

1 Friday, 11 September 2026 2 (10.09 am) 3 THE CHAIR: Good morning, have a seat. Yes, Mr Dawson, good 4 morning. 5 MR DAWSON: Good morning, sir. The first witness this 6 morning is Professor Frank Smith. 7 THE CHAIR: Thank you and this witness is giving evidence 8 remotely, I understand. 9 MR DAWSON: He is, indeed. 10 PROFESSOR FRANK SMITH (called) 11 THE CHAIR: Professor Smith. Good morning, can you see and 12 hear me all right? 13 A. Good morning, sir. Thank you very much for 14 accommodating me virtually. I can see and hear you 15 perfectly. 16 THE CHAIR: I think we can at this end. If anyone has any 17 difficulty they can obviously let me know. 18 PROFESSOR FRANK SMITH (sworn) 19 Questions by COUNSEL TO THE INQUIRY 20 MR DAWSON: Good morning, Professor. Can you see me okay 21 and hear me okay? 22 A. I can hear you perfectly, thank you. 23 Q. Excellent. Thank you very much. You are 24 Professor Frank Smith? 25 A. Correct. Page 1	1 provide certain categories of documents relevant to 2 matters covered in the statement, was that right? 3 A. That's correct. 4 Q. Thank you. Professor, by way of professional background 5 your qualifications are BSc, MBChB, MSc, MD. You're 6 a fellow of the Royal College of Surgeons of England, of 7 Edinburgh, of Glasgow and of Ireland and a fellow of the 8 European Board of Vascular Surgery, as well as a fellow 9 of the Higher Education Academy; is that correct? 10 A. That's correct. 11 Q. We've had some evidence to the Inquiry recently about 12 the role of the Royal Colleges and fellowship, in 13 particular someone from the Royal College of 14 Surgeons of Edinburgh. Am I correct in thinking that 15 you are a fellow of all of the Royal Colleges that 16 operate in Britain and Ireland, in the surgical field? 17 A. That's correct. 18 Q. My understanding is that those four colleges work 19 together to provide standards and examinations. Could 20 you give us a rough outline as to the sort of work that 21 they do in a collegiate sense with all four working 22 together? 23 A. Yes. The presidents of the four Royal Colleges, the 24 vice-presidents and the chief executives meet four times 25 a year at the joint surgical colleges meeting which Page 3
1 Q. And you have provided a witness statement to the Inquiry 2 as I understand it; is that correct? 3 A. That's correct, yes. 4 Q. And you've done so on behalf of the Royal College of 5 Surgeons of England? 6 A. Yes, that's correct. 7 Q. Could we have RCS-00021 up on the screen, please. Is 8 that an electronic copy of your statement? 9 A. Yes. 10 Q. Could we go to page 32, please. Is that where your 11 signature appears on the original version? 12 A. Yes, that's correct. 13 Q. And the statement is dated 26 February 2026? 14 A. Yes. 15 Q. And are the contents of this statement true, as far as 16 you're concerned? 17 A. Yes. 18 Q. Could we just have a look at page 33 as well. I think 19 you've also signed there; is that correct? 20 A. Yes. 21 Q. Confirming that you have -- the Royal College has 22 provided all documents which we hold to the Inquiry 23 under appendix C, is that right? 24 A. That's correct. 25 Q. And appendix C was effectively a request for you to Page 2	1 rotates around those four colleges, to discuss matters 2 which pertain to the conduct of surgery in the 3 United Kingdom particularly the development of training, 4 sometimes to do with working conditions and towards 5 developments in surgery and indeed concerns arising in 6 surgery. 7 Q. I think we also heard some evidence about there being 8 a joint examination system; is that correct? 9 A. That's absolutely correct. One of the pivotal functions 10 of the Royal Colleges is to ensure the quality of the 11 surgeons who practice within the United Kingdom and 12 Ireland and one of the pivotal sub-functions is to 13 ensure that there's an appropriate standard of 14 examinations both at the basic surgical examination 15 level, the MRCS, and also at the higher surgical 16 examination at the time before a trainee would expect to 17 become a consultant and that's the FRCS examination. 18 Between the four colleges those examinations are 19 maintained through two organisations, the 20 intercollegiate basic surgical examinations committee, 21 and the joint colleges intercollegiate examination 22 committee, JCIE. 23 Q. Thank you very much. To return to your CV, you are 24 Emeritus Professor of Vascular Surgery and Surgical 25 Education at the University of Bristol; is that correct? Page 4

