reference 8, his suspension, Term of Reference 9, his resignation from NHS Tayside, Term of Reference 10, and the removal of Mr Eljamel's name from the GMC medical register in particular NHS Tayside's role in that process under Term of Reference 11.

Also in week three the Inquiry will hear the evidence of the board's secretary of NHS Tayside, Ms Margaret Dunning. It's anticipated that her evidence will focus on the broad roles and responsibilities of NHS Tayside and other bodies which exercise control over the operation of neurosurgical services in the past as well as the roles and identities of key individuals within the board and those other bodies. Her

contribution also covers the roles of certain committees within NHS Tayside as well administrative records management within the board and data protection.

In the final week of the hearings, the Inquiry will hear from Dr James Cotton, NHS Tayside's Executive Medical Director. Dr Cotton is the signatory of the NHS Tayside written statement and has answered by far the largest number of questions in it. It is anticipated that his evidence will cover the investigations undertaken under Term of Reference 12 insofar as they involve NHS Tayside including the ambitions, remit, methodology and broad conclusions of each, as well as steps taken or not taken in the aftermath of them. His contribution also covers a number of other important aspects of the NHS Tayside evidence including the remits of various departments and committees, relative responsibilities of the board and other bodies with key roles in the provision of healthcare in Scotland, mortality and morbidity structures, professional governance structures, internal and external information sharing systems, including with patients, professional regulators, the Scottish Government and the police, the NHS Tayside neurosurgical service, the use of products and devices in neurosurgery, aspects of Mr Eljamel's career with

NHS Tayside including his teaching and training responsibilities and NHS Tayside's responsibility for investigating complaints against surgeons. Which is hopefully enough to cover in a day.

The Inquiry will hear from NHS Tayside's Chief Officer for Acute Services, Ms Lynn Smith. It is anticipated that her evidence will focus on the work of the neurosurgical services offered by the NHS in Tayside as well as its main operational methodologies including working practices between the neurosurgical unit at Ninewells and other clinical departments of the hospital, as well as document management within the neurosurgical unit and information about the spread of work covered by Mr Eljamel himself.

Also in week three the Inquiry will hear the evidence of NHS Tayside's Director of Communications and Engagement, Ms Jane Duncan whose evidence will focus on apologies which have been made by NHS Tayside in connection with the professional practice of Mr Eljamel including when and why they have been made.

Finally the Inquiry will hear the evidence of NHS Tayside's former Deputy Chief Executive, Ms Sandra MacLeod. Her evidence will include information about NHS Tayside's document management systems with a focus on the management of patient

medical records and subject access requests. Such evidence is important. As I have said, Term of Reference 14 requires the Inquiry to look at the effectiveness of such systems. It is also important, sir, for us to understand what documents exist and why they exist in order to inform our future investigations.

Sir, as I have set out at previous hearings and as I have mentioned already today, the Inquiry will also hear evidence from its three expert groups who have been instructed by the Inquiry to assist you by providing technical, factual and opinion evidence to inform and help guide your understanding as well as your investigation and assessment of the factual evidence. In terms of understanding and orientation, it is hoped that the evidence of these groups will be of value to core participants, their recognised legal representatives and others who take an interest in the work of the Inquiry in maximising their participation and engagement in our work. The areas of expertise which have been covered are neurosurgery, medical ethics and healthcare administration. Evidence from these groups will also be heard at these hearings to assist with these important purposes.

Sir, the Inquiry's approach to the instruction of experts is set out in its Expert Evidence Protocol, the

principles of which are made clear to experts not least in their letter of instruction which forms the basis of their engagement with and provision of evidence to the Inquiry, to the terms of which core participants were invited to contribute suggestions as happened with the standard form letter of instruction sent to the ICR's neurosurgical experts. Along with expertise in the area in which they are instructed independence forms an important part of the experts' instruction. Paragraph 10 of the Expert Evidence Protocol provides that individuals who are appointed as experts are commissioned by the Inquiry to give it their independent professional opinions. The Inquiry looks to receive the best available input each is able to give and to be informed by the best available independent expert opinion. No expert will be expected to act as a spokesperson for or representative of any individual or organisation interested in the Inquiry nor will they be instructed for that purpose.

All three of these groups have provided detailed written reports in response to their detailed letters of instruction to which, as I have said, core participants had the opportunity to contribute. It is important to understand that consistent with the methodology and ambition which underpins these evidential sections these

experts have not been asked at this stage to consider or address any evidence relating to Mr Eljamel's professional practice. That is because the Inquiry will continue to go about the process of gathering that factual evidence in its subsequent sections.

However, it should be understood that the instructions issued to these groups have not been compiled completely in the abstract. They have been specifically designed to seek expert opinion and technical information relating to areas, activities or matters which are a part of the Inquiry's remit already such as the training involved in becoming a neurosurgeon, the purpose and main complications of common neurosurgical procedures, or the duties of candour of neurosurgeons which feature under Term of Reference 7 or which the Inquiry reasonably anticipates will arise as its factual investigations progress, such as the ethics of taking a patient's informed consent or the pitfalls involved in operating a successful complaint system. It remains the Inquiry's intention to seek to re-involve these expert groups at later stages of the Inquiry's work in particular when more evidence of the factual matters involved in Mr Eljamel's practice come to light. To the extent that you require it to be of assistance in your assessment and analysis as well as

becoming involved when we turn, sir, to the consideration of recommendations in Section 6.

It is important to reiterate, sir, that as in court actions experts do not determine the matters which are for you to decide. That applies equally to the expert groups whom we have instructed as it does to the experts who have been instructed in the neurosurgical field by Professor Wigmore of the ICR. You are the ultimate arbiter of what happened, what went wrong and who is responsible as well as why. These experts therefore have an important part to play in providing opinion and technical support but their role should not be misunderstood or overstated. Equally, the evidence which they provide including their opinions are not conclusive on any matter. The conclusions are for you to draw.

Sir, the Inquiry has instructed a neurosurgical group from which we will hear evidence in the second week of our plan, which comprises Professor Peter Whitfield, honorary professor and consultant neurosurgeon who is the group lead, Mr Robert Redfern, a retired consultant neurosurgeon, and Mr Crispin Wigfield, a consultant neurological and spinal surgeon. This group has extensive knowledge and experience of clinical practice in neurosurgery. It is

an independent group, none of the experts has worked within neurosurgery in Tayside. The group was selected based on the experience of its members and their slightly different backgrounds, one being focused currently on spinal surgery, one on intracranial surgery and one with experience of being a consultant neurosurgeon from a period around our relevant period in which we are interested as a general neurosurgeon in an environment not dissimilar to the service offered to NHS patients in the Tayside region in which Mr Eljamel played a part.

Sir, we have also instructed and received a detailed report along with a number of documents from our medical ethics group which comprises Professor Richard Huxtable who has kindly taken the role as the group lead, Dr Catriona McMillan and Professor Angus McNair. They are respectively the professor of medical ethics and law at the University of Bristol, a reader in medical ethics and law at the University of Edinburgh and deputy director of the Mason Institute for Medicine, Life Sciences and the Law, and a professor of colorectal surgery at the University of Bristol and honorary consultant colorectal surgeon in the North Bristol NHS Trust.

As with the neurosurgical group their report has

been disclosed to core participants for their consideration in advance of these hearings. The group which has been put together deliberately comprises three slightly different perspectives on the important ethical issues which have been covered by them. One is a lawyer by training and academic with a strong interest in a number of matters of direct relevance to the Inquiry's remit. One is an academic lawyer based in Scotland and hence with a particular Scottish perspective on matters. And the other is a consultant colorectal surgeon with an academic interest in medical ethics, in particular the importance of the application of ethical principles in surgical practice.

The evidence which will be presented will in fact come only from two members of the group as Dr McMillan is, for very good reasons of which the Inquiry has been aware for some time, unavailable to attend to provide oral evidence as these hearings. We will take care in presenting the evidence from other two members of the group one of whom is the group's lead to make clear if there are any matters of detail which will be more appropriately addressed to Dr McMillan and an opportunity can be afforded for those to be addressed to her at a later date. Professors Huxtable and McNair are both based in Bristol and in light of their

considerable clinical and academic commitments you, sir, have agreed that they will give their evidence remotely from there, a matter to which I will return.

The Inquiry team has also obtained an expert report from its healthcare administration group which covers matters which have been set out in previous documentation including in our expert protocol. The members of the group are Professor Anne-Maree Farrell, the professor of medical jurisprudence and director of the Mason Institute at the University of Edinburgh who has kindly taken on the role as that group's lead. Professor Kieran Walshe, professor of health policy and management at the University of Manchester, and Dr Fay Gilder a former NHS trust medical director and consultant anaesthetist. As with other groups this group was put together with particular regard to the various experience and perspectives of its members. Professor Farrell is an academic lawyer based in Scotland who, as well as having published and researched widely in the field of healthcare administration, also has considerable experience in the field of medical ethics. Professor Walshe is a very experienced academic with a particular focus on a wide range of matters relating to healthcare administration who also, as it happens, has a particular interest in healthcare-related

public inquiries. Dr Gilder is a consultant anaesthetist who not only has considerable surgical experience as a result of holding that position but has also held the position of medical director of an English health trust and so has considerable practical experience of clinical governance issues which arise in connection with that role and which form a very important part of our remit, sir.

May I say that the Inquiry is grateful to the members of these expert groups for their contributions to date and the contributions which I hope they will make in future. The evidence of these groups will be heard in weeks two, three and four of the Inquiry respectively. It is right also to acknowledge the Inquiry's appreciation to the experts who are giving up their time to give evidence which they will provide. In particular as all have multiple other professional clinical or academic commitments which make their time extremely precious and hence all the more valuable to us.

Sir, may I make one observation about the Inquiry's evidential expectations of the witnesses. I will explain in due course what steps have been taken to ensure witnesses are well placed to provide useful and accurate evidence to the Inquiry at these hearings.

These have been thorough and systemic and deliberately so as per the Inquiry's Public Hearings Protocol. The Inquiry has received witness statements from organisations in Section 1 who were selected to speak for these organisations. In the case of NHS Tayside, as I have said, multiple contributors to the statement were selected and so there will be multiple witnesses from that organisation to speak to the various aspects of NHS Tayside's evidence.

Few, if any, of the witnesses were involved in the events of the time though some who have been selected by the organisations have deliberately been selected because of the fact that they were, at least to some extent. Witnesses who are called to evidence under oath will be expected to be able to speak to the passages that they have contributed to statements and to documents which they have produced in a reasonably discursive and explanatory way. There will be little point in simply expecting to attend to read out the statement or to point to a document for the answer. All organisations involved have committed, or are at least certainly expected to contribute, to the important public work of this Inquiry constructively. At this stage this means witnesses from those organisations attending with the aim of answering reasonable questions

about what has been produced for the illumination of the Inquiry and its wider audience within the clearly expressed aims of this section of the Inquiry's work.

Equally, from the other perspective, those who seek to have questions asked amongst our core participants should remember that the time divide between where we are now and the events we are seeking to examine as well as the approach of the Inquiry to seeking largely organisational evidence in section 1 will inevitably place some limitations on what witnesses can speak to at this stage. In particular, those who advise their core participant clients will be expected, as a feature of their professional advisory obligations, to advise when questions their clients seek to pose go beyond what could reasonably be asked of witnesses in this forum at this time. That does not mean that we are not here to probe. We are. To be effective, however, such probing must be undertaken in light of our evidential aims in this section and the reasonable expectations which can be placed on the witnesses in light of them.

Sir, I have a little more to say about some of the materials which have been collected as part of the section 1 workflow before moving on to other sections but as I tend to speak very quickly, I suspect the stenographer may require a break. So perhaps I

could suggest that we have a break at this stage maybe for around 20 minutes.

THE CHAIR: 20 minutes. If that is a convenient moment, yes, of course we'll do that. Ladies and gentlemen, you've heard Mr Dawson signal an appropriate moment where it might be expedient for all concerned to have a break. We'll do that and we'll resume again in 20 minutes' time. Thank you.

(11.30 am)

(A short break)

(11.52 am)

THE CHAIR: Yes, Mr Dawson.

MR DAWSON: Sir, I was in the process of explaining the preparations which have been undertaken for this hearing and our intentions for it and I had just got to the part where I was going to set out some information about materials which have been sought and to some extent obtained by the Inquiry as part of its Section 1 workflow which are perhaps unlikely to feature during the course of these hearings.

There is a good deal, sir, of evidential material which has been gathered under the Section 1 workflow of general contextual importance to the remit of the Inquiry and to our investigations to come which is unlikely to be ventilated at these hearings.

I will turn in a moment to suggesting what can be done with that material by core participants which would be of use to the Inquiry. However, for present purposes I would not like to seek to suggest that it is not of importance to our work when that material certainly is. It is just that other material was thought to be more worthy of public ventilation at this stage and in connection with the witnesses whose identities I have outlined. As previously announced written statements and associated documents for which the Inquiry is grateful with have been obtained from campaigning members of the Scottish Parliament, Mr Marra and Mr Rennie and from a number of other organisations, including Police Scotland, the BBC, the Health and Safety Executive and the British Medical Association.

In addition further evidence requests have been issued by the Inquiry as its investigations in this section have progressed. It became apparent that documents of relevance to the Inquiry's Terms of Reference which were held by organisations which no longer exist and possibly other documents passed to them from other bodies may be held by the National Records of Scotland. Therefore a written witness statement and document request has been sent to that body seeking further documents which may be of use and which may be

of value to you, sir, and the core participants in the Inquiry as we go forward.

The Society of British Neurological Surgeons is a national body which supports the study advancements of the neurology. Equally, it became apparent that it was a body that either did or could have had involvement in matters relating to the professional practice of Mr Eljamel and so a Rule 8 request has been sent to that body to find out more about that.

Further, it also became apparent during the course of our investigations that there was a body called the Managed Network for Neurosurgery which played a significant part in the way in which neurosurgical services have been delivered in Scotland. In particular by supporting the delivery and audit of neurosurgical units in Scotland including in Dundee and reporting to the Chief Medical Officer for Scotland as well as issuing evidence-based national standards for neurosurgery in Scotland, the first of which appears to have been issued in September 2010. A Rule 8 request has thus been sent to that organisation to understand the role it plays, played, or could have played in connection with matters relating to Mr Eljamel's professional practice.

Further, it emerged during the course of our

investigations that Mr Eljamel appears to have carried out a relatively large amount of functional neurosurgery. Functional neurosurgery is an area of that field which adopts procedures to target the nervous system for the alleviation of the symptoms of other conditions. Examples would include deep brain stimulation for conditions such as Parkinson's Disease, dystonia, tremor or pain. This is an area in which, as you will discover, the experts on our neurosurgical group have relatively less experience than in other areas of neurosurgery though they have been able to provide some helpful general assistance in understanding its goals and ambit.

We have therefore issued a Rule 8 request to the British Society for Stereotactic and Functional Neurosurgery to find out more about their role, functional neurosurgery in general and what we understand to have been Mr Eljamel's connection to that organisation in light of the organisation's apparent involvement in that potentially significant area of practice.

Assertions were recently made by the patient group to the Inquiry about matters concerning the role of nurses involved in their care. Connected to that was a suggestion that a Rule 8 request similar to that sent

to the General Medical Council could be sent to the Nursing and Midwifery Council. It has not unfortunately been specified what the particular issues are which have been experienced nor what evidence should be sought from the NMC or what Terms of Reference such investigations would be connected to or why. However, in light of this helpful suggestion a Rule 8 request has been drafted and issued to the NMC. For clarity it is not currently accepted by the Inquiry team that it would be appropriate for such a Rule 8 request to be of a similar nature to the one issued to the GMC given the fact this is an Inquiry which focuses on the systems involving the practice of a neurosurgeon as opposed to nurses and the clear, direct involvement of the GMC in parts of the Inquiry's Terms of Reference. Nevertheless, it was considered in light of this representation to be of relevance for aspects of the role and responsibilities of the NMC and of the nursing profession to be examined to a certain extent and it is expected that a draft of the Rule 8 response from that organisation will be received in early course which will be analysed and processed in the normal way.

These written statements and any exhibits as well as any other documents produced by these organisations in response to calls made of them by the Inquiry have been

or will be disclosed to core participants in due course. It should of course be borne in mind that the Inquiry will, in Section 4 of its evidential plan, assess the responsibilities of bodies that did play or could have played a role in the professional practice of Mr Eljamel to the extent that has not already been made reasonably clear by that point. I will return to the thinking behind their disclosure when I address the plans for what will happen after these hearings in due course.

Sir, I turn now to the procedural plans for these hearings.

Against that background, I would like to say more, sir, about how these hearings will work. It is important to understand that these hearings are part of a process of investigation. They are an important part, as I have said for reasons I will return to in a moment, but they are not the only part of what we do in this section. They are part of a process of investigation, analysis and planning which has been ongoing and which will continue when all of the oral evidence in these four weeks has been heard even within the introductory confines of Section 1. Beyond that they are part of a process which is designed ultimately to lead you to expressing conclusions about matters within your remit in a report or reports at a stage in the

proceedings when you feel you have heard enough to be able to reach those important conclusions. They are not the end of anything, not even a Section 1 of our evidential plan.

The importance of hearings in general terms including these hearings is set out, as it has been for some time and as I've already said, in the Inquiry's Public Hearings Protocol. What is contained there from a procedural perspective merits clarification and explanation at this time.

In order to achieve its investigatory aims the Inquiry has followed certain processes and will continue to follow others at these hearings. I will set out now what has happened in advance of these hearings and what will happen at them so that everyone with an interest knows how things will work and why.

As with all material received by the Inquiry, draft statements and documents either exhibits to statements or otherwise required by the Inquiry in terms of our requests were analysed by the Inquiry team. Comments were provided on the draft statements by the Inquiry and proposed sets of documents produced with a view to seeking to improve the overall quality and comprehensiveness of the evidence being provided by an individual or organisational material provider.

Amendments were made by the providers to draft statements accordingly and further sets of documents provided, as the material provider or witness saw fit in accordance with the comments and suggestions provided by the Inquiry team before the statements and documents became evidence in the Inquiry, at which time they were catalogued using the Inquiry's referencing system by which unique reference and page numbers are attached to all evidential documents.

The information and documents received as a result of the Rule 8 requests for written statements and documents produced went through a lengthy process of legally required assessment for relevance and then redacted in line with the Inquiry's general restriction order so as to remove sensitive material such as personal data amongst other generally applied restrictions and the two restriction-related protocols which have been prepared and published.

The Inquiry has taken a view that, given the general introductory nature of the evidence being looked at in this section, it is unlikely that individual patient cases or experiences will be examined in any detail and so it is unnecessary for the names of patients referred to in documents to be disclosed or published. Thus the names of all patients have been redacted from the

materials other than two prominent campaigners whose names do appear in the documents and may need to be referred to and who have agreed to that course, as well as having been given the opportunity to make representations about any sensitive passages within documents relating to them in connection with which they have been offered the opportunity to make representations about possible restriction. In due course, when patients' cases become a greater part of our investigations as they become more focused on patient and their important experiences, patients will be offered the opportunity to apply for anonymity. Thus, for now the Inquiry has applied temporary redactions to patients' identifying information for the sake of efficiency and respectful to the undoubted wish of some of them to remain anonymous.

For those who do it will be the default that anonymity orders will be granted to patients who wish them. In such cases the redactions protecting the identity of these individuals will remain in the documents which have been which have had temporary redactions applied for present purposes.

There are other redactions which have been applied to documents for reasons of the proper administration of the work of the Inquiry in accordance with the Chair's

statutory power to do so. Some of these may be able to be removed when certain further steps are taken, in which case documents will be redisclosed and if necessary republished. Given these decisions about the application of potentially temporary redactions, the Inquiry's General Restriction Order and relevant protocols have been slightly altered to cover this course for the sake of clarity. Updated versions are available on the Inquiry's website.

For the sake of completeness, those who follow these matters keenly will have observed the Scottish Ministers made an application to have the names of junior officials mentioned in their documents redacted. That application was refused by you, sir. Your reasoning is available on the Inquiry's website. With the result that these names of these junior officials remain to be seen in these documents, as will the names of other public officials unless there is a reason why, sir, you have thought it fit to redact them whether permanently or temporarily for a good reason in accordance with the balancing exercise you're obliged to carry out of openness and transparency on one hand and other competing rights on the other.

Documents including written statements have been gradually disclosed to core participants in the lead up

to these hearings in tranches as the processes I have described have been completed and the redactions have been applied to the documents. It is neither necessary nor proportionate for the Inquiry to disclose every document it receives. That is not required and would hinder the Inquiry in the performance of its functions. It would also be a derogation from the Inquiry's functions were it to pass to the core participants all the material that it receives.

However, in this section at least a liberal approach to disclosure has been taken to maximise the information available to core participants and to provide them with a broad context in which to participate in these hearings but also to assist the Inquiry with the steps we intend to take next to which I will return.

A draft list of witnesses was sent to core participants to contribute to in the week of 6 July 2026 as had been planned after initial contact had been made prior to that with proposed witnesses themselves to seek to understand where they had any availability issues which the Inquiry sought to respect as far as possible. Alterations and additions to the witness list were made according to the reasonable requests and suggestions of the core participants, a final witness list was then published after accommodation had been incorporated to

deal with reasonable witness requests based on availability. Further, some witnesses have been allowed to give evidence remotely, to which I will return.

In accordance with our published processes, documents called Evidence Proposals have been drafted and circulated for every witness. These are contributed to by core participants and the witnesses themselves and serve two broad purposes. Namely (a) to inform the witness and core participants of the broad topics which may be covered with the witness in the oral evidence session and (b) to list the documents which might be put to the witness in their evidence. That is in the interest of fairness but also to allow the witness to prepare properly for their evidence session.

Further, on the basis of the materials they have received in the disclosure, core participants have been provided with the opportunity to contribute proposed questions for witnesses. The input of core participants to the Evidence Proposals and their proposed questions have been and continue to be considered by myself and my learned junior Mr Crawford. We are grateful for them and the contributions made and to be made by core participants to the list of witnesses, the Evidence Proposals and the questions in due course.

The way that witnesses will be called to give

evidence will be that they will enter the room, for remote witnesses they will appear on screens. They will sit in the witness seat which is opposite me there. They will either swear or affirm that they will tell the truth, the whole truth and nothing but the truth before their evidence commences. The oath or affirmation as the witness prefers will be administered by you, sir. The witness will then be asked questions by me.

Previous consultations with our core participants have made it clear that for very good reasons those with an interest in our work who are either here in person or watching via the YouTube link prefer to have regular breaks and be aware in advance what our plans are in this regard. Anyone who has experience of inquiries, courts or other similar tribunals will know there are numerous factors which can scupper the best laid plans for hearings like this but in light of these reasonable requests and the need for careful management of the precious time at the hearings we have put some time into developing a detailed plan, at least as our starting point. We will generally work on the basis that the hearings will commence 10 am and will aim to finish the day by 4.30 pm. As was clearly conveyed in previous consultation there is a need for breaks to be incorporated into our planning as I have said and we

have listened to that reasonable request.

Though there are many factors that can influence running times, such as unexpected turns in the evidence, technological hitches which we will do our best to avoid and reasonable requests by core participants for important questions to be put to a witness, the following is the basic timing structure which we intend to adopt. The day will be split into a morning and afternoon session. On most days a witness will be called in the morning and in the afternoon but on some days there will be a full-day witness or a group giving evidence. The morning and afternoon sessions will generally be split into two equal sessions of 2 hours 45 minutes with a break for lunch from 12.45 until 1.45 which will occur every day.

There will generally be breaks in the morning session and in the afternoon session totalling 30 minutes meaning that evidence will be heard for up to 2 hours 15 minutes in each half-day session. It is important to understand that core participants' main opportunity to contribute proposed written questions was 7 days before the hearings when these were communicated between counsel. As I have said these have been and will continue to be considered by myself and my learned junior and incorporated into our planning as we see fit.

In light of our plans and areas we think are likely to be useful in illuminating you, sir, and the public more widely, some have been retained for later use as I have said as they are too detailed for now. However, there will be a further opportunity on the day of a witness's evidence for questions to be proposed. Guidance on the timings and opportunities which this window affords have been explained between counsel.

Therefore for a half-day witness whose evidence will be heard over a total 2 hours and 45 minutes, there will be 2 hours notionally allocated to examination by the Inquiry with a 15-minute break in the middle. That will leave around 15 minutes for a further break during which time proposed further questions from core participants will be considered and 15 minutes will be reserved for those additional questions to be asked.

Some witnesses will be shorter than that, given the limited scope of their evidence, but that is the basic structure. For a full-day witness we will follow the same plan as that in the afternoon session with a half-hour break in the morning. Lunch will usually be taken, as I say, for an hour between 12.45 and 1.45. For the expert groups we will endeavour to leave a bit more time for the core participant input given that their evidence is wide-ranging within their specialist

areas. Core participants' recognised legal representatives have been informed they will need to develop systems for gathering possible questions from their clients, formulating them and deciding upon proposed questions as we go along. There will not be long breaks, the timetable will simply not permit it. In our view they would be unnecessary.

Equally, those recognised legal representatives have been reminded that these are introductory hearings and that matters of detail beyond our stated remit in this evidential section will need to wait until later. Though questions from client core participants are welcomed, recognised legal representatives will be expected to use their professional judgments in making their proposals for further questions in light of our plans and not simply act as a postbox for their clients. They are all experienced and skilled professionals whose role involves judicially picking what questions need to be asked and advising their clients why. In particular, they will be expected to propose questions which are designed to fulfil the basis upon which their clients were recorded CP status in the first place, their ability to assist the Chair of the Inquiry in the investigation and the determination of key matters within our remit.

It is against that context that proposed questions will be judged. We have every confidence that those core participants have a huge amount to contribute and that their recognised legal representatives will represent their clients with skill and judgment. Being a core participant does not equate to the role of a spectator, sitting on the sidelines passing judgments or a criticism. Your role is to be part of the play on the pitch suggesting and supporting the Inquiry team and the Chair in progressing towards our common goals.

Witnesses whose evidence go over a break will be told that they are not permitted to discuss their evidence with anyone during the break. They will be held to that and are therefore not entitled to discuss their evidence with anyone including their recognised legal representatives over that period. When witnesses return they will remain subject to the oath or affirmation they are given. The Chair may see fit to remind them of that but whether he does or not, that will be the position. I will generally ask witnesses at the end of their evidence if they have anything to add. That can be a pre-prepared statement if they wish, that is a matter for them, but witnesses are asked to bear in mind the purposes and remit of the Inquiry and that ultimately the purpose of their evidence is to assist

the Chair. Therefore we do not expect or require witnesses to come along with pre-prepared scripts in the expectation that they will be delivered at the start of their testimony. Our experience is that such statements are often unhelpful to the extent that they tend to be subsumed within the testimony given anyway in response to questions and by the end of his or her testimony the witness can, in light of our plan, reassess what they feel needs to be assessed in light of the general final question which I intend to ask.

The Chair will normally give me or another questioning counsel the opportunity to ask follow-up questions arising from that response to that overarching question. Core participants will of course be entitled to propose follow-ups to this or any other part of the witness's evidence as I have set out.

Witnesses should remember that their evidence is their responsibility even if they are giving evidence on behalf of an organisation or a group. As with written evidence to which they have attested in written statements that they have said is true, they are giving evidence under oaths or affirmations administered by the Chair under his legal authority to do so under the Act.

Some witnesses will give evidence remotely. What that means is they are not physically here and will give

evidence via a videolink. The default position the Inquiry expects witnesses to appear before the Inquiry in person. If they have been granted dispensation by the Chair to give evidence remotely it's because the Chair considers it within the public evidence that their evidence be taken in this way in the exercise of his statutory power and responsibility to regulate the procedure of the Inquiry as he sees fit within the strictures of Section 17 of the 2005 Act.

Witnesses will be treated as best we can and in all legal respects in precisely the same way if they appear remotely as if they have been here in person. They will be subject to the same oath or affirmation as other witnesses and be subject to the same rules about not discussing their evidence with anyone during breaks or otherwise.

As I've said at previous hearings, the video feed by which we are watching the evidence via YouTube will be transmitted with a delay of 3 minutes. This mechanism is part of the systems we have to try to prevent any confidential information being transmitted to the wider public which should not be. In the event that something is said by me or by any another contributor which seems to contain information which ought not to have been referred to, I will cut the feed or told to do so by the

other members of the Inquiry team. They will stop the transmission. We will most likely have a short break to work out how to proceed. My apologies to all in advance for any interruption which we need to make to the evidence of any of the witnesses for this purpose. This is why it will be necessary to do so.

I would urge witnesses to avoid revealing any matters which are likely to be potentially confidential including patients' names other than of the two prominent campaigners, Ms Jules Rose and Mr Pat Kelly, who have waived the right to be anonymous and whose name does appear in materials which have been disclosed by the Inquiry in this section. Any such information which is inadvertently referred to must not be referred to or otherwise shared outside this room and is subject to the Inquiry's First Order covering those in attendance including members of the media.

For the avoidance of doubt you have pronounced a further Order of the Inquiry, sir, shortly in advance of these hearings relating specifically to the information which may be transmitted to those within the hearing room but ultimately not published via the YouTube feed or becoming part of the published video of proceedings or in published documents. If there is any doubt about what can be transmitted or broadcast outside

the room the Inquiry legal team can be contacted or spoken to for clarity.

Sir, these proceedings are not adversarial and parties do not have the same rights to object as they do in adversarial litigation. The question of policing restricted information is largely a matter for you and the Inquiry team in accordance with the approach which has been adopted or ordered by you in connection with the disclosure and publication of documents which have been produced in connection with these hearings. If a recognised legal representative wishes to assert the materials should be restricted they should ordinarily communicate that to the Inquiry's solicitors by email on their legal email address that they think material ought to be restricted or that they wish to apply for restriction bearing in mind that time to do that is limited in light of the feed delay being only 3 minutes.

Sir, the statutory rules relating to the rights of core participants to make opening and closing statements are to be found in Rule 10 of the 2007 Rules. As there will be no opening statements in addition to those delivered in November, for the reasons I have already touched on, the same logic underlies the position that there will also be no closing statements or submissions by core participants at this time. The focus of these

hearings is evidential and core participants have had the opportunity to contribute via question proposals as I have set out. We had a separate opening statement hearing so we could listen to what core participants had to say and incorporate their helpful contributions into our plans and investigations as well as allow the focus to be on the evidence at these hearings. There will be an opportunity afforded to core participants to make closing statements and written submissions at the end of our hearings.

This may not be the experience of some participants from other public inquiries where core participants have the opportunity to make opening or closing statements in each evidential section. Those that do adopt such an approach tend to be more modular in scope where their subject matter lends itself to sections or modules on different subjects with separate submissions being appropriate on each. Examples might be the UK Covid-19 Inquiry or the Scottish Child Abuse Inquiry. Our approach to our remit is different. As our Terms of Reference all relate to the systems surrounding the NHS career of one man and our sectional approach looks to the totality of the evidence relevant to each section and focuses on different categories of witnesses. It has thus been thought to be of more use to the Chair if the

core participants' contributions at this stage focus on the evidence and that statements and submissions on the totality of the available evidence will be invited later in order to assist you, sir, in the compilation of your final report or reports.

That is not to say that core participants may not be invited to make submissions as we go along in the course of the Inquiry on a particular matter which you, sir, deem to be of any particular assistance at any time. Indeed, I will return to a proposal for such a submission to be made later in this opening address.

Finally, sir, in relation to the plans for these hearings I would like to say something about publication of material. The Inquiry's protocols differentiate between disclosure on the one hand and publication on the other. Disclosure relates to the dissemination of material or information to core participants or others such as witnesses or recognised legal representatives who are bound by the Inquiry's First Order and confidentiality undertakings provided to the Chair of the Inquiry by individuals from publishing beyond the groups in which they reside. Publication, on the other hand, involves information or documents being available to the public at large which generally removes the restrictions on core participants and their lawyers from

discussing or disseminating the information or documents more widely.

Generally certain materials will be published at the end of the day of the evidence or the next day. This may be in addition to the information contained in this speech and the oral testimony of any witness which by that stage will have been published publicly via the YouTube feed. The material which will generally be published will include the statements of witnesses who have given evidence or the statement of an organisation on the last day on which evidence is given about it or extracts from those statements as the Inquiry deems appropriate. In addition the Inquiry will publish documents referred to in the evidence that day or extracts from them as appropriate.

Care should be taken by those who are in possession of information or documents which have been disclosed to them to make sure that they are aware of what has been published on the Inquiry's website so that they do not release information or material which has not been more widely disseminated than is permitted.

I would like to take the opportunity to reiterate the principles of the First Order and the further Order of a similar nature relating to these hearings which I have mentioned. I should say that I do so for the

sake of completeness and not out of any particular concern or by way of censure. In fact our experience has been that our core participants, in particular patients and their recognised legal representatives, have been careful and respectful of the need to observe the Inquiry's confidentiality rules and have taken care to seek advice where necessary and otherwise to respect and observe their terms. Again, if those in attendance who have otherwise received materials or information from the Inquiry have any questions about their publication or the rules in that regard the Inquiry legal team is on hand to deal with any such queries.

Sir, moving now beyond the intentions for these hearings I'd like to say something about Section 2 progress and the plans for the next set of evidential hearings in December of this year.

As those with an interest in this Inquiry will know, Section 2 of the Inquiry's workflow is the part in which we gather and examine the evidence of former patients of Mr Eljamel and in certain cases their personal representatives. There are two components to this work, both of which are well underway, namely the oversight function which the Inquiry holds over the work of the ICR and the direct gathering of evidence by the Inquiry from patients and patient representatives. The ICR, as

those who take an interest in our work will certainly be aware, is a review process in which applicants, former patients of Mr Eljamel or their representatives, can seek to have their cases subjected to clinical analysis by one of a term of independent expert neurosurgeons appointed by Professor Stephen Wigmore, the chair of that process.

The ICR evidence itself has two main parts, namely the completion of statements of applicants to the ICR and exhibits to those statements and separately the neurosurgical reports themselves as well as any exhibits associated with those. The Inquiry has the ability to nominate patients' cases which it wishes the ICR to prioritise either by way of identifying cases where individuals have applied to the ICR to be amongst this priority group or by referring cases for neurosurgical review. I will return to progress in the ICR and its impact on our procedural plans in a moment.

A provisional outline of the scope of Section 2 of the Inquiry's evidential plan has now been published on the Inquiry's website which provide some further detail of the matters which we intend to cover in that section. The broad areas set out there are the areas in which the Inquiry feels patients are most likely to have an important and valued perspective and on which

neurosurgical experts in the ICR may have relevant opinions to offer. Around 6 weeks ago, the Inquiry issued Rule 8 requests to 23 former patients of Mr Eljamel and two spouses of former patients of Mr Eljamel, 25 Rule 8 evidential requests in total.

These Rule 8s had been issued in accordance with the Inquiry's known duplication principle which seeks to minimise the number of times a patient requires to repeat their story about what happened to them. Amongst the means by which the patient voice will be heard in this Inquiry on matters of systemic significance or the matters foreshadowed is in paragraph 22 of the Inquiry's protocol on its approach to evidence and written statements which form part of what patients have been asked about in this Inquiry Rule 8 requests. In most cases in addition to their perspective on clinical matters which they have already provided to the Inquiry via their ICR applicant statements and associated exhibits.

Sir, in terms of the Inquiry's Term of Reference 16 the Inquiry will be obliged to take account of the ICR's finding in its work. The intention is that the ICR will set out what went wrong clinically. The Inquiry's role will then be to investigate what systems should have existed to detect and prevent those things going wrong

and harm occurring and whether those systems were in any way defective.

By way of reminder, patient evidence contained in the Inquiry Rule 8 statements will be taken into account by you, sir, in addition to the ICR applicant statements and any exhibits. For individuals not called upon to provide Inquiry statements their ICR applicant statements and exhibits stand as their evidence in the Inquiry.

Sir, I will return in a moment to the progress of the ICR but those with an interest in our work will recall that concerns were expressed by me at the time of the procedural hearing in May as to progress in the ICR's work in light, in particular, of the need to be ready for the important evidence of patients to be heard at the hearings which have been scheduled for December of this year. At that time I reiterated the need for efforts to be redoubled within Levy & McRae, in particular in light of the fact that they would soon become responsible, as they have been over the last six weeks, for assisting with two important streams of work at the same time, namely the ICR applicant statements with which they had been supporting their clients during the course of this year and the Inquiry Rule 8 statements which were issued around six weeks

ago.

In order to assist with this development, sir, you have funded an additional solicitor to be involved in the work of the Inquiry within the firm of Levy & McRae in order to enable the clear targets for the drafting of the Rule 8 statements to be met. As will be in hearings when draft Rule 8 are due, which is this week as it happens, progress will be able to be monitored and discussions can take place alongside them as representatives of the Inquiry and the patients will be on hand to address any issues which may arise. Given the reasonable demands on the part of Levy & McRae and indeed other parties at previous hearings for clarity and advance notice of what would be expected of them, we have made efforts to be clear about what will be required, when and perhaps most importantly why, as well as you, sir, going the extra mile to ensure that adequate funding for the process was in place.

We helpfully received a breakdown from Levy & McRae a couple of weeks ago about the progress which had been made towards the completion of the Rule 8 statements for the recipients of the Rule 8 requests whom they represent. I was also pleased to learn from my learned friend Ms Cherry recently that she has been taking a keen interest in trying to ensure that reasonable

progress is being made, for which the Inquiry is grateful. We hope that the process of drafting these written statements by those who have been called upon to do so by the Inquiry has been a profitable experience for them and very much look forward to reading and commenting on the written drafts of them in early course. A team is waiting and ready to do so as soon as they are received. We are appreciative of the work which has gone into the production which we are sure will not have been easy for some. It is integral to the success of this Inquiry that the voices of patients are heard, in particular at our hearings in December and those ongoing efforts play, and will continue to play, a pivotal part in that aspect of our plans and of our evidence.

By way of an update on the work of the ICR I can report, sir, that as its work has moved into the sphere of the instruction and production of neurosurgical reports in order to provide additional assistance to the ICR in this expert stage of its work in addition to the oversight which the Inquiry provides by way of commentary on draft neurological reports the Inquiry team has also created a draft template for the surgeons, much like the template for the applicant statements to ensure consistency, both from the point of view of

evidence being provided to the Inquiry in both form and substance, but also clarity and consistency amongst the applicants who are the primary recipients of the ICR evidence.

It is important to understand that the evidence of the ICR plays a number of important roles in the investigation of the Eljamel affair. It allows for the ambition of the appointing Cabinet Secretary to be met that patients who wish to have one will have an individualised review of their care. It allows a wide variety of patient voices to be heard in the Inquiry on a variety of clinical matters in addition to evidence they provide on systemic matters to the Inquiry directly. It constitutes a body of clinical evidence of what went wrong across the period of Mr Eljamel's working life in Tayside both in the NHS and in private care upon which basis the Inquiry's systemic investigations of the NHS can proceed.