1 A. That's correct. 2 Q. And you trained in vascular surgery in the 3 West Midlands, Edinburgh and the Southwest, undertaking 4 travelling fellowships in Boston, Denver, Los Angeles 5 and Seattle; is that correct? 6 A. That's correct. 7 Q. We were interested in the fact you'd spent some time in 8 your training in Edinburgh, when was that? 9 A. I spent one year in training having completed what was 10 then my house jobs. In those days that was a one-year 11 period, the house job, now it's the two years foundation 12 programme. Following that in order to prepare myself 13 for the surgical examinations I undertook a year 14 teaching anatomy at Edinburgh University Medical School 15 in the role of demonstrator in anatomy. 16 THE CHAIR: Mr Dawson, I'm just going to pause. I think we 17 might want to turn the volume up very slightly. It's 18 capable of doing that and I think if those who are in 19 control of these matters can hear me and can attend to 20 that, that would be appreciated. Right, assuming the 21 message was heard, perhaps you can continue. 22 MR DAWSON: Thank you very much, sir. We heard some 23 evidence yesterday from the Medical Director of what was 24 NHS Education for Scotland who told us about the 25 importance, in particular the surgical field was the Page 5	1 in terms of how one deals with patients, how one deals 2 with one's peers and one's colleagues, learning things 3 like communication skills. So you've hit upon 4 an important point there, thank you. 5 Q. There's a word that's come up in some of the evidence 6 that we've heard so far which is been used in the 7 context of standards being applied to surgeons and 8 I've seen it appear in some of the documentation you've 9 supplied, which is the word "probity". Is that 10 an important quality in a surgeon and could you give us 11 a brief definition of what the Royal College of Surgeons 12 of England would think that means? 13 A. Yes, you've highlighted an important point. In fact, 14 I had never come across probity until -- the word 15 "probity" until it began to appear in appraisals along 16 the way. And it really refers to the intrinsic honesty 17 and conduct of any clinician with respect to how they 18 look after their patients, how they deal with their 19 colleagues with respect to honesty and, in effect, it 20 encompasses the quality of surgical care as well as just 21 integrity and honesty. 22 Q. So it would be a feature of a good surgeon's 23 relationship with patients, with his colleagues, his or 24 her colleagues, with other professionals and 25 organisations with whom he or she comes into contact? Page 7
1 context in which we were discussing it, of moving around 2 to different places to get different surgical 3 experiences because where one might be based might not 4 offer all of the surgical experience that one would need 5 to be able to pass the examinations. As someone who 6 appears to have travelled around to various places, is 7 that a phenomena that you recognise and how important is 8 that in surgical training? 9 A. I think it's important to get a perspective from a broad 10 spectrum of sources across the healthcare system as 11 a trainee so that you don't just become imbued with the 12 practices from one particular institution and indeed 13 certainly currently, and in the past, one applied for 14 training posts. Nowadays there's a system of national 15 selection in which there may be relatively random 16 allocation of trainees to particular posts and then they 17 will rotate around several hospitals within a region, 18 picking up various aspects of different experiences. 19 Q. And the perspective that you talk about, does that cover 20 both a technical perspective on surgery, perhaps what 21 one might describe as non-technical approach to the way 22 a surgeon should conduct him or herself? 23 A. Yes, I think that is true. Certainly it's vital for 24 surgeons to develop their technical skills and 25 non-technical skills, of course, are just as important Page 6	1 A. Absolutely. 2 Q. Thank you. You have, I think, been nominated to provide 3 this evidence on behalf of the Royal College because of 4 the fact that you hold the position of the Chair of the 5 Royal Colleges' Invited Review Mechanism and have held 6 that since July 2023; is that correct? 7 A. That's correct. 8 Q. Could you tell us broadly what the Invited Review 9 Mechanism is and what it's designed to achieve? 10 A. Yes. I can. The Invited Review Mechanism was set up in 11 the late 1990s in order to provide a mechanism which 12 could assist hospitals, trusts, where necessary or where 13 wished for by the trusts, to improve the services that 14 those trusts provided to patients and to the public and 15 underpinning everything that the Royal College of 16 Surgeons does really are quality improvement measures to 17 improve outcomes from patients and the public. 18 And the Invited Review Mechanism, it has to be -- 19 it's what it says on the can, it is invited by a trust 20 to come in and carry out one of three sorts of review. 21 Where a trust has particular concerns over an individual 22 practising surgeon, they may invite the IRM to come in 23 to perform an investigation on aspects of that 24 individual surgeon's practice. They can also carry out 25 a case review and that may be of an individual case or Page 8