A Rule 8 request has been issued to Professor Wigmore as the Chair of the ICR some weeks ago. I'll return to the intention with regard to oral evidence of Professor Wigmore and potentially from the ICR beyond that in due course in connection with our plans. You will however recall, sir, as part of my opening address at the opening statement hearing back

in November I had occasion to point out that delays in getting the ICR initially up and running had become, by that point, intolerable.

A plan was put in place based on a timetable which had been put in place by Professor Wigmore involving a three-month projection for the completion of an applicant's case which involved the top 50 cases being completed by March 2026. No objection to that plan at that time was raised though an opportunity was afforded to everyone represented at the hearing to do so. As a result of the forced postponement of the Section 1 hearings to this hearing slot now in September, and the subsequent knock-on delay of the planned Section 2 hearings to December, a further opportunity was taken to get a second batch of priority cases underway so as to increase the pool of cases to which the Inquiry might have regard in Section 2 in addition to plans for our own investigations amongst the patient group via the Rule 8 requests which I've already referred to.

Thus the priority group was increased to 111 cases, an increase designed to mitigate the effects of the forced procedural delay. That group of 111 cases is comprised of three separate batches of cases. The first is the top 50 priority cases which were selected by the

Inquiry for the ICR to handle first based on materials to which the Inquiry had access. A further group of the next priority cases, 51 as it happens, was identified by the Inquiry thereafter using the same materials and criteria. Further, a third group of ten cases was set in motion by the ICR itself thus completing the set of 111 priority cases now making their way through the ICR process.

At the procedural hearing in May the process was up and running but had continued to be affected by delay predominantly arising from the need to address issues relating to the quality and comprehensiveness of draft applicant statements prior to their consideration by an expert, this resulted in deadlines set down by the ICR process being missed often by considerable margins. As I say so far 111 cases are making their way through the ICR process. Of these 18 are cases which were referred to the ICR by the Inquiry for review. 93 are applicant cases, meaning cases in which an application has been made by a patient or patient representative and an applicant statement has been provided. Of those 93 applicant cases I understand that 46 applicant statements have now been completed and are available for evidence to the Inquiry along with their attached exhibits. Those statements will be used by the

neurosurgical expert instructed in those cases as part of the evidence to which they will have regard in compiling their final reviews. All applicant statements and neurosurgical reviews which emanate from the ICR will, as I said, ultimately be evidence in the Inquiry in accordance with our processes.

I will return to the subject of progress of these neurosurgical reviews in due course, but as a general observation progress in the ICR remains too slow with various consequences which I will outline momentarily. It is worthy of note, sir, that in order to address the issues which were debated at the May hearing the Inquiry redoubled its efforts to perform its support and oversight role in the work of the ICR. This has involved a full-time team of two junior counsel and one assistant solicitor as well as a team of three paralegals doing nothing but the work of the ICR for most of the time since May. In addition the Inquiry will shortly benefit from the services of a new assistant solicitor whose role will, in part, involve that function also. The plan for the longer term had been, and remains, that the two junior counsel and one assistant solicitor will move on to later sections as befits the systemic focus of the Inquiry's work. However, systems we put in place to ensure that cases of

novelty or apparent significance continue to be analysed by the Inquiry throughout, all will be evidence in the Inquiry and available to you, sir, in the determination of your ultimate findings.

Sir, as far as the December hearings are concerned it had been the intention, as I announced previously, that the Inquiry would hear evidence at that time both from patients, patient representatives and the evidence of Professor Wigmore who was due to provide a Rule 8 statement in the form of an interim report on what the neurosurgical experts in the ICR had discovered in their reviews. In order to enable necessary preparations for that evidence to be made, it had been intimated to the ICR that the 50 preliminary priority reviews required to be completed by the end of July and the remaining 61 by the end of August.

At this moment I understand that only one neurosurgical review has been finalised and signed. There are a few more which, as I understand it, are in their final stages towards signature. While that situation is likely to change hopefully in early course it is unrealistic in our view to think that reviews will be advanced in sufficient numbers and to a level which would permit consideration at hearings as soon as December, in particular in light of the time it will

take for the Inquiry to go through it's own risk disclosure processes relating to the materials associated with the examination of the ICR's neurosurgical evidence. The result of this is a necessary change of plan for December and beyond, the main goals of which are to try to make what progress we can and to seek to maintain the important concept of stability for patients.

Accordingly, the intention is that the December hearings will involve patient and possibly patient representative evidence only.

In order for this to be able to be achieved once again I must stress to those patients who have received Rule 8 requests and their legal advisers the importance of meeting the Inquiry's deadlines both in terms of time but also in terms of comprehensiveness, of clarity and of formatting as are clearly set out in the Rule 8 request in its terms. The position and experiences of the witnesses will, as with all such statements, be expected to be set out as clearly as the witness is able. Exhibits will be expected to be clearly referenced and their significance to the witness clearly laid out in the statement. Those responding to Rule 8s and their recognised legal representatives are reminded of the provisions of the Inquiry's protocol and its approach to evidence in this regard. Paragraph 59 says

that not every document in the medical records will be relevant. For instance, many may contain details of other medical issues of no relevance to the Terms of Reference. Only key documents for medical records, if they are available, should be exhibited to any written statements together with any other documents that may be relevant to matters outlined in the Rule 8 request.

The Inquiry's clear and consistent formatting requirements will need to be respected in order to avoid delay after a first draft is produced. A failure in this regard will jeopardise the Rule 8 statements being completed and the witness not being eligible to be considered as a witness for the hearings in December. Sir, it is anticipated that their now considerable experience of solicitors at Levy & McRae in providing assistance and advice in connection with the ICR applicant statements since the start of this year will prove to be of considerable assistance in this regard, given that the processes involved there were deliberately designed to be similar to the Inquiry's own process for completing written statements as well as the additional funding to which I referred which you have provided.

Your further guidance in that regard features as parts of correspondence you have also sent to the firm

in July and should, I anticipate, have proven useful in responding to the Inquiry's evidential request for written statements as well.

In addition the Inquiry will continue to have regard in its oral witness selection process to completed ICR applicant statements which of course focus on the clinical experience of the applicants. Of the 93 applicant cases going through the ICR presently, as I have said, I understand that 46 applicant statements have been completed. These are being further analysed by the Inquiry team as we speak. However, those which are near completion may also be considered for the oral hearings and so should be attended to as quickly as possible by the applicants for that important purpose.

For the sake of clarity the Inquiry team intends to meet and discuss the finalisation of a witness list of patient or patient representatives whom it would like to call to give oral evidence in December. That process is planned to take place in the week after these hearings, the week commencing 5 October, at which time the Inquiry team will take decisions about whom to invite to call in December soon thereafter. Those on the list will be contacted about specific dates thereafter and a final timetable will be issued to core participants and published as soon as possible.

Disclosure of documents received in response to Rule 8s will continue to be done in an order which is appropriate to the way in which the Inquiry's sections are structured. Given that the Inquiry will, in Section 2, focus on the evidence of patients and in due course evidence emerging from the ICR it is considered likely that disclosure for the updated December hearings will focus on written statements from patients and exhibits, applicant statements and exhibits, as well as relevant complaint files and extracts from medical records which the Inquiry or the patients may wish to ventilate in their evidence.

These materials are the most closely related to the patient experience of and perspective on the subject matter of the Inquiry.

Sir, entirely understandable concerns have repeatedly been expressed to the Inquiry about its intentions with regard to the publication of material emanating from the ICR including applicant statements and associated exhibits as well as Inquiry materials which may reveal the identity of individuals who wish to be anonymous. Before publishing an applicant statement and any attached medical records or other exhibits and any Inquiry statement, the patient in question will be given the right to apply to the Inquiry for anonymity

before these materials are disclosed or published.

As I have said, the default position for patients is that such an order will be granted with the result that identifying information redacted from any materials disclosed or published. Anonymous witnesses will generally give evidence in the room where they can be seen by those in attendance and will be restricted from revealing any information publicly about the individual in question. They will normally be able to be heard on the YouTube feed, but their faces will not be shown. Any other adjustments which any witness wishes to apply for will be listened to and sensitively handled by the Inquiry. The patient's voice must be heard but not in a way which causes undue distress or risks retraumatising patients at all.

The same process will apply to the Inquiry Rule 8 statements and exhibits as I said where witnesses do not wish to apply for anonymity. Where witnesses do not wish to apply for anonymity sensitive passages of the materials relating to them will be put to them for their views of possible redaction of them as well as their right as material providers or interested parties in the contents of the material.

Sir, as far as the preparations going forward are concerned as part of the preparations for the Section 1

hearings organisations or some selected individuals which were thought to hold relevant documents were issued with requests for them. Some were issued by way of Section 21 notice given the sensitivity of the material which it was anticipated they would contain. Where it was thought that the documents held by any recipient would be of a relatively small scale those organisations were in fact asked for all the documents they hold relating to the Inquiry's Terms of Reference. Examples of organisations falling into that category were NHS Education for Scotland and Healthcare Improvement Scotland.

Where it was thought that these documents would be more numerous or where the types of documents held were not yet well-known by the Inquiry, the Inquiry issued more specific requests for documents of a more specific nature relating to the matters to be covered in Section 1 only. Examples of organisations falling into that category NHS Tayside, Police Scotland and the BBC.

After these hearings the Inquiry will issue wider documentary Rule 8s seeking documents more generally relating to the full ambit of the Inquiry as appropriate to an organisation or individual's involvement in the subject matter with which we are concerned. These will be processed and assessed as above, a process which the

Inquiry anticipates will take a longer period of time to do due to its likely volume and potentially the sensitivity issues which may be associated with some of the documents.

Sir, to move then to our planning beyond December 2026.

It remains the position that the section in connection with which we are to hear evidence this month will be an introductory one designed to try and help us and those with an interest in our work to understand the roles, structures and key milestones in the story underpinning our remit. There's always been and remains a section in which we seek to uncover the extent of the disputes which lie within our Terms of Reference and try to understand where the answers might lie beyond these hearings to be looked at in more detail in later sections of our evidential plan be it in documents or, where documents do not exist, in the written and oral testimony of those who live through the events on which or focus is centred. A precise plan for where we go next will depend on where we get to and that cannot be known until the evidence laid over the next four weeks has been heard and an opportunity has been taken to reflect upon it.

It will for example be necessary for the Inquiry

team to reflect on what documents it has received, what documents it has been told exist beyond the sets which have been recovered to date and to formulate a plan as to whether existing Rule 8 requests can be relied upon with more extensive searches being required under their terms or whether further, more wide-ranging or more specific Rule 8 requests will need to be issued for further documentation to be recovered. It will only be in light of the recovery of those materials that we will be able to plot a clear and detailed way forward. These hearings should help us know where to look and what we expect to find.

The progress made as a result of the section 1 investigations to date and the changed circumstances resulting from the impediments to progress in Section 2 which I have already outlined have, however, led to us slightly altering our Section 2 plans. Further given the change in the planning for the Section 2 hearings which I have already set out there is a need in my submission for core participants to be given an opportunity to contribute to the details of those hearings which will involve evidence of the ICR neurosurgical output being examined by the Inquiry. We have currently planned an evidence session for May 2027 to hear that evidence. Therefore, as a result of these two components of our

work on which we feel that contributions would be of benefit, we have sketched out the following working plan.

Details of what precisely will be required will be provided in due course but as clarity, transparency and advance notice are always aspired to and I know are appreciated, in particular by my professional colleagues but also by others, it is hoped that the following broad plan will be of value.

It is intended that considerable efforts will be required all round to prepare for the Section 2 patient-focused hearings which will now take place in December. Though that will involve all participants to an extent it will be a particularly busy time for those who represent witnesses whom we plan to call to give evidence at those hearings, particularly in the firm of Levy & McRae and their instructed counsel and those witnesses themselves. It would not be reasonable to expect that group to be doing more than focusing on that important work for the rest of 2026.

The focus then becomes on 2027 and what is planned for then. The broad plan is as follows. The Inquiry plans to hold a procedural hearing in mid-March 2027. Core participants will be called upon to make a written

submission to the Inquiry in advance of the hearing. The details of the precise dates and the content of those submissions will be clarified in due course. For planning purposes the dates of Thursday and Friday, 11 and 12 March 2027 have been provisionally booked.

The purpose of the hearing and the written and oral submissions will be twofold. In the first place core participants will be asked to address the Inquiry in writing and orally about the evidence which has been gathered, led and shared with them in Section 1 for the purpose of identifying what investigations they say should be undertaken by the Inquiry in the more detailed sections which are to follow. Which witnesses should be contacted for Rule 8s. Which further documents should be sought. Which other organisations should be contacted for statements or evidence in light of the framework which Section 1 of the evidential plan will hopefully by then have created.

Core participants will not be being asked to provide a final submission containing their analysis of the evidence which will have been gathered to date but proposals based on that evidence as to what should happen next within the broad evidential framework which the Inquiry has already announced. As I say, a more detailed list of matters to be addressed such as the one

which was circulated to core participants in the advance of the opening statement hearing last November will be provided at the appropriate moment but this is the general direction of travel.

It may be that the opportunity will be taken by core participants in that submission to address written material which has or will be disclosed to them by that time which is not the focus of these evidential hearings. As I have said, some evidence has been gathered from certain bodies which provides context to our work whether in the form of organisational information, such as from the HSE or BMA, or other bodies which have been or are conducting investigations relating to the professional practices of Mr Eljamel, which are not themselves the subject of the Inquiry's investigations which may provide a useful base for forward planning within the Inquiry. As I have said, examples of such bodies are the BBC and Police Scotland. I mention these as I know that some core participant groups questioned why and what we wanted them to do with that material. The answer is to analyse the material to the extent you wish for question in these hearings but also for the purpose of these later submissions.

The second purpose of the contemplated March procedural hearing will be to address what core

participants propose should be the format of the hearings in May, which as I have said will form the second part of the Section 2 hearings of which the Inquiry will consider, to the extent the Chair ultimately considers appropriate, neurosurgical evidence which will by then have emanated from the ICR. In order to inform the decision-making around the preparation for that hearing, the Inquiry intends to disclose to core participants gradually over January and February materials which will enable submissions to be formulated about which witnesses should be considered to be called to give evidence in that context and why. Those submissions will then be able to be taken into account in deciding the final format of the May hearings.

It follows logically from that intended hearing in March that the precise format of the hearings in May must remain up in the air until those submissions are heard. It may be possible that at those hearings evidence is only taken from Professor Wigmore about the interim findings of the ICR process for which a Rule 8 request has already been issued or it may be that evidence will need to be taken in the public interest from others in connection with the work of the ICR most notably the neurosurgeons or some of them who have provided opinions to it. It is not currently

anticipated further evidence on issues relating to the ICR will be heard from patients at that time not least because they would already have made positions clear in written applicant statements or in some case would be continuing to do so as the ICR progresses or would have been called at the evidence sessions which will be dedicated to patient evidence in December of this year.

Given the uncertainties, the Inquiry has reserved the hearing suite for the whole of May and more details will be released after the March hearing about what dates will be used for the ICR evidence sessions in Section 2.

By way of reminder, in section 3 the Inquiry will hear evidence from medical professionals. In section 4 the focus will be on evidence from other organisations not covered in section 5. Section 5 will focus on NHS Tayside and the Scottish Government and section 6 we will focus on recommendations.

Again, beyond the plans I have already announced the timings of the hearings in Section 3 shall be focused on the evidence of medical professionals. It's hard to predict with any precision. It will of course depend on the submissions made by the core participants at the planned procedural hearing in March. The experience of Section 1 has shown even though clear deadlines are set

by the Inquiry they can sometimes not be adhered to often due to draft statements or materials not produced with sufficient quality by the deadlines necessitating a more prolonged second drafting period than should have been required and elongating the process. Rule 8s need to be prepared which are fair but probing, precise but not long-winded, if they are to serve their purpose. When documents become evidence to the Inquiry it requires to undergo lengthy but necessary processes of review for disclosure and ultimate publication. These are inherently time-consuming.

It is anticipated that evidence will be sought from a wide range of medical professionals in Section 3 such that a significant amount of time will be taken for these processes. These inevitable labours are all part of undertaking an investigation of this scale and dare I say importance. Within the Inquiry structures and processes have been devised to seek to minimise delay but ensure substantive process such as having teams which work ahead for future sections of the plan while an earlier section is going on. The Inquiry constantly reviews and refines its processes and operations to maximise efficiency. Operational plans are regularly updated to adapt to difficult or unforeseen eventualities. The Inquiry remains, however, reliant on

those who have evidence to provide adhering to its deadlines and providing what has been requested or demanded to the desired quality. This does not happen at times with significant results as far as planning is concerned. The support provided by the Scottish Government in connection with recruitment and other logistics remains slow, a feature of our requirement to rely on the systems of a large organisation when we strive to be a small and nimble operation.

Slower than anticipated progress in the ICR to which I have alluded has resulted in significant need for the Section 2 operation for whom there are other operational plans to remain committed to that section for around six months longer than had been planned. That too has had and will have a significant effect on our planning.

Despite these vicissitudes we remain committed not only to striking the best possible balance between speed and reasonable thoroughness, to which you have committed us, sir, but also to our principles, including clarity, honesty and cooperation. Our planning remains orientated towards having Section 3 hearings in late 2027; November is currently earmarked for that purpose. We will keep our core participants and the public aware of our progress as ever and the achievability of that aim.

Sir, to turn now to some other important developments in our work.

As explained at previous procedural hearings the Inquiry has undertaken a consultation exercise as a means of creating an evidence base for its trauma-informed policy which sets out the Inquiry's practical approach to the way in which it intends to honour its commitment to be trauma-informed, one of our fundamental principles. As a result of that consultation exercise the Inquiry has now published on its website a statement of its approach being trauma-informed for the consideration of those who have an interest in contents. Given the importance of that development I have a few things to say about the Inquiry's intended and now published approach.

Sir, there is no existing model for making a public inquiry trauma-informed. In fact we have been told and have discovered in our consultation process and have accepted that for a trauma-informed policy to be effective it must be responsive to the particular trauma experienced by the people engaging with a particular process. That is why we have aimed and continue to intend to deliver a bespoke approach for our trauma-informed public inquiry. That is why we undertook the public consultation exercise and those who

wished to participate in it who had direct involvement and interest in the subject matter of this Inquiry were consulted, as opposed to relying solely on information arising from other related, though possibly different, contexts.

Thus our response is and will be based on the four core lessons which have emerged from the consultation, namely complexity and unfamiliar process can overwhelm participants who have had traumatic experiences. Roles and responsibilities require clear explanation. Trauma-informed principles are interconnected. Safety relies on trust, trust relies on collaboration and choice and all depend on independence and clarity. And finally, participants strongly value being heard. Former patients want the Inquiry to understand their experiences without requiring repeated retelling of traumatic events.

Our policy, sir, is built on the definition of "trauma" that it is in response to extreme or intense experience which is frightening or distressing to the person involved particularly if it is overwhelming, difficult to cope with or feels out of their control. It is derived from the evidence base to which we have paid attention that such traumatic experience has the potential significantly to affect the way in which the

traumatised individual interacts with the rest of the world. In our sphere such interaction includes interaction with the Inquiry as a core participant, as a witness, as a provider of information or material, or otherwise.

Thus the focus of the starting point of our policy is on those who have suffered trauma of this nature. It is people who have had such experiences whom our policy is designed to help, with a view to listening to them and taking steps to maximise the value to them and to us of their interaction with, connection to, experience of and role in the Inquiry. Our policy also makes clear that though others may have suffered trauma of this nature it will be assumed that patients who assert that they have, have indeed been affected by such past trauma. We will not seek to interrogate those individuals or have them vouch for their trauma. They will be believed and they will be treated as set out in the policy.

This approach to being trauma-informed does not mean that the Inquiry does not acknowledge that being involved in an Inquiry in any capacity be in itself an unsettling and difficult experience, for many it may be. Those people deserve to be treated with courtesy and respect and have their experience of the Inquiry be

no more disturbing or unsettling than need be. They will be.

It is not, however, with such individuals that the trauma-informed policy and the putting of it into practice is concerned. To have a trauma-informed policy which did not recognise that trauma is something more, something more impactful and more long lasting would be to have a policy which was not sufficiently tailored to those who need to have such a policy the most.

As I have set out before, the principles upon which the policy is based will be safety, trustworthiness, choice, collaboration and empowerment. However, the statement of approach goes further than principles, important though they are to the way we intend to work, it also proposes practical steps which we intend to take to help counteract aspects of the effects of trauma which have been identified to us in our consultation process. Those steps also seek to avoid retraumatising individuals who have suffered trauma and to avoid undermining any efforts they are already taking, to seek to alleviate or address the impacts of trauma on them.

These will include information being shared about the work of the Inquiry in a regular written communication to which recipients are free to sign up as they wish, sent directly to those who wish to receive

it. This information will update people on the progress of the Inquiry or lack of it for any reason but will also seek to justify what we have done, are doing, or will do, and seeks to respect and promote our trauma-informed principles. Other initiatives the Inquiry already has in place are set out in the statement of approach.

These initiatives include ensuring that support mechanisms which the Inquiry has put in place and which I outlined at our procedural hearing in May and details which are available on our website continue to be available and to be effective. Support is available from representatives of Spark, the Scottish-based charity which provides counselling and mental health support for individuals, couples, families, children and young people, which has provided such services for 60 years. Information about the support services which can be obtained can be found on the Inquiry's support hub, a new dedicated section on the Inquiry website. Such support is provided in two forms: emotional support and participant support.

Emotional support is available to all those who need it during hearings such as these, including virtual hearings, though in person at in-person hearings. Trained counsellors can be accessed online or in person

to deal with the immediate emotional reactions to involvement in the Inquiry's hearings. Participant support is available for a wider range of situations including witness support but also other support for participants. It will involve a number of support sessions being made available at times when they may be needed. It can be accessed via details on the website or via our Inquiry phone line. The Inquiry's witness liaison manager, Tracy Millar, an experienced professional from the charitable sector who is and will be in charge of directing people to the most appropriate support mechanism for them.

Our approach to being trauma-informed will be one which listens, adapts and evolves. The next step towards that aim will be a further consultation which will be launched after these hearings into the nature and form of direct contact which those who have suffered trauma would like the Inquiry to have with them beyond efforts which were already made in this regard as are already set out in the statement of approach.

It is contemplated that meetings between members of the Inquiry team and those who wish to participate in them to keep individuals informed, answer their questions and interact with them in an appropriate and helpful way will be part of the plan going forward.

However, precisely what this interaction should involve is a matter on which we wish those who have suffered trauma to express a view. We wish to listen as we have done to this point and to tailor such meetings to what precisely is needed and what realistically can be delivered.

We are fortunate this work continues to be led by the Inquiry's Deputy Secretary, Dan Farthing, who has many years of experience of working with, promoting the interest of and advocating for a wide range of traumatised individuals in the charitable sector. His efforts are supported directly by the Chair and other members of the Inquiry's senior team, not least myself. Sir, under Dan's expert direction in this area we remain committed to making this Inquiry work for traumatised people. That commitment is real. Informed by consultation with our traumatised participants, built on believing them, respecting them and accepting the profound effects of their trauma and their ability to engage with this Inquiry as a result. That commitment will not diminish.

Sir, I have set out in previous hearings ongoing issues that we have had with our engagement with Scottish Government other than those relating to the fire safety of this building. Needless to say a number

of those issues relating in particular to the recruitment of appropriate staff for the Inquiry, your reasonable requirement, sir, for those interacting with the Inquiry to sign confidentiality undertakings and the still unsigned management agreement between this Inquiry and the Scottish Ministers are still outstanding. It is hoped that those are matters which will be addressed by the Scottish Ministers responsible for sponsoring this Inquiry in early course.

Sir, as you have alluded to in your opening speech I already set out the direction of travel as regards our evidence gathering at previous hearings and in addition a call to provide evidence or information about how that could be done is to be found at paragraph 24 of the Inquiry's approach to evidence and written statements.

That request and that information has been heeded by some individuals who have got in touch with the Inquiry with information about their involvement. However, as we start to move towards the more detailed investigation which will be involved in Section 3 and beyond I wish to use this opportunity to issue a further, clear and unequivocal public call for evidence as we plan or move beyond the first two sections.

As we move beyond the evidence of the patient group on which we will focus on in December and in our

this stage to those medical professionals who had an involvement in the work of Mr Eljamel and who feel that they may have something to contribute. They may be other neurosurgeons or doctors or surgeons involved in associated medical disciplines linked to Mr Eljamel's work, such as but not limited to radiology, neurology or anaesthesia. They may have been contemporaries or subordinates. They may be nurses or other staff who worked with him or had knowledge of his work either at a hospital or somewhere else, like in the University of Dundee. They may include medical professionals who were involved in investigations into him or who made complaints, raised concerns or provided feedback about him. Any such individual who may wish to contact the Inquiry can be assured that their approach will be treated confidentially and professionally.

You are committed, sir, to accept evidence from such individuals anonymously if appropriate to protect the individuals concerned. As I have stated the Inquiry's entirely prepared to deal sensitively and respectfully with individuals who suffered trauma as a result of their experiences or be otherwise apprehensive about interacting with us. We are flexible about the way that evidence can be provided to us or gathered by us, we can help with finding ways of evidence being provided in the

continued oversight, input to, and analysis of patient evidence emerging from the ICR which will continue as I have said, I wish to invite any medical professionals, current or former employees of organisations with an interest in our work including NHS Tayside or the Scottish Government, to make contact with the Inquiry directly to explain what evidence they feel they can offer relating to any matter falling within our Terms of Reference or a more detailed List of Issues.

Though we will continue to do what we can to identify and approach those whom we think may have evidence to give, we are open to being approached by such individuals. Some such individuals, as I say, have already contacted the Inquiry directly. We wish to make clear to others who may have stories to tell that, as with all those with whom the Inquiry comes into contact, they will be treated with courtesy and respect. Those who may have something to add may have documents to provide or simply recollections or views about matters with which we are concerned. All are welcome and all are encouraged to get in touch via any of the channels available, which are carefully set out on the Inquiry's website, www.eljamelinquiry.scot.

Though that is an open-ended invitation, I would like to extend that call for evidence in particular at

way that suits the individual, for example by providing oral evidence remotely and/or anonymously. Our emotional support services are available to these individuals as well. We are committed to our staff upholding all of the principles to which I have referred and upon which the Inquiry is based.

Equally the Inquiry is keen to hear from those with an interest in surgery, in particular those who have perspectives on how things may be improved for the betterment of patient care in that field of practice which gives rise to certain issues, considerations, requirements and responsibilities which apply in particular to it. We remain committed to inclusivity, open-mindedness and going where the evidence takes us. You do not need to wait to be contacted by us, proactively contact us through our witness liaison manager or the legal inbox. Witness engagement initiatives are already being put together as part of our investigations but we also welcome contact in this way.

It should be stressed that it's not necessary for an individual or organisation to be a core participant in order to provide information or evidence to the Inquiry. Many individuals and organisations beyond the core participants will have relevant information to

provide in relation to the matters we are looking at. There are many things that we do not know. We cannot know unless those who were there and have recollections about what happened and views of them shared with us. We have power to investigate and to compel but do not assume that we know everything. We have not prejudged, it would be quite wrong for us to have done so absent evidence. We will go where the evidence takes us but we need evidence to move forward.

Like us, many who have evidence to provide will, I am sure, have a commitment to the betterment of health services in this country, in particular in the field of surgery. It is only through wide engagement and careful and meticulous evidence gathering that we will achieve this important aim. If you have evidence to provide please get in touch.

Sir, I have a few closing observations to make at this stage.

Even though this section of the Inquiry is introductory, there is a significant risk that the evidence which will be heard will be difficult and traumatic for some. For those who may require it in any way, they will find support and assistance from your dedicated team led by Natalie Smith, the Secretary to the Inquiry and Dan Farthing the Deputy Secretary. They

and their team will be on hand to offer support and assistance at any time. Equally, as I have explained, emotional support from the Spark team will also be available.

In addition, a room has been made available in the hearing suite for the use of the patient core participant group and their recognised legal representatives as they are the biggest group and also a separate room for NHS Tayside and their legal representatives as they have the most witnesses to represent, as I have set out already.

Rooms will be available for witnesses each day where they can meet with their legal representatives and with the Inquiry team. Other rooms can be made available to other teams. If they require them they can be booked with the Inquiry secretariat team. The Inquiry legal team, under the stewardship of Lynn Carey will also be on hand to handle questions or queries more appropriately directed to them.

Sir, against that background I repeat the Inquiry's expectations that its work, including the proceedings of these hearings, will be conducted in a spirit of dignity, courtesy and respect. As I've set out in some detail, sir, our organisational participants all pledged in their opening statements and in other written and

oral submissions made at, or in connection with, the Inquiry's three previous procedural hearings that they would support the Inquiry's work and respect this approach. They will be expected to do so and witnesses who will come and give evidence, some from those organisations, also deserve to be treated with the same courtesy and respect. I have every confidence that all those who participate in our work will adhere to these important considerations.

Sir, you do not expect this Inquiry to be a forum for grandstanding or protest, you expect it to be a forum in which the aims of this process to which all participants have pledged their commitment will be achieved. As such you expect this to be a forum in which all voices are heard and all willing participants are given an opportunity to contribute. It is in that spirit and in that expectation that it is a joint endeavour in which we are all engaged that these hearings will proceed.

At the first of the Inquiry's public hearings in September 2025 I explained that this Inquiry had a number of key themes. These themes remain at the centre of what we are seeking to achieve and run through all that we do. They bear repeating at this stage as we turn to examining witnesses in public about them.

This Inquiry is concerned with patient care. Where that goal has been lost sight of, forgotten or undermined, where it has been neglected or diminished either in medical care or by corporate action or inaction, this Inquiry will seek to find out why.

These hearings are the starting point of that journey. Though it will be at the hearings in December that we will turn to hear oral evidence from patients, as I have outlined at these hearings, patient safety will be a focus not least in the evidence to be heard from Liz Smith and the Patient Safety Commissioner but also in expert evidence which will focus on how patient safety can be kept paramount in healthcare systems.

This Inquiry is built on an understanding of the importance of trust, trust in any emanation of the state but those parts which are responsible for healthcare in particular. It is about when and how trust has been undermined and lost, how that loss of trust has manifested itself, whether and how it has been addressed and how harm may have been compounded when it has not been. These hearings, sir, have been built around the Inquiry seeking to foster trust amongst those who will participate in them. They will also be an opportunity to examine the importance of trust and will examine instances where, even in recent times, it appears to

have been lost.

This Inquiry's main area of investigation is in the field of surgery, a theme which was emphasised on behalf of the patient group by Ms Cherry KC in her opening statement. In the field of surgery it might be said the requirements of patient care and trust are at a premium. Situations where surgical intervention is contemplated or undertaken are, by their nature, situations of extreme complexity, severity and vulnerability. Considerations of respect, dignity and humanity are thus paramount both from those involved in the surgery and those involved when things go wrong. These themes will be part of the evidence led from our neurosurgery and medical ethics expert groups from whom we will hear at these hearings.

This Inquiry is concerned, sir, with the importance of communication. Communication is at the heart of good patient care and in particular in the surgical field before, during and after the surgery and where things appear to have gone wrong. Communication is about truth and the effective communication of it, both of which patients deserve. The Inquiry requires to look at the adequacy and candour of communication often with vulnerable, distressed and harmed patients both in the operative sphere and from and with the corporate

structures around it. It is about the maintenance of ability to communicate the truth, by the maintenance of records to be able to do so. It is also, sir, about the way in which these structures and organisations whose ultimate aim it is to promote good patient care communicate internally and with each other. Again, at these hearings communication will be a prevalent theme not least in the evidence of the medical ethics group.

Sir, this Inquiry is about the need for people and organisations to take responsibility. Our National Health Service owes a legal and moral duty to patients in its care beyond the more immediate duties or by treating medical professionals. When patients go to hospital they reasonably expect they will be protected by a system beyond the individuals normally in charge of their care. That responsibility will extend to other professionals, the health board and other bodies with responsibilities in that regard accorded to them by law.

The Inquiry will look at the whole system whereby health and well-being are meant to be promoted and maintained and analyse whether that system was and is fit for purpose. This hearing session has responsibility at its core. Witnesses will include all contributors to the NHS Tayside's Section 1 statement,

a senior representative of the Scottish Government and senior representatives of numerous major organisations who played or could have played a part in matters falling within our Terms of Reference.

Sir, this Inquiry aims to be a part of achieving improvement. The Inquiry has a forward-thinking function to seek to make meaningful recommendations for change so that aspects of medical, and in particular surgical care, which have not worked well will work better in future in the ultimate service of patient care. At these hearings, though we are at the start of our hearings process, we will have an eye to the future and what might be done to make systems upon which patients rely better and safer.

It is on the foundation of these themes, sir, and the advice received from those with whom we consulted that the Inquiry's bespoke principles of being trauma-informed, open-minded, independent, to listening, cooperation, clarity and thoroughness have been constructed. Though, as is perhaps inevitable, hurdles and impediments have been encountered along the way, I said at the procedural hearing in May that we remain committed to these principles and to the endorsement of them provided by and on behalf of the patient body in particular. I am proud to report, sir, that despite the

difficulties we have encountered this Inquiry has maintained its focus on the fulfilment of its Terms of Reference and its adherence to the principles which you set out at the start of this process.

In addition, the investigation of its remit has been carried out without fear of favour, facts being investigated as fully as the current stage of our progress will permit as well as fairly, as we were told by the patient core participant group that it expected us to do in its opening statement. It is on the basis of these considerations and those principles that these hearings will be conducted.

Thank you for your attention, sir, and for the attention of those who are joining us here in person and those who are joining us online. I would suggest that we now break, sir, with a view to the Inquiry calling its first witness in the afternoon session, beginning around 2 pm. As is not uncommon with public inquiries, there will no doubt be many issues which can be canvassed and addressed so that all those in attendance are comfortable and their needs catered for. The Inquiry team stands ready to assist with any such queries and we look forward to hearing the evidence of Ms Liz Smith CBE this afternoon.

THE CHAIR: I'm grateful to you, Mr Dawson. Thank you very

much indeed. It's gone 1.10. We'll break now for lunch. As you've just heard evidence will commence this afternoon with the first witness in this hearing at 2 o'clock and I look forward to seeing you all then. Thank you.

(1.14 pm)

(The short adjournment)

(2.07 pm)

THE CHAIR: Good afternoon. Please be seated. Mr Dawson.

MR DAWSON: Sir. Yes, the first witness is Liz Smith CBE.

THE CHAIR: Thank you, and you'll let me know when we reach a suitable point for a break.

MR DAWSON: Of course.

MS LIZ SMITH CBE (sworn)

Questions by Counsel to the Inquiry: MR DAWSON

MR DAWSON: Good afternoon.

A. Good afternoon, sir.

Q. You are Liz Smith. If you could speak into the microphone in front of you and try to keep your voice up so that people can hear you around the room, that would be extremely appreciated. You have received a Rule 8 request for evidence from the Inquiry?

A. That's correct.

Q. And the Rule 8 request asked you to provide a written statement to the Inquiry and documents, is that right?

A. That is correct, sir.

Q. And you provided a witness statement to the Inquiry which I think was dated 10 March 2026, is that right?

A. That is also correct.

Q. For the record the reference for that document is G0001-00032. Could we have that statement up, please. Is that your statement?

A. Yes, sir, it is.

Q. Could we go to page 14, please. That's the last page, I think. Is that correct?

A. That's correct.

Q. And although it's blanked out for our purposes, you have signed that, haven't you?

A. I have.

Q. And are the contents of that statement true as far as you are aware?

A. Yes, they are.

Q. You helpfully tell us in your statement that by way of educational background you have I think a joint honours degree in economics and politics from the University of Edinburgh from which you graduated in 1982?

A. That is correct.

Q. And you also hold a diploma in education from Moray House College of Education, Edinburgh, which you received from the following year?

A. That is also correct.

Q. And you have a professional background in teaching?

A. Yes, correct.

Q. And you tell us in your statement that after graduating you taught economics and modern studies at a school in Edinburgh between 1983 and 2001?

A. That is also correct.

Q. And within that employment you were assistant head of department between 1989 and 2001?

A. Those are the correct dates, yes.

Q. I understand that you worked for a period as a policy adviser to Sir Malcolm Rifkind, is that right?

A. That's also correct, yes.

Q. What period did that cover?

A. Largely the period between me finishing my teaching career and at the time when the Scottish Conservatives had, let's say, not done terribly well in the election and so Malcolm had lost his seat, I was an advisor through my work in conservative central office.

Q. And so what role did Sir Malcolm occupy at that time?

A. Really having to look at the reasons in politics why the Scottish Conservative Party had not done particularly well in the election and he was asked by the then chairman of the party to look at all aspects of policy delivery and why perhaps that was not resonating with

the general public and I was asked to be the secretariat to that policy review.

Q. Understood, thank you. And we understand from your statement that in May 2007 you yourself were elected as a Member of the Scottish Parliament?

A. That's 2007, yes.

Q. In 2007. And you served in that position for 19 years?

A. I did. I was stood down from the parliament at the most recent election.

Q. Indeed. And you are a Conservative MSP?

A. Yes.

Q. And I think that you were a regional member for Mid-Scotland and Fife; is that correct?

A. That is also correct, yes.

Q. Could you tell us how you came to be a representative of that geographical area in particular?

A. I had a long-time interest, particularly in the Perthshire angle of that, both from sort of sporting and general interest in that part of the world and I'd been born and brought up in Edinburgh, been at school in Edinburgh, been at the University of Edinburgh as well and I wanted to broaden my horizons because I felt there were a lot of political issues in Mid-Scotland and Fife that resonated a lot with my own interests and I was lucky enough to be selected in a seat there.

Q. Okay. And could you help us a little bit, one of the things that sort of interest us is the geographical area that's covered in terms of catchment of NHS Tayside and the evidence that we have from other sources suggests that NHS Tayside serves the population of the Tayside region which encompasses the local authority areas of Angus, Dundee City in Perth and Kinross, but also that acute healthcare services are also delivered by NHS Tayside or have been by other bodies in the past relating to north east Fife. If you can, because I'm sure these things are sometimes quite difficult to do, tell us, to the extent to which the area that you represented coincides with NHS Tayside's sphere of operation, if you could?

A. Largely it coincided but not entirely. As you've just mentioned, it covered different local authorities and part of the Angus constituency was not part of Mid-Scotland and Fife, that was part of the north east regional alliance in Holyrood. So largely speaking, the constituents from Mid-Scotland and Fife who were coming to me broadly speaking were ones who had an interest in NHS Tayside and the services provided by it.

Q. Right. And was that particularly the case in relation to that aspect that I described which is to do with the acute services, that it also provided it to the part of

Fife?