1 a series of cases where there have been concerns about 2 outcomes or, for instance, the trust may have received 3 complaints that have promoted concerns and they then 4 might invite the review mechanism in to investigate 5 those complaints. 6 And finally, in trusts in which it's perceived there 7 may be some dysfunctional problems in a service or some 8 problems that may need to be improved in a particular 9 service, the IRM can be requested by the chief executive 10 or Medical Director of that hospital trust to come in 11 and to perform an investigation of the particular 12 service in question and to provide a report on that. 13 So those are the three areas in which the IRM helps. 14 I should emphasise, even at this point of the 15 Inquiry, that the Invited Review Mechanism is 16 an advisory body. It sets up terms of reference for any 17 particular investigation very carefully with the trust. 18 It is hired by the trust, so in effect we're a private 19 body, and bear in mind the Royal College of Surgeons is 20 a membership organisation and a charity, and therefore 21 the IRM and the college have no regulatory or statutory 22 powers, and I think that's important to understand in 23 the context of the IRM. I hope that does answer your 24 question. 25 Q. Thank you. That's very helpful indeed, Professor. You Page 9	1 United Kingdom. 2 Q. Thank you. And I think that in considering the various 3 different types that you set out of the types of review 4 one can look at, you mentioned, I think, a service 5 review. One of the important features of our Inquiry is 6 that rather than looking at clinical circumstances of 7 cases we are looking at -- the word we tend to use is 8 "systems". Would a service review -- would "system" be 9 a synonym in those circumstances for service or is there 10 a particular difference between the two? 11 A. No, I think you're quite right that it could be regarded 12 as a system as well as a service. Indeed, services work 13 on the basis of systems. 14 Q. Thank you. And I think the documentation that you've 15 helpfully sent of the various sort of rules and 16 regulations which govern the invited reviews over 17 various different time periods indicate that there is 18 a payment made for the review being undertaken, is that 19 right? 20 A. That's correct, it's a private contractual arrangement 21 between the trust and the Invited Review Mechanism. As 22 the invited review oversight Chair, I actually rarely 23 see any of the financial contracts, those are dealt with 24 by the management team within the college who look after 25 that. Page 11
1 mentioned there the possibility of a trust approaching 2 the Royal College to instigate the Invited Review 3 Mechanism. Although at one stage we did have health 4 trusts in Scotland, the operation largely over the 5 period we're looking at is run by the health boards 6 rather than trusts, although the initial periods there 7 were health trusts in Scotland. Do I take it such 8 a mechanism was as freely available to health boards in 9 Scotland as it was to trusts in England? 10 A. It was. It's available, in fact, to any of the devolved 11 nations in the United Kingdom to the Channel Islands and 12 indeed to Ireland as well and to private healthcare 13 systems as well as NHS systems. 14 Q. Thank you. And do I take from that, that the bodies who 15 are able to invoke the service of the Invited Review 16 Mechanism are healthcare providers broadly in both the 17 public and private sector? 18 A. That's correct. 19 Q. Rather than individuals, for example? 20 A. Individuals can ask for an invited review but, to be 21 quite honest, in the context of the many reviews that we 22 have carried out I am unaware of any contracted 23 individual reviews, they're almost -- well, inevitably 24 undertaken by either, as you say health boards perhaps 25 in Scotland, or NHS trusts in the rest of the Page 10	1 But my understanding is that the fees are 2 proportionate, depending upon the amount of perceived 3 work that will be involved within the review. 4 Q. Right, and obviously we'll come to this in due course 5 but there are reviewers who are appointed to undertake 6 a review and do the -- does the payment which goes with 7 the contractual arrangement go to the college or to the 8 reviewers or split between them, how does that work? 9 A. Again, I'm not fully conversant with that but the 10 payment, the overall payment for the review, goes to the 11 college. The reviewers are either individually 12 remunerated to the tune of £450 per day if they are 13 attending a review, and it's done -- undertaken in their 14 private time. If they are undertaking a review -- and 15 these are all experienced volunteers who volunteer for 16 a review but are screened to become reviewers, if they 17 undertake it within NHS time that £450 fee is paid to 18 the trust. 19 Q. Thank you. And is it, based on your understanding of 20 the system, an important feature of it or perhaps 21 an attraction to it for boards or trusts that wish to 22 have an invited review, that it is independent? 23 A. My feeling is that it's completely independent. The 24 people who tend to be put forward or asked to undertake 25 these reviews are all experienced clinicians. In terms Page 12