A. Yes.

Q. Yes and I think as we'll come on to find out, that was an area -- a geographical area in which you had a particular interest in relation to the Eljamel matter?

A. That's correct.

Q. Just reverting again to your CV. You told us you stood down as an MSP at the election. I understand that you're now working as a freelance education advisor, is that correct?

A. Yes, I am.

Q. And that you've been appointed to the Court of the University of St Andrews?

A. Correct.

Q. And that you're a patron of the Cricket Development Trust (Scotland)?

A. Correct.

Q. I understand you played cricket for Scotland; is that correct?

A. I did. Don't ask me the scores.

Q. And that you were awarded a CBE in 2024?

A. Yes.

Q. And was that in connection with your services to sport?

A. It was, sir. It was largely I'd convened the cross-party group on sport at Holyrood for a very long period of time following the death of the late Margo MacDonald and during that period of time I had a lot of involvement in trying to widen access in the sporting world and particularly for people with disabilities and those who perhaps were not able to access sporting facilities so I did a lot of work -- kind of the cross-party group at Holyrood was a representative body for lots of different sporting interests and what I tried to do was to involve some of the more minority sports and I think I was quite successful in doing that, and it was a great privilege and a great pleasure to be the convenor of that group and I was taken aback but nonetheless very delighted to receive a CBE two years ago.

Q. Thank you. Obviously we're keen on asking you questions today about your long-standing representation of patients who were former patients of Mr Eljamel, and in doing so could I just point out a couple of aspects of our approach to you.

As I highlighted in my opening address this morning for various reasons we have taken the approach to these hearings that where individual patient's names may become involved we've decided to redact from the evidence, not at all because we're not interested but because we'll revert to a more specific analysis of their case at

a later date. There are, however, two individuals with whom I think you have had some contact who I think it will be almost impossible to conduct a hearing of this nature without mentioning. They are Ms Jules Rose and Mr Pat Kelly.

If I can ask your indulgence to try to avoid, in our discussions, mentioning any other patients but feel free to mention them as we have already had conversations with them about them being happy that that should be the case. The other thing I wanted to say to you is we're very interested in trying to understand from you your experiences as they have been relayed to you by patients over the years to try to provide an important context for our hearings, but you shouldn't take any of the questions that I am asking you as in any way seeking to replace or be deemed more important than the evidence of patients themselves. It's useful to speak to someone who has spoken to so many patients to try to give us a flavour of their experiences, but to reiterate, we will return to ask them directly in due course. So again, don't be worried too much about the details which we will get from the patients directly but your testimony in that context is very useful to us.

Could we have a look, please, at paragraph 2.1 of the statement, if we could have that up on the screen.

Thank you very much. You tell us there that:

"In my role as a Member of the Scottish Parliament for Mid Scotland and Fife, my primary responsibility in terms of Eljamel case work has been to represent Mrs Jules Rose (resident in Kinross) but l have also provided a great deal of advice to other former patients and their families and, in several of these cases, particularly those relating to Mr Pat Kelly, I have worked with other MSPs, principally Mr Michael Marra MSP and Mr Willie Rennie MSP."

THE CHAIR: Sorry, Mr Dawson, just before you pose a question can I just check that everyone in the public gallery and elsewhere can make out the text of what we're reading? I think we may need to enhance paragraph 2.1 please.

MR DAWSON: Yes. So the text that I've just read out is the text that I'm going to ask you some questions about but that's very helpful, sir. You mention there doing case work for Ms Rose. What does "case work" mean generally and in connection with what you did for Ms Rose?

A. It's a parliamentary term that is used when a constituent comes to you with a specific issue that they would like you to investigate, and you have an obligation, a responsibility as a member of Parliament to ensure that you listen to all the points

and information that that constituent is putting in front of you and if there is a concern or a complaint, or in several cases concerns and complaints in plural, then it is your job to go and find out exactly what happened and that was my role in representing Mrs Jules Rose but also representing some other patients.

Q. So you had a role then in trying to engage with them to understand their experiences, their --

A. I did.

Q. -- views on things and what they wanted you to try and achieve for them?

A. Yes.

Q. I understand Ms Rose is herself a former patient of Mr Eljamel?

A. Yes.

Q. And she's also been a prominent campaigner on behalf of a large number, I think, of other patients; is that correct?

A. That's absolutely correct and a very good campaigner.

Q. Did your involvement generally or through Ms Rose lead to you becoming involved with other patients?

A. Yes, it did. I first heard about the Eljamel situation way back in 2015 when my former colleague, the late Alex Johnstone, had issued some comments in Parliament

on behalf of Mr Kelly at a time where he was doing similar case work and he wanted some information. So I was aware of the Eljamel situation but nothing like the depth of information that I received from Mrs Rose as a constituent. And the information that I then received having gone into lots of different directions thanks to Mrs Rose pointing me in the right direction, I then picked up an awful lot of information about the case.

Q. And you provide us with a list which is heavily redacted in your statement of individuals I think on whose behalf you campaigned you did this case work but also a secondary list if you like of people who have been in contact with you to thank you for your work or to acknowledge it. Does that list represent an accurate reflection of cases that you would say you know about or is there a wider pool? And could you put a number on the sort of number of patients whose experience to some extent you have visibility of?

A. In terms of the detail, both from a medical perspective and also the interactions that they had with NHS Tayside and with the Scottish Government and in some circumstances with Police Scotland and other agencies, I would suggest to you, sir, that there are probably five individuals from whom I received a very considerable amount of detail that allowed me to pursue quite a lot of aspects of this

case in very considerable detail. But I was picking up, right throughout my time as a member for Mid-Scotland and Fife from 2015 onwards, an awful lot of information partly through what the media was presenting but also from what I was hearing from other angles and people would phone me up about and it I would get a sort of reference to some of that as well.

Q. There's an interesting aspect of what you just said that interests us in the Inquiry because it's not just about learning with the individual's clinical experience and engagement with individual doctors or nurses but their engagement with the wider systems of healthcare. I think you mentioned NHS Tayside there. Was it a facet of the patient experience with which you became familiar that there were concerns being raised about their clinical experiences, their experiences with healthcare services more widely, or both?

A. It's a bit of both, sir. I was reading some extraordinary pieces of information that upset me greatly about what was being alleged from a medical angle. They upset me greatly and I found it difficult to accept that that kind of situation could happen but I was absolutely determined as a Member of the Scottish Parliament that it was my job to help these patients who had gone through incredible trauma both physically and

psychologically, and their families had too, that I became exceptionally interested in this case because it alarmed me, it appalled me. I was very upset to read some of the documentation and I saw it as my moral responsibility to ensure that I was going to represent these patients because they were not getting the answers that I felt and I'm sure they felt should have been forthcoming from NHS Tayside and from the Scottish Government and so I made it my business to put this case work really at the top of my agenda.

Q. Just so I understand the means by which you sought to advance those issues and get those answers. You were a Member of the Scottish Government and therefore able to address questions to the Scottish Government?

A. Yes.

Q. And in your role as an MSP you had a responsibility to scrutinise them, is that right?

A. That's correct.

Q. And the Scottish Government is ultimately responsible for the delivery of NHS healthcare in Scotland?

A. Yes.

Q. Including NHS Tayside?

A. Including NHS Tayside, yes.

Q. So you felt, and no doubt those who contacted you felt, that this would be a legitimate means by which to try to

get to their answers which I think you said they had struggled to get through other means?

A. Yes, that's correct. I'm not a medic and I was very conscious that I was reading a lot of, firstly, confidential private material that constituents had chosen to allow me to see but I was also very conscious that I was coming up against terminology and descriptions of medical procedures that I had no knowledge of and I had to go and find out a lot of material to help in my understanding of exactly what had gone on, but I thought, more importantly than that, was to look at the procedures that had manifest themselves within patients asking questions about why a lot of malpractice had happened and why some aspects of the surgery, in most cases, had been so appallingly delivered and why the oversight of that and the management procedures had, in my impression, completely failed.

Q. So just to unpack that a little bit. Your experience of patients was that in the first instance they were interested in finding out why their surgeries appeared to have gone wrong?

A. Mm-hmm.

Q. But beyond that they were interested in trying to find out whether there were other bodies who could have

played a role in trying to prevent that happening?

A. Yes, that's correct, sir. There are two aspects to my mind and this has been the case right throughout. There is the case of the alleged medical malpractice of Eljamel and obviously the clinical reviews are overseeing a lot of the aspects of that. But there are the systems management, or lack of management in many cases, of why Eljamel had been allowed to continue practising when quite clearly there had been very deep-seated concerns raised at earlier stages and why this had been allowed to happen and I was interested not only in that but in the accountability. Somebody somewhere must have known why this was allowed to happen and I was interested in trying to help the patients to find out the answers to that.

Q. I think in your statement -- I'll get into this in a moment -- you talk about learning about a particular case in 2016 but you've mentioned in your evidence today that what sparked your interest was in 2015. You've explained what that is. Was it always a feature of the patient's position in trying to get the answers that you say that they sought that they were interested both in getting answers to questions about their own clinical experiences but also about that wider context of oversight that you've talked about?

A. Yes, I think I could safely say that in the case of all the patients and constituents that I saw that there was the medical malpractice. There was a horrendous pain and suffering that they had had to endure and they want answers it that, quite rightly. But the bigger picture in this is not least because there are so many -- we now know there are so many patients who are seeking these answers -- there is the much wider question and I think very substantial question about why on earth was this allowed to happen?

Q. Okay. Could I just ask about your preparation for giving evidence today. Have you discussed your evidence with some of the patients or their representatives whom you act on behalf of?

A. Well, I think throughout my whole time of looking after this case, I had a very large amount of case work and in the documentation that I submitted to the Inquiry back on December 4th, a lot of the discussion had already happened. In preparing for this session, I have re-read many, many pages of that case work and gone back over it. Have I spoken to a lot of the patients again? I have spoken to some just to check things rather than just to go back over and try to revise things because the patients have been outstanding in giving me the facts about the situations that they have had to face.

So I think -- I hope that I was quite well informed about their situations right throughout, and my job as a representative in Parliament was to ask the questions of the agencies or NHS Tayside or the Scottish Government to answer the questions that I thought were standing out almost in all the evidence that I saw.

Q. To be clear, Ms Smith, in case there's any doubt those conversations either before your involvement in this Inquiry or in connection with it were all done in your capacity as their representative?

A. Correct.

Q. Understood, and I think you said that any conversations that have taken place more recently have been on points of detail?

A. Yes.

Q. Which I assume is to try and assist the Inquiry as best you can?

A. Absolutely and obviously the Inquiry has sought confirmation of certain bits of paperwork since early August and so I took time -- especially when the documentation came through again, I took time to re-read all the bits of case work that I've had and that was very helpful actually in preparing for today.

Q. Thank you. Could I ask a little bit -- you mentioned in the passage that we looked at there that you formed

an association in your capacity as an MSP with, in particular I think, two others, Michael Marra and Willie Rennie. Now they are individuals who have an association with the broad geographical area in different capacities as I understand it but they are also individuals who come from a different political persuasion to you. Could you tell me how it was that you joined forces, if I could put it that way, to try to represent the constituents on whose behalf you were speaking?

A. Well, they were both representing constituents, as you say, within the wider geographical context but party politics didn't come into this at all. I have the greatest respect for both Michael Marra and Willie Rennie and I saw them as colleagues in the Scottish Parliament who I knew were wanting to get to exactly the same answers as I was and the more the parliamentary debate went on the more I could see them in action, asking many of the same questions that I was and I felt that partly -- maybe because we were from different political parties, I felt it was very powerful several MSPs were coming forward with the same questions of the Scottish Government and as time went on when I felt -- I think we all felt we weren't getting the necessary answers, it was actually very helpful that

there were three of us from different political parties and I hope that had some credibility from the First Minister and some of his ministers because of that but you know that was our job. As I say party politics didn't come into it at all.

Q. Is that a common phenomenon in the Scottish Parliament?

A. In some things but in others not at all.

Q. I'm interested in that aspect of things, Ms Smith, because if it is the case that is a rare-ish phenomenon that that might be said to be an initiative from which the Chair may be able to draw some conclusions. Now, first of all as I think you've identified, my understanding is that the other two represent sort of different constituency, if I can use that word broadly. Was it the case though that the questions that emanated from their groups and the issues, was there a commonality in that between what they had been told and what you had been told?

A. Yes, it was almost identical I have to say and we met very regularly, particularly in the last three years. Particularly when the public inquiry was first announced we met very regularly and it was very evident I think to all three of us that people we were representing were asking exactly the same questions.

THE CHAIR: Just to be clear, both the surgical aspect of it

and how it was led to happen aspect?

A. That's correct, sir, yes.

MR DAWSON: I mentioned a moment ago, Ms Smith, you tell us in your statement that -- you told us that you became aware of Eljamel related issues in 2015 but there was a particular case that was brought to your attention in 2016, I think August of 2016. What was the context in which that individual's case came to your attention?

A. That member wrote to me from the Perthshire area and it was a heart-rending letter that I received about a family member's maltreatment and it was a very long letter. And I had a couple of phone calls thereafter and one of my assistants in parliament likewise dealt with some of the aspects of that case, finding out more information and it was really quite appalling what I was led to believe had happened in the family member's treatment and I dealt with that as best I could. It set me off on trying to find out other things about the Eljamel situation and it wasn't terribly long after that where I realised that this was not an event on its own, that there were other patients who were involved in this -- what became a dreadful scandal.

Q. And you've helpfully provided us with -- well, you've provided us with a lot of documentation but in relation to that particular case you managed to find the

documentation. Do you recall broadly what the clinical circumstance of that case had been or we can go to the document if you like, but it's as you say quite --

A. Yes, I recall it vividly and it was obviously a case of misdiagnosis alleged by the constituent who got in touch with me about her father and the details about what she was telling me were horrific and it was very traumatic actually. I had a very difficult conversation. Naturally she was very upset and I think what came across to me was not just the appalling treatment by Eljamel, but the fact that her whole family had been turned upside down because of the failings and the malpractice of Eljamel and it had a big effect on that family and as I say it was a very traumatic experience.

Q. I think as you say, this was a case in which it was put to you that Mr Eljamel had failed to diagnose a serious condition in the individual concerned, is that right?

A. Yes, that is correct.

Q. And that certainly the letter that was written to you suggested that on what might be described as relatively cursory examination of the symptoms and the presentation, the family member effectively was able to recognise them almost immediately and so had been very shocked that the diagnosis had been missed?

A. That's absolutely true. I think she had looked into various internet aspects of the symptoms that her father was suffering and she came up with the accurate diagnosis and it was quite clear that Eljamel had pushed the whole thing aside and misdiagnosed and I think the letter I received spells out all the dreadful material thereafter.

Q. I think just to get the sort of timescale though that correspondence came to you in August 2016 that it was in 2012 that the alleged misdiagnosis or the missed diagnosis had occurred, I think that's right?

A. Yes. Yes.

Q. And this letter goes on to tell us in some detail about the fact that the patient, if you like, had been left with permanent brain damage, is that right?

A. Yes.

Q. And that the assertion that was made by the relative who spoke to you was that if this had been picked up, that permanent brain damage could have been prevented?

A. That's absolutely correct, yes.

Q. I'm interested in looking at some particular aspects of this letter which go beyond the clinical case into the kind of area that you were telling us about. Could we go to G0001-00002, please. I'm looking at page 5 of the document, second paragraph of that. So we have there

a narrative. There's a narrative that comes before that about the individual case and this passage starts to go into some other areas and it says there in the second paragraph that:

"We now have a copy of Dad's notes from NHS Ninewells. Surprisingly it took 3 months for them to 'find' the notes as they '...had been misplaced'. Alarmingly, there are 3 years missing AND there are no notes of his detailing excruciating headaches (and I was with him on occasion when he detailed this), nor upper neck pain. Something is not right here and we are seeking legal advice."

So I wanted to focus on that passage in particular, Ms Smith, because there seems to be a suggestion that in this very sad case that not only had there been an alleged -- in fact the letter calls it "non/misdiagnosis" because it's hard to describe exactly what it is, but that there had been issues accessing the medical records?

A. Yes, and I think that paragraph that you've just read out tells a dreadful story that it took three months for them to find the notes or they might have been misplaced and alarmingly, there are three years missing and there are no notes of dealing with excruciating headaches. I'm sorry this --

Q. This was in 2016 at the latest?

A. Yes.

Q. And the treatment that we were talking about had only been in 2012, so it's not as if you might have -- either particularly historic or anything like that?

A. No, there's just alarm bells ringing for me about the overall lack of oversight of what was going on and I'm sorry to say that this is an example of some of the other --

Q. This is precisely what I wanted to ask you next, Ms Smith. This passage tells us, as well as the circumstances of the individual case, about problems with the accuracy of notes and the time taken to locate notes, in particular in this case a significant period of time of being apparently missing. I was very interested to know whether this was a pattern or a complaint both relating to the accuracy of medical records and the time taken for people to be able to access medical records that came up in other patient's experiences that you learned about later?

A. Yes, it did and it's particularly true I have to say for the case of Mrs Rose and Mr Kelly for whom there is a huge amount of documentation about things not being properly documented and the delay in trying to access some of the relevant notes. I'm sure we'll hear more

a little bit later on about just how difficult that was. So, yes, I'm afraid this is a pattern and it was a pattern with some of the other constituents with whom I was dealing.

Q. I'm interested in just expanding on that a little bit further because one of the themes that seems to come through from your statement is the extent to which the harm suffered by patients in the clinical experience can be compounded or worsened by the response of the state, if I can put it as broadly as that, because that could be Tayside or the government thereafter. Is that a phenomenon you recognise in the Eljamel patients whose cases you have experience of?

A. Absolutely and I think it is probably one of the aspects that frustrated and annoyed me the most, that I was finding it incredibly difficult to get answers about what I thought should be relatively simple questions and patients were finding it very difficult to get to the relevant notes and the accurate notes that I would have thought should be there as a matter of course that in particular when it's very difficult operations that are being undertaken in difficult -- whether it's brain surgery or spinal surgery, these notes should have been immediately available and you know the documentation that Mrs Rose gave to me -- and I had oversight of

Mr Kelly -- it's obviously appalling about some of the things that were happening and the lack of the accurate medical notes that they had a right to be able to see. So I'm afraid, yes, it is a pattern.

Q. So just to be clear, that passage was talking about patient records and you mentioned that. You've also emphasised the interest of patients to try to look beyond that into the systems of oversight. Had patients attempted, as far as you understood, to access documents relating to that aspect of things, as well as their own medical records?

A. Well, yes, they had. In Mr Kelly's case he was seeking information about what had happened in theatre and who was present in theatre. Mrs Rose was largely doing exactly the same thing, quite rightly so. She was wanting information about what had happened, particularly as she was obviously going to have a second operation, and I think there was a pattern as well that those patients were wanting that information because by that time they knew that serious questions had been raised about Eljamel continuing with his surgery and medical practice and alarmingly, very alarmingly, those who should have been having proper oversight of what was going on during operations and the aftercare, it's quite clear that that was not happening.

Q. It's almost as if you know where I want to go Ms Smith but this is exactly what I want to ask you next because if one read on in this interesting letter from 2016, in paragraph 3, what your correspondence says is that:

"My worry is that, it transpires, Eljamel had accusations made against him from 2008. Why, on earth, was this gentleman allowed to continue until 2013? Ninewells have stated that my father did not receive the care he should have done. My formal complaint was admitted 6 weeks before the stories started to hit the papers. We thought Dad was the only one to have been permanently damaged. It is so upsetting to hear he wasn't and there could be upwards of 140 people -and those are the people who have a voice. How many people died at his hands?