1 of remuneration, although it may sound like a lot of 2 money to be paid £450 per day, the work involved in 3 these reviews is significant. They are there are often 4 significant travelling implications and the people who 5 undertake these reviews by and large do it for 6 altruistic purposes and because they want to see 7 improved standards for patients and public across the 8 healthcare spectrum. So we would look at reviewers and 9 we would make sure that any reviewer who was appointed 10 to a specific review had a completely independent 11 process, there were no conflicts in terms of their 12 commitment to the review, that they had no, for 13 instance, role within the healthcare organisation that 14 they're investigating or indeed any personal contact 15 with any individuals who might be under review. 16 Q. Thank you. You've helpfully, in your statement, set out 17 a history of how the Invited Review Mechanism came about 18 and I think you describe that it was something that was 19 set up for the reasons that you've already given 20 evidence about in the aftermath of the Bristol Royal 21 Infirmary Inquiry; is that correct? 22 A. That's correct, yes, the Royal College and the 23 Federation of Surgical Specialty Associations, and there 24 are ten surgical specialties, met and felt that they 25 should convene a body which would be helpful in advising Page 13	1 expert independent and objective advice. An invited 2 review supplements -- but does not replace -- 3 a healthcare organisation's existing procedures for 4 managing surgical performance or the processes of any 5 formal regulatory body." 6 So you're making clear there, as I think you do on 7 a number of occasions in the report, I think that it is 8 an important thing to understand about this review 9 mechanism that it does not, in any way, remove or 10 diminish any responsibility that the healthcare provider 11 asking for it would have in connection with the subject 12 matter of the review? 13 A. That's correct. 14 Q. And indeed I think you allude to the fact that, in the 15 event that there were matters that were being looked at 16 which gave rise to the need for it, it wouldn't, in any 17 way, replace or diminish the requirement for the General 18 Medical Council to become involved in certain 19 circumstances? 20 A. That's correct as well. 21 Q. Indeed, I think you tell us in your statement, and the 22 material shows, that the Royal College requires that for 23 a review to take place one of the conditions is that the 24 healthcare body requesting it requires to provide 25 an indemnity for the college, associated bodies, any Page 15
1 hospitals, trusts or boards on how to improve services 2 where there were perceived problems within those 3 services. 4 Q. That Inquiry, I think, was an Inquiry about deaths in 5 the paediatric cardiac unit at the Bristol Royal 6 Infirmary, is that correct? 7 A. That's correct. 8 Q. Could I ask please to have up on the screen 9 paragraph 4.2 of the statement -- sorry, paragraph 7.2 10 of the statement? 11 A. If you'll forgive me, I have my papers in front of me. 12 I find it hard to read on the screen, but I will try and 13 focus on my papers in front of me. 14 Q. I have exactly the same next to me, Professor. So 15 there's no apology required at all. 16 In this paragraph you provide, I think, what is 17 another important feature of the Invited Review 18 Mechanism because you tell us that: 19 "[It] provides a fair, independent professional 20 review which will support, but not replace, a healthcare 21 organisation's existing local procedures for dealing 22 with such matters (or the processes of any 23 United Kingdom formal regulatory body). In certain 24 circumstances where a healthcare organisation needs 25 an external opinion, an invited review can provide Page 14	1 specialist association involved and the reviewers; is 2 that correct? 3 A. That's correct as well. 4 Q. Thank you. And I think you've touched on this already, 5 Professor, but my overall impression from the materials 6 you've provided is this is really a service provided in 7 association with the college's commitment to high 8 surgical standards, public service and indeed what you 9 tell us in your report is one of its core values which 10 is "putting the interests of patients at the heart of 11 all we do". Is that correct? 12 A. That's correct. 13 Q. And those are important elements of the college's 14 philosophy and function? 15 A. Yes, absolutely. 16 Q. Thank you. Could I just ask you please could we get 17 paragraph 3.9 up. A particular feature of the RCS as 18 a body which is of interest to us that you say: 19 "RCS England is a professional membership 20 organisation and registered charity ... funded through 21 membership fees, income generated from its activities 22 and investments and charitable donations, grants and 23 legacies." 24 This is the bit I wanted to focus on: 25 "RCS England is independent of the UK NHS and Page 16