Eljamel has now handed his Licence to Practice back to the GMC and can no longer carry out spinal surgery nor neurosurgery. However, it has now come to light that he has been attributing his education and experience to institutes which are now refuting that he completed training with them and are publicly distancing themselves from him."

And it goes on to call for a public inquiry. Now, I'm particularly interested, Ms Smith, in what information you, either at this time, had or had

acquired in your extensive representation of these patients later about what, as it's put here, accusations had been made against Mr Eljamel from 2008 or indeed any other time period?

A. Yes, I think one of the most important things was the review that was undertaken by the Royal College of Surgeons where it was very clear indeed that some of the independent analysis had grave reservations about some of the medical actions of Eljamel. But there were also other concerns that we were being pointed to by patients whereby when they were quite clear about some specific bits of information in medical notes that had been given, they were quite sure that these were not correct and their questions to NHS Tayside were not providing them with the answers that would help them to understand what had happened. So this was an ongoing process for a very long period of time, I'm sad to say, whereby we were not getting to the real information about what had happened and why it had been allowed to happen when the concerns had been raised that there was something wrong within Eljamel and the department that he ran. That's the big concern and yet he was allowed to continue in his medical practice.

Q. Understood. So part of the purpose of this section of our Inquiry is to try to orientate ourselves and the

different timescales and that may provide an opportunity for me to do so. The Royal College of Surgeons report to which you're referring is one -- we'll come on to examine that in more detail, I'm not going to ask you about that today -- but it is one that was commissioned and reported in 2013 and looked at aspects of Mr Eljamel's practice. What I'm interested in is trying to understand what evidence base there was of there being more historic problems because this correspondence, in the very difficult circumstances of her father's case, has had not only that to deal with but has also had exposure to information which appears to suggest that this had been going on for a number of years. The treatment here is in 2012 and the suggestion is that this had been going on since 2008. What was it that you learned or campaigners told you was the basis for their understanding that something had been going on which was harmful to patients or potentially harmful to patients before the case that we are talking about here?

A. I think it was a combination of some of the medical notes that I saw and the fact that some of the information did not tie up with what we had been told had been documented officially. Plus I think the questions I was asking of NHS Tayside at the time and also of the Scottish Government but on a slightly

different line, when I asked for specific information that this information should be released to the patient -- because it was my understanding that the law should allow that, and it wasn't forthcoming -- and I think there are various aspects within my evidence that I have provided where I think we can safely say that on at least four or five occasions we had to ask several times over for answers to the questions.
I think there's one piece of evidence, if my memory is correct, whereby I think -- Jules Rose I think we had to ask five times for evidence to be provided back to the patient and if I may be allowed to say so, sir,
I thought it was very interesting two weeks ago when the Information Commissioner David Hamilton produced his criticism of NHS Tayside that they were not responding to FOI material, I think that was part and parcel of a lot of the difficulties that my patients -- sorry, my constituents, they were at the same receiving end of this as well.

Q. But had been for a considerable period into the past?

A. Exactly.

Q. I understand. We'll get to that in a moment, Ms Smith, but I wanted to ask you about -- if we can go back to the statement now. Please take that one down and go back to the statement, we're at paragraph 5.3 and 5.4.

So it says there, you tell us there in your statement:

"Several of the former patients also expressed very considerable concern and anger about the alleged cover-ups within NHS Tayside. These sometimes related to the perceived silencing of whistleblowers when they wanted to raise issues about the medical malpractice they believed they had witnessed, often in the operating theatre, the alleged bullying by Mr Eljamel of medical staff who worked with him, and the alleged refusal of senior managers to address the situation even after Mr Eljamel had left the employment of NHS Tayside.

Some patients alleged that the Scottish Government had not taken the relevant action required given its statutory responsibility towards NHS boards. A number of patients allege that, at times, the Scottish Government and NHS Tayside have been guilty of collusion in order to cover up the true facts. These concerns remain current for some patients."

So packed into those two paragraphs a lot of interesting lines of investigation. But first of all, again trying to understand the reasons why patients told you about these things and asked for your help, what were the reasons or what was the evidence that led you to understand that patients considered that there had been a cover-up within NHS Tayside?

A. Well, I think it started with the fact that many of the patients found it very difficult to get access to their information that would have helped them understand the medical procedures that they'd had to undergo and more importantly about the management procedures and the oversight of Eljamel and those who were in his department and we had Mr Kelly with his notes suggesting that perhaps Eljamel was not actually in the operating theatre at the time.

We had other allegations that perhaps some of the people who had been allegedly assisting Eljamel were not actually there throughout as they should have been. We had some allegations that patients felt that NHS Tayside had not responded to some complaints within the -- and this comes out in the Royal College report -- had not responded to some of the concerns that Mr Eljamel had not been particularly caring about his staff or caring about the patients and had taken himself off, some allegations that he was preferring to go off and do some private work and he was referring patients to do the same, to get themselves on to a private register so he didn't have to deal with them in NHS Tayside.

We had all that kind of allegation going on. But these were allegations and I had to go and find out if there was truth behind that. But I think those

whistleblowers who were quite clear in their mind that there was something wrong in the Eljamel department. As it transpired there were and I think the Royal College of Surgeons report is pretty damning in its evidence in that.

Q. Okay. And the passages here that I have just read out go further than that because they then start to talk about -- so you've detailed all the various NHS Tayside -- or a number of the NHS Tayside-related issues but you've then gone to say there were allegations made against the Scottish Government and allegations made of collusion between NHS Tayside and the government. What was the basis of the concern or where did that come from?

A. That we couldn't get to the answers. There were allegations, and I stress that again, but we felt that when it came to basic information that should have been available in NHS Tayside, sometimes -- this happened to me several times, as my documentation evidences. I was pushed along to the Scottish Government. Scottish Government will be able to answer that. Scottish Government comes back: no, it's a matter for NHS Tayside. And it was just this back and forth and we could not get to the relevant answers and sometimes patients had to use FOI information to try to address

that.

But there was this obfuscation the whole time and sometimes this was taking months and you know it was frustrating for me as a parliamentarian but it was even more frustrating for the patients who were obviously suffering very considerable trauma. Some of this was going on for such a long period of time and it was infuriating to keep asking the same questions and we could not get to answers which I was very sure should have been available. And I think David Hamilton's comments a couple of weeks ago suggest that this was quite a problem.

Q. Okay, and you say you kept on asking the same questions so I'll unpack that a little bit. Do you mean you were asking the same questions on behalf of multiple patients and/or were you asking the same questions on behalf of a single patient because you weren't getting the answers?

A. In both cases, yes. And you know the documents I think show that sometimes we had to go back and forth to ask the same person: why have you not responded to this, why have I been referred somewhere else? Somebody must have the answer to this and it was just this back and forth and it was actually very time-consuming but I wasn't going to give up on my search for the relevant

information and neither were the patients, quite rightly so.

We absolutely had to get to the right information and there were sometimes I was beginning to ask myself: am I asking the right question here? Because it's possible that I wasn't, but I think I was and I was encouraged by not just the patients but other parliamentary colleagues who agreed with me the information we were seeking was not forthcoming and we had a duty to ask: why was that.

Q. Perhaps summarise where we've got to so far. Very interesting evidence. What you have here is a situation where across the various patients whose cases you knew about as well as those represented by others, Mr Marra, Mr Rennie and others whom you've mentioned, there was a multiplicity of patients all of whom had been former patients of Mr Eljamel or their representatives of course, like the lady whose letter we looked at and they were all relaying broadly similar sorts of problems, is that right?

A. Yes, that is correct.

Q. And then a number of those patients started to try to find out the answers to the questions and the issues that they had and that there was a broad picture of them being met with what you've called obfuscation on the

part of NHS Tayside, is that right?

A. Yes, that is correct.

Q. Is it then the case that as they considered their requests to be entirely legitimate and reasonable, that the fact that there had been this obfuscation gave rise on their part to concerns as to whether there might be something going on that they didn't know about or that NHS Tayside didn't want them to know about?

A. I think it gave rise to suspicion as to why we weren't being given the answers that we were seeking and that suspicion -- especially as some of the delays that were over quite a long period of time, that suspicion grew, particularly amongst the patients who were having to wait an awful long time for letters coming back, emails coming back or parliamentary questions to be answered or whatever it was. And that was a very frustrating time because I don't think -- the investigative process which should, in my opinion, have been much quicker, was just causing more and more concern and I think it was feeding the suspicion that nobody was wanting to be held accountable for what actually happened.

Q. So the suspicion was fed by the questions not being answered, the amount of time that it took to get a response and the accuracy of the information that was provided at the end of the day if there was anything?

A. That's correct, sir.
Q. Thank you. And this, as I understand it -- please correct me if I'm wrong -- is a process involving a lot of people with similar issues and similar frustrations at their attempt to sort out those issues that led to what you've described in your statement as a -- you described today as a suspicion?
A. Yes.
Q. But you've said in your statement a suspicion of a cover-up by NHS Tayside, is that right?
A. Yes, this suspicion was very strong and there was a suspicion that things were being covered up because -- and I include myself in this -- I think there was a growing belief that NHS Tayside must have known more about what had happened in the oversight of Eljamel than they were ever letting on and that was fuelled I think by the fact that we have this quite long time period and it was actually very distressing, very distressing for the patients, but I think there was a feeling that nobody really wanted to delve too deeply into this because they knew that there was a substantial concern and by this time there were far more patients who were coming forward in the media to explain what they had gone through and, you know, we now know the numbers that are involved and I think that that suspicion that there

was some kind of cover-up going on was certainly growing amongst the patients.
Q. And then in the subsequent paragraph you extrapolate this out to involve the Scottish Government and suggest that some of the patients thought there was collusion between NHS Tayside and them. Is that because when patients and the likes of representatives like you tried to get answers from NHS Tayside and didn't, as you described earlier in your parliamentary role than of others, efforts were made to turn to another agency Scottish Government for responsibility in this area and that similar problems were encountered?
A. That's absolutely correct. The frustration was very real because there were certain periods of occasions, which again I have documented in my evidence, where we had asked for very specific meetings with the health minister of the time -- and there were various health ministers involved throughout this case -- to meet with the patients and could we get a date for this meeting? It was put off and put off and put off and they would have to go and inquire with NHS Tayside for some more information. NHS Tayside sometimes gave some of the information but not all of the information and it just seemed to go on with this awful period of waiting and it was tough getting time to see the minister, or

eventually the First Minister, to ask some of the very basic questions which in my opinion should have been answered long ago.
Q. You mentioned in relation to Mr Kelly's case specifically that he had been looking for information I think particularly focused on whether Mr Eljamel had been in the surgery that he had and also who else had been there or not been there at the time, is that right?
A. Yes, that is correct.
Q. Do you know what a theatre logbook is?
A. I do know what a -- I didn't before this case but I very much know about logbooks now.
Q. Is that the kind of document that you might expect to contain the kind of information Mr Kelly was looking for?
A. It should contain it, yes.
Q. Could I just ask you -- I'm very keen that we understand at this stage of the Inquiry -- you've been very helpful in giving us a flavour to the progress of the patients' views and experiences, but one of the things I think I don't want to lose sight of or I'm sure the Chair doesn't want to lose sight of is the outcomes for some patients. Can you give us -- you've already given us some evidence about the potential for a compounding bad clinical outcomes through the sorts of processes and

frustrations that you've experienced but as far as the sort of clinical outcomes are concerned could you give me a flavour of the sort of range of physical and mental consequences that you have experienced in patients and these are patients of course who are trying to find answers to things?
A. Yes, I mean there's a whole range of disability, physical disability for a start. There are allegations that some body parts -- the wrong body parts were removed and the physical disabilities that have -- well, they're with the patients for the rest of their lives, as we know. And some of these disabilities are quite horrific. People have lost their mobility, people have lost all their means of being able to look after themselves, some of them can't look after themselves without carers. Some of them have been through the most traumatic of physical disability, but there's also the psychological problems and the effects on families, the effect on their well-being, the effect on the fact that they can't do the things that they used to be able to do, that they can't go out, they can't drive in some cases, they can't walk in some cases. The list is endless I would suggest and that's what makes it all so terrible.
Q. And so it's important I think -- would you suggest that

the Chair of the Inquiry should bear in mind that the frustrations, concerns, issues, questions, responses that you have outlined as being at the core of the experience of representing the patients in trying to get answers, from their perspective also includes all of those physical and psychological problems to start with?

A. Yes, and also the fact that it's gone on for such a long period of time when these answers were not forthcoming and so the trauma that they have endured, particularly from a psychological aspect, it's just never ending.

Q. Okay, thank you. Can I ask you about another document that you helpfully provided to us. This document is G0001-00024. It will come up on the screen. I should say for the sake of clarity, core participants will already know this but you've provided to us, as we asked you to, a very large body of material and a huge amount of correspondence with lots of details of the sorts of experiences patients had and sorts of things you did on their behalf. If we were to try to go through anything like that we'd be here for several weeks with just you, Ms Smith. So I think that, as the Chair has already indicated, is all evidence in the Inquiry but this is a document which was of particular interest to us.

This document purports to be a CV of Mr Eljamel. Can you tell us how you got this?

A. Yes, I was provided by -- this document largely through the efforts of Mr Pat Kelly and Mrs Jules Rose in understanding what the background was to Sam Eljamel and there was a bit of investigation on the internet and on various medical journals to establish what his background had been, and you know when you see a CV like this which goes on for several pages, if I remember correctly, you think: well, you know there must be something very impressive about this medical expert, all the books and pamphlets that he produced and the more we sort of dug away in the background the more we found out quite a lot.

Q. Well, that's the sort of thing I'd like to ask in relation to this document. Could we just very briefly go to page 20 of this document. This comes at the end of the curriculum vitae part of this bundle of documents and we can see it's dated May 2009. Now if we go back to the front page -- thanks Rory -- that's a particularly interesting date --

A. It is.

Q. -- because if certain evidence of which we are aware is ultimately to be accepted by the Chair -- of course it's a matter for him to decide -- that date around about the spring of 2009 might, on one interpretation of that evidence, represent a time when Professor Eljamel or

Mr Eljamel's career started going in a different direction to the one that you've described as being represented in this very impressive CV. Based on your experience is that a fair assessment? I know that others may take different views about that, but --

A. Yes, I think it is a fair assessment it certainly begs various questions and we know that some aspects of the CV that he said that he had various -- undertaken various studies and medical practice in America, in Connecticut et cetera and it turned out they denied all that. So it begs a lot of questions about what is real on this CV and what was alleged fabrication.

Q. I mean, without needing to look at the -- I know you've looked at the document before and the document will be published and people can look at it but the document contains a broad variety of high-level appointments on Mr Eljamel's behalf; is that correct?

A. Yes.

Q. And it contains information about -- which goes on for many pages -- about the sort of training and others he's been involved in?

A. Yes.

Q. In various guises and that it contains a number of references to publications he's been responsible for, largely in the neurosurgical field?

A. Mm-hmm.

Q. And it contains information about a number of professional bodies of which he is a part; is that correct?

A. That is correct.

Q. And it contains references as well to committees that he sat on to do with the governance of others, such as clinical governance committees, is that right?

A. Yes, that is correct.

Q. It would seem to suggest as at May 2009 Mr Eljamel could, if one looks at this CV as a guide, be deemed to be quite a daunting figure with a very significant array of broad professional experience, would that be fair?

A. Yes, it's absolutely fair.

Q. And moreover that the kinds of things he had been involved in meant that his reach, if you like, in terms of the number of people and organisations that he influenced was very significantly wider than one man but in fact no doubt influenced all these committees, all these educational establishments, all the students, all the readers of his books and all that kind of thing; is that a fair impression?

A. Yes, if this CV is taken at face, then you could easily assume that he had very many connections not just with his own professional medical governance but with

teaching bodies and with students, with trainee doctors etc. Yes, you could easily assume that.

Q. So even though this looks like a very impressive professional background, if hypothetically something were to go awry in the professional practice of this individual it would have the potential to have very significant and wide consequences?

A. Absolutely.

Q. And so although it might be tempting to look at a CV like this and say: goodness me, what an impressive individual, another way of looking at it would be to say that this man needs to be monitored as much as systems should permit in order to try to minimise the possibility though those wide-ranging consequences of things going wrong don't materialise?

A. Yes, I think that's fair. I mean, let's be honest that when it came to the concerns that were first raised within NHS Tayside that something was wrong and he was under supervision, the reason for that was not what was on his CV. The reason for that was the concern about what had actually happened within theatre, or within medical care, aftercare, and that he was not carrying out, on a professional basis, the medical procedures as he ought to have done.

That's what raised the concerns within NHS Tayside

and within the wider public and of course with the patients. So I think the CV, from my perspective, is interesting in that you know he's obviously been documenting a huge number of professional links that he has and things that he's written, but we then find out that some aspects of the CV might not be quite so accurate.

Q. We'll be investigating that, don't worry, Ms Smith. If I could just ask you -- or get you to look at a few of the entries on this which may again just help us set some context. On the first page we see that the current roles are set out where it says that Mr Eljamel was Head of Department and Section Surgical Neurology in the University of Dundee from 1996, is that right?

A. Yes.

Q. A little bit further down, about five lines further down, it says he, at that stage, was the Chairman of the Clinical Governance Committee Specialist Services Group from 2006?

A. Yes, it does.

Q. It also says that he had been the Secretary of the British Stereotactic and Functional Neurosurgery Group from 2006?

A. Mm-hmm.

Q. At the bottom of that section it says he was a clinical

specialist advisor to the National Institute of Clinical Excellence from 2008?

A. Yes.

Q. And that's a body I think that seeks to try to promote high clinical standards in medicine?

A. It is.

Q. And he also indicates then in a section of his past appointments one of which, the last one of course, on that list is that he was a consultant neurosurgeon and was elected a member of the Medical Advisory Committee BMI Fernbrae Hospital Dundee in the past?

A. Yes.

Q. Also, as far as his qualifications are concerned, it points out his medical qualifications but also indicates that he was a fellow of the Royal College of Surgeons Ireland and had been since 1986, yes?

A. That's correct.

Q. And it also points out he was a fellow of the Royal College of Surgeons of Edinburgh, an accolade he had received in 2003, but it notes that that was without an exam, is that what it says?

A. It does say that, yes.

Q. As far as experience is concerned, he lists a number of his past positions including experience in Britain working in Liverpool and working in Dublin. In relation

to the first three entries it talks about graduating with honours in December 1982, him having an internship in surgery and medicine between January and December 1983 and a general professional and basic surgical training which he claims took place between '84 and '87. It doesn't give details where those took place, is that right?

A. It doesn't say so.

Q. Over the page there's one entry I think you were keen to make reference to which is the one at the very top which suggests that in 1995 he was a Clinical Fellow in Neurosurgery at the University of Connecticut, in Hartford Hospital in Connecticut. Was that the one you were referring to earlier?

A. Yes, it was.

Q. And I think you referred to there being some investigations into the legitimacy of that entry?

A. Well, I think the implication was when various aspects of people that he says that he was either helping and assisting or being a student of or helping to teach students in, some of these could not clarify that that was correct.

Q. You mentioned that one in particular. Were there others that you understood had been --

A. I think there is interest to me in what he was claiming

to have done with the Walton in England. And I think it's very important -- and it was particularly important quite late on in the Eljamel Inquiry situation -- that, you know, bodies in England were being asked to consider whether they should look through their records to see if Eljamel had had any -- what activities had he undertaken in these English institutions and that was a good question to ask.

MR DAWSON: Okay. That would be an appropriate time to take a break, sir, if that would be convenient.

THE CHAIR: Can I ask one basic question and I probably missed an answer given some moments ago, but can I be clear what the provenance of this CV is? Is this something that you managed to generate as part of your investigations?

A. Yes, but assisted by the patients who obviously were very interested. And patients who suffered at the hands of Eljamel quite rightly were trying to find out as much as they possibly could about his professional background and so I was furnished with this information.

MR DAWSON: Had it been found on the internet as far as --

A. Some of it had been.

Q. Because quite a lot of the information looks to us to be the product of extensive, no doubt, research on the internet?

A. Indeed and also through medical journals. When someone like Eljamel will produce medical papers or academic studies that's all documented in certain medical authorities. So some of that was easy to find.

MR DAWSON: Thank you very much.

THE CHAIR: Thank you.

(3.14 pm)

(A short break)

(3.25 pm)

MR DAWSON: Thank you, sir. Ms Smith, we've encountered in your evidence so far on a few occasions, to put it mildly, issues which were experienced with patients' access to documents and you've explained the role that that played in the conclusions about what was going on to which they were driven and which they asked you to help with. You've produced to us a lot of documentation I think that is on this subject, including -- although we don't need to go it -- one document in particular, it's a bundle of documents really that relates to issues experienced by Ms Rose in I think 2022.

A. Yes.

Q. In the particular context of an FOI request. So I wonder if you can remember the circumstances that surrounded that but also try to tell us more generally about the sorts of problems that have been experienced particularly in the FOI context?

A. Yes, I can. Mrs Rose was asking very pertinent and very sensible questions to provide more information particularly about who had oversight of Eljamel and Mrs Rose had her operation, in fact she was the last patient for Eljamel to operate on. And that was just beyond the days where it had been fully exposed about Professor Eljamel's malpractice. So she was quite rightly asking the very important questions about who knew what when, why was this allowed to happen? A whole range of questions. I think my document details all of the questions and there were a large number of them and we were not getting very far in ascertaining what the answers will be. So we -- and I advised her in this -- that we would have to have some process through FOI material to get to the necessary information. I think it's fair to say, and I'm sure Mrs Rose would agree with this, that sometimes when we ask very specific questions, a list of questions, we might get one answer or two answers but we would never get the whole raft of the answers that were required. And some of these were extremely important questions and I think point very much to some of the -- what I would allege were some of the difficulties in oversight with Professor Eljamel. So I think it was that frustration and then sometimes it

was suggested that: well, some of that information might have to come from the Scottish Government. Scottish Government would tell us: well, some of that information is definitely at NHS Tayside and there was just this constant ongoing back and forth. And the FOI material, which is absolutely the correct thing to ask for, we were -- well, we know from the information commissioners comments we were only getting some of the story and that was a sense of very considerable frustration not just to Jules Rose but to me as well.

Q. And obviously just for context what you mean I think when you talk about using FOI is trying to use the Freedom of Information legislation in circumstances where a patient has been unable to access the information via the normal routes. Trying to use other legal mechanisms to try, in many ways, force the organisation to give you the information?

A. Yes, that's correct and I think -- and I'm sure Mr Marra and Mr Rennie would agree with this -- that we tried every which way that we could to assist the patients in directions that we felt were the right places to be trying to draw the information from and there was a constant feeling that we were not getting there. So we had to try some other avenue.

During my time dealing with this case I was dealing

with three First Ministers, I was dealing with five different Cabinet Secretaries for Health and seven Chief Executives of NHS Tayside and that's the extent of some of the timescale that this has been going on for and we had numerous meetings with various people within NHS Tayside and within the Scottish Government and I can't fault any of them for having some sympathy for the patients but were they actually dealing with the real questions that were being asked by these patients? We were not getting the answers. So sometimes FOI material was the only way we were going to establish some of that.

Q. So you've explained already in your earlier evidence about using what I have described as the normal processes to get hold of the information. You might have thought that if you -- as no doubt you advised patients to do -- you escalated, if you like, to the Freedom of Information level and that at that point public authorities would sit up and take notice and give you what you need; is that fair?

A. One would have hoped so, yes.

Q. But I think you've explained that was not the experience?

A. No, it wasn't. That was largely my demand for this public inquiry which the patients had been campaigning

for, for quite some time, but I felt it was my responsibility as a parliamentarian to go through every possible channel that I could that I thought was appropriate to get the answers they were seeking. And so it was that sense of frustration that persuaded me that a public inquiry was absolutely essential because all the other means of trying to get to the truth had been exhausted.

Q. That's not an unfamiliar story in public inquiries, unfortunately. Do you think that is -- that you have been involved in looking at public inquiries wearing a different hat I know and do you think that that process of failing to get the answers through these escalating stages is one of the reasons why there are lots of public inquiries in Scotland?

A. Yes, I do. I mean I come to this with a bit of experience, having been on the finance committee and my colleague Mr Marra was on the finance committee at the time and we decided that there was a case to be answered about why there was an increase in the demand for public inquiries but being the finance committee of course we're interested in the cost of public inquiries as well. But I think just referring back to your colleague John Sturrock KC when he provided evidence to the committee I think he was pointing out that there

were various reasons that he believed were behind the increase. Firstly, that the public trust in government and agencies has been diminished. Secondly, that there were too many occasions where perhaps the government of the time felt that: well, if a public inquiry dealt with this it takes it away off our desk and let the public inquiry investigate something that we've not been able to solve ourselves. But my fundamental reason -- and I think John Sturrock said this too -- I think the basic reason why there is an increase in a demand for public inquiries is because government and its agencies are not, for one reason or another, being able to answer the questions that they should be able to answer and therefore we are seeing this increase in the demand for public inquiries on specific instances.

Q. Was that your understanding of how this public inquiry came about?

A. Yes, I mean I was responsible for coming to the public inquiry -- the patients had been asking me to take this up for probably the best part of two years and I said: well, let's continue trying to get answers from various government ministers and NHS Tayside in particular, and I was then persuaded that because we were not getting the answers that a public inquiry was the only way, not least because I think there is a trust in the public

inquiry, not least one that is overseen by a judge and witnesses are providing evidence under oath, that has credibility in the eyes of the public, and I think that's very important. But should we have as many public inquiries? Probably not if the government and its agencies were doing their work effectively.

Q. And by "doing their work effectively" I suppose that could comprise providing good services in the first place to the likes of users of healthcare?

A. Yes, absolutely. You know, there is a demand for efficient public service. It suggests to me -- this case is a classic example, where there has not been good public service, in fact very difficult malpractice and public service. So I think that's all part and parcel of the same thing and the conclusions of the finance committee -- they were unanimous conclusions of the finance committee and also parliament agreed to that report. It wasn't just us presenting our thoughts, this was accepted by the parliament as important, that there is a real issue about public inquiries that is for future parliaments to investigate how that might be addressed.

Q. Okay thank you. Could I just take you to the document that you've been referring to which is ELJ-00553, this goes back to FOIs and this is a publication from the

Scottish Information Commissioner dated 11 August 2026 which is directly relevant to what we're looking at because it says, if we can zoom in a little Rory on the first paragraph there:

"A new decision by the Scottish Information Commissioner has found that NHS Tayside fell short of the requirements of Scotland's freedom of information ... law when responding to requests for information about a report into its investigation of Professor Sam Eljamel, the former head of Neurosurgery at Ninewells Hospital in Dundee whose conduct is currently the subject of a public inquiry."

Reading just down to the bottom, it says the Commissioner's ruling finds that NHS Tayside's response to those requests failed to comply with the requirement of FOI law in a number of ways. He found, for example, that NHS Tayside:

"Carried out inappropriate or inadequate searches for some of the requested information.

"Incorrectly informed the requester that it did not hold some information.

"Failed to provide appropriate advice and assistance to the requester.

"[And/or] incorrectly withheld some information."

Now you have referred I think to a number of these

phenomena having been experienced in the past. Does this suggest that there is an ongoing problem with the way in which document management works at least within NHS Tayside?

A. Yes, it does and I have great respect for any Information Commissioner but I think -- when I saw this two weeks ago I thought it was a pretty damning indictment of the way NHS Tayside had not been performing its duties as would be expected from not least the Information Commissioner but the public at large.

Q. One of the statements that's frequently been made to this Inquiry by NHS Tayside is it's a learning organisation. In this important regard, has your experience been that it has learned how to respond to requests, via FOI or otherwise, as you have been involved in it or not?

A. This would partly suggest not, that there are still ongoing problems. I mean there are documents in my files that -- NHS Tayside persuaded us that new systems had been put in place for certain aspects and I think in some part that was correct. There were new systems of oversight that were put in place to try to involve greater transparency and ensure there was a greater check on documentation, but then not that long ago we

find the appalling situation where logbooks went missing, were destroyed and that was after do not destroy notices had been issued. So I'm afraid that undermined some of the trust that the new procedures are effective.

Q. Your understanding is that the logbooks were destroyed?

A. Yes.

Q. Not that they were lost?

A. No, I'm sorry I misspoke there.

Q. No, not at all. I'm just clarifying that with you for other purposes. I think in your statement you use the word which I'm quite keen to focus on "obfuscation" because presumably within document management which -- it does form a key element of all of this -- there will especially with things that are historic like this be circumstances in which normal document retention procedures will mean that unfortunately the documents that are needed are not available. But your use of that word and some of your other evidence today suggest that we're dealing with a very different situation it that. What's the basis for that analysis?

A. Well, I used the word "obfuscation" where you're not getting to the direct transparent information that you want you might be getting other aspects of sort of semi-relevant information that would surround the sort

of key theme but you're not getting to the core issue that you're wanting to find the information about. And I think obfuscation to me suggests that there is a bit of sort of delay tactic or there's trying to sort of put the onus on somebody else to try to find the information, and it's just -- you know, we should be clear that when somebody asks for this kind of information if we can't find it somebody should know why we can't find it and be able to be accountable for that. But most of the time we should have been able to find the information because it's, you know, been part of medical records and a management procedure where I would like to think that the National Health Service of any part of Scotland would be effective in the management of that kind of information. That's what part of good healthcare should involve.

Q. You mentioned the phrase there used was "putting the onus on someone else". I think you mentioned earlier there had been difficulties sometimes within you've been involved in FOIs or other attempts from patients to get information that there had been a sort of passing of the buck between NHS Tayside and the Scottish Government. If one looks, just as an example from the paperwork at the sort of information Mrs Rose was looking for, that sort of information as I think you've said, was quite

specific --
A. Yes.
Q. -- to do with the circumstances in which she underwent her surgeries in 2013 and could only have been answered by medics or NHS Tayside?
A. Yes.
Q. Was your experience in that that the buck was passed to government to suggest they might know the answers?
A. No, not that they would know the answer but that they would be able to ensure NHS Tayside would be able to provide the answers.
Q. I see.
A. By this time the Eljamel case was a very big public issue and it was essential that both Scottish Government and NHS Tayside were working in the same direction to ensure that we got answers to these questions and I didn't feel at some occasions that we were -- in a situation where they were working together, that it was being passed over to somebody else, passed back again, eventually coming back to me and I would then have to go back. As Jules Rose would evidence, some of the questions that were being asked might be answered but they wouldn't all be answered and within the ones that weren't answered there would be some key nuggets of information that we needed to establish who was

responsible for what had happened.
And so this -- and that's obfuscation to me as well because you're not answering directly what somebody has asked and it was just that frustration that, you know, when I put this to a Cabinet Secretary for Health, as I did on four or five different occasions, they implied that they agreed with that but we still didn't get the answer and then they said that they would go and find out from NHS Tayside. We would get a letter from NHS Tayside, but some of that was never forthcoming. And I think there's an occasion where the NHS Tayside had agreed to a meeting with some of the patients and I think we asked for that three times and it never happened. You know that's obfuscation to me as well.
Q. You've mentioned already the process you went through or advised patients to go through to get to the point of asking for a public inquiry by exhausting other avenues.
I think the evidence that you've provided suggests that the public inquiry was being called for by patients since at least 2015. Indeed, Ms Cherry in her opening statement on behalf of the patients suggested it might in fact be 2014, but you've explained this systematic process that you advised them to go through. When was it that your view became: okay, enough is enough, we need to have a public inquiry for the sorts of reasons

associated with public inquiries that you set out?
A. About a year before it was in fact announced by the Scottish Government that they were going to have a public inquiry. And obviously there were lots of demonstrations outside parliament about this public inquiry but I believed I had responsibilities as an MSP to try every possible avenue that I could as a parliamentarian to get the answers for these patients and I became so frustrated in my efforts that I felt that the patients were quite right in making that call for a public inquiry and so I was relieved when eventually that announcement was made.
THE CHAIR: So that would be the middle of 2022?
A. Correct.
MR DAWSON: I wondered, Ms Smith, whether that might have been coincident in time with the publication of the Scottish Government's review of unresolved and outstanding concerns regarding Professor Eljamel which was the Scottish Government's investigation published in May 2022. Would it have been around about that --
A. Yes, that was around about the same time but I don't think that was just the issue that determined my support for a public inquiry, I think there were other aspects as well. Specifically that as I say my own frustration was building and I felt I had the case work to

demonstrate why I had every right to demand a public inquiry and obviously I had a lot of discussions with the patients at the time and they were very helpful to me in persuading me why they felt that, you know, enough was enough as you rightly suggest.
Q. You mentioned a moment ago the fact that you had had to deal with a number of different Health Secretaries over the years and a number of different First Ministers I think and probably also I would imagine with Tayside a number of Chief Executives and others as well?
A. Yes.
Q. I think you've explained that they all were sympathetic towards the position but couldn't provide the answers; is that a fair summary?
A. Yes, that is a fair summary and I don't think I found any of them who were unsympathetic to the cause of what the patients had suffered but the long and short was they weren't providing us with the support at some time and the answers that we were trying to establish.
Q. And just to focus in on that time period where you say that your view that a public inquiry was the right thing to do, around about the middle of 2022, the Cabinet Secretary for Health at that stage was Humza Yousaf; is that right?
A. That's correct.

Q. And the Cabinet Secretary for Health who eventually announced that public inquiry on 7 September 2023 was Michael Matheson?
A. Yes.
Q. Could you clarify for us, in that period where you were campaigning for that outcome, who was it that you were dealing with and what was your experience of the interaction in response to your now support for such cause?
A. I had two meetings with Humza Yousaf before when he had been Cabinet Secretary for Health and then once when he was First Minister and then we had --
THE CHAIR: Sorry, two meetings as Health Minister?
A. Yes, as Health Minister, yes, correct. And then there was a situation where jointly we had a meeting with Michael Matheson and that was, I think -- I think I'm right in saying that six MSPs turned up to that meeting so there were other MSPs who by this stage were interested in that.
MR DAWSON: Yes.
A. But you know we eventually had meetings further on down the process after the public inquiry had been announced. We met with the Cabinet Secretary for Health and we also met with the First Minister.
Q. I'd be interested to try to understand from your

perspective of having been someone amongst others who was involved in that process, what your impression was of the Scottish Government's thinking at around that time and who it was, if you like, who was exceeding perhaps gradually towards the idea of a public inquiry. The reason for that is the explanation given publicly by the Scottish Government when the Inquiry was actually announced focused very much on the outcome -- or the content of the NHS Tayside due diligence review which had come out only a matter of weeks before the announcement was made. I'm interested in sort of trying to probe the idea as to whether that report was perhaps the straw that broke the camel's back in a process that was moving that direction anyway or whether it was that report and its outcome that was the reason that that Inquiry was announced?
A. I think there's a strong indication that that report was seminal in making up minds because the due diligence report presented the public with identifying so many problems and I think that certainly was beginning to get quite a lot of coverage in the media apart from anything else. And by this time we knew that there were more and more patients coming through that the volume of patients who -- of patient complaints I should say, was very substantial. And I think if I look back at the answers

I was receiving from either First Minister's questions or health questions, of which you have a copy, the tone was beginning to change to be almost hinting that there might be a change in government approach. And that change was undoubtedly around that time of the 2022 report.
Q. The 2022 government report?
A. Yes.
Q. So effectively as I understand it, that 2022 to 2023 period straddles Humza Yousaf being the Cabinet Secretary for Health and then Michael Matheson?
A. It does.
Q. But would it be fair to say that there had been a start of a move towards it in 2022 when Humza Yousaf was still the Cabinet Secretary or was it really more under Michael Matheson's leadership that that became the case?
A. I think it was a bit of both. I think at First Minister's questions there was a bit of a move as well I felt and that was obviously Humza Yousaf for a short period of time and then John Swinney and I think there was definitely a softening of the tone that maybe this is very much bigger than we thought it was and there was tremendous courtesy -- I can't fault them in the way that you know they responded to my concerns, nor can I fault them on the fact that when we were in a meeting

if we eventually got it organised they were sympathetic and took it seriously, but I think that the scale of what was being uncovered not just in obviously the malpractice issue but what had not happened in terms of due diligence of the oversight, I think that was beginning to send shockwaves through the Scottish Government.
Q. Okay so one aspect of this which I wonder might relate to the softening we're keen to try and understand is our understanding in April 2023 there was a move towards having something in the nature of the Independent Clinical Reviews -- we're going to investigate exactly whether that is what it ended up being -- but as I say the due diligence report by NHS Tayside came out in around August 2023 and by the 7 September 2023 there had been a move towards having a public inquiry but also retaining the Independent Clinical Reviews. Do you recall your understanding of what the clinical review side was to be when it was first announced earlier in 2023?
A. That those people who felt they had a case with Eljamel on that one-to-one and very confidential basis would be able to have their own clinical situation reviewed and I think that's absolutely right and proper actually and I know there's a very welcome reception to that amongst

many of the patients. And there are patients there who are extremely private about the difficulties that they encountered and find it difficult perhaps to articulate some of the issues that they suffered and have appreciated the opportunity, especially with Professor Wigmore, to undergo these clinical reviews. But I think the overall concern was growing about the extent that the due diligence of the oversight had not been effective and that was definitely sinking in I think with Scottish Government ministers. It took a long time but I think it was sinking in.

Q. Had it been -- I understand the two different elements obviously quite intimately but the clinical side and then the more systemic side. Had it always been part of the patients' campaign that they wanted this two-step or two processes or had it been something which the government had given them, as far as the clinical side was concerned in spring of 2023, but they said: well, what we actually want is a public inquiry?

A. I think it was inherent in the circumstances because quite rightly they had suffered tremendous physical and psychological harm. Naturally they wanted to know why this had happened and in many case why this had happened after warnings and they want answers about why it was allowed to continue for such a long period

without anybody being held accountable. So I think the two go hand in hand, but I think the scandal for me is not just about Eljamel's horrible medical malpractice and all the dangers that he has put upon his patients, it's about the oversight or lack of oversight especially when concerns were raised. That's the nub I think of the concern among most patients.

Q. So logically, I'm taking, it must have been your position earlier -- your and the patient's position earlier in 2023 that, although welcome, the clinical reviews were not sufficient as they would never address that aspect?

A. Correct.

Q. And do you know why it is that Michael Matheson effectively changed his mind on that and decided that there should be a public inquiry shortly before 7 September 2023?

A. I got the very strong impression that the government ministers were pretty shocked by the report that came out that you mentioned whereby it was quite clear that there were inadequacies within NHS Tayside. I think that was a big shockwave to the government.

Q. As I understand your evidence, had that not been what you and patients had been telling them for some years before that?

A. Indeed, sir.

Q. And what was your view/the view of the patients on whose behalf you were advocating about the retention of the two processes? The reason I ask that is there's an impression from some evidence there might have been a degree of confusion as to why there needed to be two processes.

A. Yes, I can understand that up to a point but I think, as you rightly said a few minutes ago, there are really two issues -- they're very strongly connected to each other but there are two issues here. The first is the medical malpractice but the second is why it was allowed to happen. And so I believe that there is a very strong case for not just the public inquiry but for Professor Wigmore's clinical reviews and I think my reaction, certainly from listening to what patients are saying, many of them are very grateful for that opportunity to talk about their actual individual medical cases, but as you rightly said that was not going to be enough to answer the most important questions about why it was allowed to happen.

Q. And as regards the systemic issues with which you were keen there should be a public inquiry for some years, did you have the impression that the Scottish Government had a clear list of what those issues would be?

A. In some respects I felt they had but not in the detail that I thought was going to be sufficient to be able to address all the circumstances of what had happened. Governments are busy, they have loads of other things to think about and there was Covid at some aspects of the Eljamel situation and you make a little allowance for some of the delays that happened in 2020, 2021 particularly, but I never got the impression until very much later in the day that the Scottish Government really saw this right at the top of the agenda and I think credit to the campaigners but credit to my parliamentary colleagues who assisted me in pushing it right up there because we believed it was a matter of very considerable public interest.

Q. To continue on the theme of documents but in a slightly different context you mentioned having had not as many or as quick meetings with the Scottish Government as you might have liked but there have been some as I understand it?

A. Yes.

Q. And who was the Cabinet Secretary with whom you first managed to get a meeting on behalf of the Eljamel patients?

A. I think if we go back through the different Cabinet Secretaries for Health, including the late Jeane Freeman

who I found very helpful in some respects and I think perhaps Jeane Freeman was the one who commissioned the report -- the investigative report.

Q. The one that reported in 2022?

A. Yes. So from that angle I felt that we were -- I had a very brief meeting with Nicola Sturgeon when she was Health Secretary -- that's obviously going back a long period of time -- when Eljamel came up in the conversation about various other things but she wasn't responsible for the other meetings that I had because we met obviously with Michael Matheson, we met with Humza Yousaf when he was Health Secretary with Jeane Freeman, with Neil Gray, so there was a long list of Cabinet Secretaries for Health. I met with them all at some stage, some with patients but some with colleagues and some privately myself.

Q. As far as meetings of that nature were concerned, were you aware of whether the Scottish Government officials/civil servants minuted those meetings?

A. There were certainly civil servants in the room and I think it's the understanding I have and I think my colleagues would agree that there were civil servants there who were doing their duty in terms of taking minutes and therefore these minutes should be available.

Q. Did you get copies of the minutes of those meetings?

A. No, but in the circumstances we wouldn't expect necessarily to get all the detailed minutes of these meetings but these can be sourced and it's a matter of record I think that -- it is our understanding that civil servants were present and taking notes.

Q. Could I ask you about -- you asked a question on 12 March in Parliament, on 12 March 2026, relating to the postponement of the hearings in this Inquiry and you asked the First Minister at First Minister's questions: is the First Minister as appalled as I am that the former patients of Sam Eljamel who were allowed to attend in person the first and second sessions of the public inquiry to hear what was being said in evidence we were told yesterday that that would no longer be the case for session 3 and they would have to listen to the Inquiry's proceedings online? Does he agree that that decision is completely unacceptable? Is it contrary to the principles of a patient-centred and trauma-informed approach? When were Scottish Government Ministers first made aware of that decision?

Obviously there was a significant amount of concern which you expressed to the Inquiry about that decision and that's entirely understood. But what I was keen to know was when asking that question had you assumed that

that was a decision taken freely by the Chair of the Inquiry?

A. I wasn't sure, I'll be quite honest. I felt very strongly that there should be no circumstance where patients -- you know, as you say it's all about patient-centred inquiries and Lord Weir has always, in all his public utterances, been very careful to assure patients that you know they are at the centre of this Inquiry and that's absolutely right and proper and should be. And I didn't feel if they were going to be moved online that that was going to be acceptable, particularly as we'd obviously had two information sessions of this Inquiry when they were free to attend and I think it's important that they can attend but I wasn't sure, I got the impression that this decision to -- well, there was a problem about the room etc, but at the time I thought maybe Lord Weir had had to take the decision because he was forced into a circumstance where this room was not operational and if there were safety concerns I could understand that but that concerned me. So I wasn't entirely sure what had happened.

Q. I'm not in any way seeking to criticise you in this regard because I'm aware I think quite precisely of the amount of information that would have been available to

you about it at the point where you asked that question. What I'm quite interested to know, however, is what it is that the Scottish Government told you as a result of that question or otherwise about what the problem actually was? Because of course it's entirely understandable that patients whom you represented wanted to know more and we totally understand that, however, the government could have given you more information at that point I might suggest and I'm wondering whether they gave it to you?

A. I thought they could have given me a lot more information because it then transpired that there had been some problem with the council and about the availability of this facility and I think many people in the media were a bit taken aback by this decision as well because I think there was a bit of incredulity if there's a really big public inquiry, why is there a room problem? You know, that just didn't quite sink in and didn't seem to be entirely accurate. But it was quite clear that there was a problem but the conversation I had with Neil Gray at the time, he intimated to me that there was an issue about the local council and how this building would be leased and I didn't feel we got the full facts about that.

Q. Okay. If I could just read out what the First Minister

told you in response, he said:

"I understand the significance of the point that Liz Smith raises but as I understand it the decision that's been taken by Lord Weir who is the Chair of the Inquiry. Liz Smith will know the obligations that I am under in terms of the Inquiries Act 2005. The Chair of the Inquiry must be free to take the decisions they decide to be appropriate for the running of the Inquiry. They should certainly not be subjected to interference by Ministers and they certainly will not be subjected to interference by me, whatever my personal sympathies are on the issue. As Liz Smith knows, just last week I met those who were affected by Eljamel and had a constructive discussion with them. I have to respect the independence of Lord Weir's Inquiry. It would be thoroughly inappropriate for me to intervene on any matter of that nature." (As read; not shown on screen).

Would it be fair to say in his response, Ms Smith, that the First Minister rather gave the impression that the decision-making in this regard had been that of the Chair and the Chair alone?

A. Yes, what you have just read out, in terms of the 2005 Act that is correct, that you know it is a matter that the government can interfere in issues that will be decided by the appointed Chair of the Inquiry. That is

correct, that's a correct summary. But I think given that there were specific issues about why this building could not be used, and obviously there were problems about the lease, about the local authority, I think perhaps they could have given us a little more information about what exactly had happened.

Q. I'm sure you know, Ms Smith, because you follow these matters in detail that I have, in minute detail, set out now two hearings exactly what's happened in this regard.

A. Indeed.

Q. In light of what you now know about the underlying reasons for the proposal and the Scottish Government's responsibilities as tenants of this building, do you think that the response of the First Minister was entirely candid?

A. No, I don't actually. I think what he said was correct up to the point of the interpretation of the 2005 Act but that was a general tone. But obviously there were very specific issues which, as you have pointed out, you made clear. I think we could have had more information at the time.

Q. Connected to that general area -- I have asked you a few questions already I don't want to dwell on it too much, but the subject of the Finance and Public Administration Committee report into the cost-effectiveness of public

inquiries is one that we're interested in hearing from you on as well and of course both yourself and Mr Marra sat on that, and you've already given some evidence about what you heard from Mr Sturrock KC and his views which I think you accepted about why there are so many public inquiries and difficulties in that regard.

One of the things that is of interest because this Inquiry is almost introspectively looking at why it itself was created which is why I have been asking you these questions to try to illuminate that a little bit further, but in many ways it's interesting to understand what the understandings were within the committee because it looked at public inquiries in some detail and indeed looked at systems abroad as well as in Scotland.

A. Indeed.

Q. I'm interested in understanding what the committee broadly made of the evidence it had about the extent to which its recommendations about limiting, at the start, the budget and timescale for an inquiry might interfere with the essential principle of an inquiry's independence?

A. I think it's a very interesting question. I mean, the evidence that we took particularly from some jurisdictions abroad was quite compelling in a way that they limit the timescale for any particular public

inquiry and therefore the cost of that public inquiry is not necessarily as extensive as it might be if you let the time run on and I think up to a point there is an interesting debate about that, but -- and I think it's a big but -- there are really big public inquiries like this one whereby I think it is very important that you -- particularly as it's on quite a long historical period, where you -- the judge would not necessarily be able to come to a full comprehensive conclusion without very extensive time with witnesses, particularly if it's a situation like this where there are so many stakeholders involved. And therefore you could ask the question: if you don't allow the time to take place with that in mind, do you hear all the evidence that is necessary to come to the right conclusion?

So we had this put to us, quite interestingly actually by witnesses who represented New Zealand and Sweden, and we also looked at some situations in England and there was a case -- I think, from the Finance Committee's point of view, there is -- we are responsible for scrutinising the fiscal side of Parliament and there was a real concern that the cost of public inquiries is way up to £260 million over, you know, quite a short period of time that increase has taken place. And therefore that begged the question

about why that cost had risen and why in essence there was this increasing demand for public inquiries. And that really focused our mind I think as a committee to try to provide the evidence about what we thought was causing a lot of concern there.

And then I can well understand the administration costs that go along with a public inquiry. I fully understand and I'm very grateful to all the people in your team who do the support work with bits of documentation and filing and that's essential. But naturally witnesses need to be represented legally and if that goes on for a long period of time, the legal fees obviously increase understandably and sometimes these legal fees were getting pretty big and so there was a bit of a concern in the Finance Committee that, you know, public inquiries -- and if you do allow them to extend to whatever timescale the judge decrees then, you know, that could go on for quite a long period of time. And you know there have been calls -- I can think of four or five former colleagues in the last session of Parliament who were wanting to put forward motions for a new commissioners and the reason for wanting new commissioners was because they felt that some of the public agencies were not doing their job properly and that I think is all tied up in the same sort of

argument.

Q. Thank you. So to understand there's a couple of elements there. Would you say that it was either you and/or the committee's view that for "inquiries like this" as you've put it those sort of limits shouldn't apply?

A. I would argue that -- I'm not sure I could speak on behalf of all the committee members but I think there was quite a strong feeling that -- I think there was this dilemma about trying to ensure that the costs of public inquiries were at least under control. I think that was a strong commitment within the committee members but also that we had to get to the answers and I think the public feel quite strongly that public inquiries should have a judge who leads the whole inquiry because there's great respect for a judge in that situation and that witnesses are compelled to give evidence under oath which I personally think is very important. So there's a big debate about public inquiries, I don't doubt that for a minute, but there is a cost problem.

Q. Was it assumed -- and I can understand if one reads the statute why it might be -- that the Chairs of inquiries have a complete control over how much they cost?

A. Well, it was some interesting divisions within the legal

authorities within Scotland about that. Do you take a stance -- would you have to change any of the legislation in the 2005 Act, for a start? You know, does that have to be reformed? That's one question. Then: do you have to have a situation whereby public inquiries are controlled in terms of their timescale and should they all be judge-led, or can you have a mixture of public inquiries, some that are judge-led and some that are much less legalistic, if you like?

And so I think there's lots of arguments going on about that but you know if I'm a member of the public I want to know that a public inquiry is going to be able to answer the questions that the, in this case, patients have been asking for a long time who have tried all sorts of other means. And so public inquiries are absolutely necessary sometimes to get to the root of the truth of what happened.

Q. Because based on even the experiences you raised in parliament about this Inquiry earlier in this year, it should perhaps be apparent that chairs of the inquiries do not completely control how much inquiries cost in particular relating to things like tenancy of a property which might be used?

A. Indeed.

Q. So therefore to set those financial limits or to set

time limits does, I think, rather work on an assumption that the Chair is completely in control of those matters which I think perhaps we've discovered, would you not agree, is not the case?

A. And I think that's correct. I think one of the interesting debates that we had in the first sessions we took is that for some public inquiries -- and I think it was Lord Hardie who said this to us -- there was a lot of duplication of some of the facilities in servicing that goes into a public inquiry that, you know, every time that a public inquiry is set up you have to go through the whole process of setting up all of the administration of that. And he was making the point that actually you could probably get some economies of scale to try to combine some of that administrative background that's so important and you know I think he's got a good point there. But I'm no expert in you know how these costs are administered but I do think parliament is going to have to take a view on how to proceed with public inquiries.

Q. I think it was perhaps Lord Hardie who said that, Ms Smith, not least because he wrote an entire chapter in the Edinburgh Tram Inquiry report on exactly that subject?

A. Indeed.

Q. Did you ascertain in the investigation whether the Scottish Government had done anything to take into account of what you'd set out in so much detail in that report?

A. No, we didn't get any information about that side of things. I think our timescale for the public inquiry was actually in itself a little bit limited because you were doing a lot of things relating to the budget, fiscal framework, all sorts of things. But I think we had four or five evidence sessions with the legal profession, all of them extremely interesting, I may say, and we tried our level best to get to the nub of, you know, if there were going to be cost savings where might some of these cost savings be made and Lord Hardie was very direct in his evidence about that.

Q. Thank you. Those are all the questions I have for you, Ms Smith. As will become the tradition at the end of this part of the evidence, I'm going to ask you now whether there's anything that you would like to add?

A. No, sir, I don't think so. As you probably can tell from my evidence, I'm just very keen that one day we'll get to the truth about what happened and why so many patients feel so badly let down and nobody has been held accountable.

MR DAWSON: Thank you. I'm afraid you're not quite off the

hook yet. We'll have a short break now and there'll now be an opportunity for the core participant legal representatives to suggest some further questions which hopefully won't take too long.

THE CHAIR: Well, that necessarily means that it's perhaps unclear how long that will take, but if those in the public gallery just bear in mind that it's probably sensible not to travel too far from the hearing room and you can let me know when we're ready to resume.

MR DAWSON: Thank you, sir.

(4.15 pm)

(A short break)

(4.22 pm)

MR DAWSON: Sir, just for the sake of clarity for those who are in attendance this will be a normal pattern whereby at the end of my questions we'll have a short break, as I explained this morning, and then the core participants' legal representatives are afforded the opportunity to ask further questions in addition to the ones they've already proposed. So that's for everyone's information the process we've gone through.

Ms Smith, to return to the subject area of calls for a public inquiry, there's one area I have been asked a question about which I had actually intended to ask myself but I forgot. I know this is a subject that you

know about, and again for others it might be helpful to contextualise it. When a Scottish public inquiry is set up the statute makes clear that there are jurisdictional limitations on what a Scottish Inquiry, as it's called in the Act, can look at. And it can only look at matters within the remit of the Scottish Parliament, ie which are not reserved to the Westminster Parliament under the devolution settlement.

As I know you know, there were significant concerns expressed by a number of patients that as a result of this being a Scottish Inquiry there were certain bodies which fall within Westminster's exclusive jurisdiction, including for example the General Medical Council and the Health and Safety Executive, that would not be able to be investigated in the same way as other bodies like NHS Tayside. So that in that context which I know you understand you are aware of there having been any consideration given at any stage within Scottish Government of seeking to have this Inquiry made into a joint Inquiry which would have enabled that full range of bodies to be examined?

A. Yes, on an informal basis I completely understand the legislation and Mr Marra and Mr Rennie and myself, we wrote on behalf of the patients regarding the Terms of Reference that we were slightly concerned that HSE and

the General Medical Council could not be investigated on the same basis that some others might be. The reason being, particularly with HSE which you know in future parliaments I'd like to see a bit of further work done on this, because there is a responsibility through Westminster when it comes to HSE's operation but when it's a specific medical issue or a health matter that has to be investigated by another health board, HSE does not by statute have the right to do that. But there was deep-seated concern, and I appreciated that and as did my colleagues, that if you were looking as one of the core issues within this public inquiry that the oversight had not been effective and HSE does have a role to work with other bodies like HIS in Scotland -- and in a letter that Jeane Freeman had sent to me she made clear that HSE does have a responsibility to look at various issues there -- there was a concern that the oversight of some of the health organisations would not necessarily come to the attention of the public inquiry unless HSE and the General Medical Council could be properly investigated. But in his letter back to us Lord Weir made it clear that it is within his remits to call witnesses who might provide the assistance that is required in answering some of these key questions and I hope that that might be the case in the future because

I think there are some genuine questions that were raised by patients when it came to HSE and to the General Medical Council, but you know the legislation of 2005 is very clear about that.

Then just in relation to what the Scottish Government might have done with the Westminster Parliament, there were moves made by MPs, by Richard Baker being one, to make the Westminster Parliament aware of some of the issues that might actually be common to some aspects of public inquiries south of the border. Particularly at the time when it was revealed that Eljamel might have had connections with other hospitals south of the border, there was a very clear reason why it might have been appropriate to delve further into that because obviously that could have some way of uncovering some of the most important material.

So yes, we were aware of some of the -- letters were written. It was Wes Streeting who was the Secretary of State for Health at the time and that discussions had taken place on that. And the Scottish Government wasn't shutting that down but -- it's not a matter for me but I think there is a strong case that in some cases HSE and the GMC do have a role to play on this.

Q. Just to focus on the time periods, my understanding

despite the fact that there were certain things that HSE could not do by dint of legislation but they set out very clearly why they felt they had a responsibility when it came to patient safety about what might be required. And that's where I have sympathy that if Lord Weir has the powers to call witnesses that might obviously address that problem.

Q. Just to be clear, I know you'll understand but just for the sake of people who are listening, it would never have been within the Scottish Government's gift to announce an Inquiry that went into these areas, that's right?

A. Yes.

Q. But the Scottish Government could have sought talks with the UK Government to try to see whether they would like to enter into a joint inquiry arrangement?

A. Indeed.

Q. For the sake of clarity we will be hearing oral evidence later in this session from two representatives of the GMC. We have a written statement from them in this section and we also have a written statement from the HSE as well as very voluminous documentation, I can assure you, from them which either has been or will be disclosed to our core participants in due course.

A. Thank you.

certainly is the time period you were talking about there when Mr Baker was writing letters and that sort of thing was in the period after this Inquiry had come into being?

A. Yes.

Q. So it would still be open to the Scottish Government at that stage to say: well, we could now make it into a joint Inquiry and you said they weren't shutting that down?

A. They weren't shutting it down.

Q. What about in the period before this Inquiry was raised, was there anything available to you that the Scottish Government considered the possibility of a joint inquiry before the Inquiry was actually announced?

A. Not to my knowledge and that was not part of any formal discussions I had had. We were probing on the HSE situation and to a lesser extent on the GMC but did it come to formal discussions about -- before the Inquiry was announced about trying to have a joint basis to this? No, not in terms of formal discussion.

Q. When you say you were probing about HSE and GMC that was before the Inquiry and subsequently?

A. Yes, correct, and in Mrs Rose's evidence and also in Mr Kelly's evidence, they set out the reasons, very strong reasons why they felt that HSE did have a role

Q. Thank you. That's everything, sir.

THE CHAIR: Thank you very much. Ms Smith, it's obvious from your evidence that you have been a prominent and valued representative of many patients in connection with this matter and it's in that context that I'd like to thank you very much for coming to the Inquiry this afternoon as its first witness and to share not only that evidence but also your insights and reflections on the matters about which you've been asked. I'm very grateful to you. You're now free to go.

A. Thank you.

THE CHAIR: Now I take it that there are no other matters that I need to be undertaking this afternoon?

MR DAWSON: That's correct.

THE CHAIR: Thank you very much everybody. We'll see you at 10 o'clock tomorrow morning. Thank you.

(4.32 pm)

(The hearing concluded)

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