1 government." 2 So it is independent full stop, if you like, but it 3 is also independent in particular of those two 4 organisations. Perhaps putting it in -- to put aside 5 its vast resources and experience in surgery, it also is 6 independent of those institutions? 7 A. That's correct, yes. 8 Q. Thank you. 9 Could I ask you to look at paragraph 4.3, please? 10 A. I have that, thank you. 11 Q. Just getting it up on our screen. One aspect that I was 12 just wanting to pick up with you is you helpfully have 13 tried, I think, to put the statement in a Scottish 14 context for us which is extremely helpful. You mention 15 there that: 16 "Healthcare Improvement Scotland ... (founded [in] 17 2011) is the systems regulator for healthcare in 18 Scotland and inspects, reviews and enforces standards in 19 Scottish Health Boards." 20 If I might, Professor, I might suggest a slight 21 correction to that because Healthcare Improvement 22 Scotland is in fact not the regulator of public 23 healthcare deliverers but it is of private healthcare 24 deliverers in Scotland. In England, is there a body 25 that regulates public healthcare providers? Page 17	1 Which you've helpfully provided to the Inquiry: 2 "Internal oversight and governance of the IRM was 3 provided by the Invited Review Mechanism Joint Standing 4 Committee ... subsequently known as the Invited Review 5 Oversight Group ... from November 2015." 6 Now, in relation to these oversight groups, one 7 aspect that I wanted just clarify with you, does that 8 mean that those groups oversee the operation of the 9 mechanism in general or that they oversee specific 10 reviews? 11 A. People within the group would oversee specific reviews 12 but we have meetings of that group too, to have a look 13 at the process in general, to pick out learning points 14 from the reviews we're involved in. And not every 15 person on that committee would be involved in specific 16 reviews. The chair of the Invited Review Mechanism and 17 the individual members of the invited review group who 18 represent their own surgical specialties would be 19 involved in any specific reviews related to a specific 20 specialty. 21 Q. The reason I ask is just because, as we will come to in 22 a moment, Professor, we're trying to piece together, 23 with perhaps not all available information, what 24 happened in the timeline, if you like, related to the 25 invited review which was undertaken by the Royal College Page 19
1 A. Well, the GMC and CQC would be bodies that influence and 2 regulate healthcare, certainly. 3 Q. As far as the providers are concerned, the Care Quality 4 Commission that you've mentioned would have a role in 5 the regulation of those? 6 A. Yes, and in monitoring standards within trusts. 7 Q. Yes, because although Healthcare Improvement Scotland is 8 a national agency for improving health and social care 9 in Scotland, and has been since 2011, it is not 10 a regulator in that sense. 11 A. I stand corrected. 12 Q. Thank you. There is a wider significance of that aspect 13 of the evidence to the Inquiry so I thought it important 14 to make that slight correction and also thank you of the 15 clarification of the position in England which, I think, 16 is different. 17 Could we go to paragraph 5.1, going back to the 18 Invited Review Mechanism again. 19 A. Yes, thank you. 20 Q. You tell us there that: 21 "The structure of RCS England and a list of key 22 individuals and their roles within RCS England over the 23 relevant period (i.e. the period in which the invited 24 review took place) are included in the RCS Annual 25 Reports ..." Page 18	1 in relation to Mr Eljamel's practice, and to an extent 2 wider matters in 2013. And a matter of interest in that 3 regard is the process which was gone through and 4 therefore I'm interested to know whether part of that 5 process would have involved some level of oversight by 6 someone beyond the three reviewers whom we know 7 undertook the actual review and whether time in the 8 process -- I'm not suggesting in any way time that was 9 not well spent, but time would be taken for someone in 10 an oversight role to be checking a report, or being 11 involved in some way? 12 A. If I could just sort of elucidate that a little bit. It 13 works now, as it did then, I believe. A request would 14 come in from the chief executive or the medical director 15 of a trust to -- which would initially be vetted by the 16 chair of what it would have been at that time, the 17 IRMJSC that you refer to now, that would be myself as 18 chair of the invited review oversight group. Together 19 with the manager of invited reviews, who is a college 20 employee, that request would be vetted carefully, 21 a formal request would be accompanied by a covering 22 letter and vetted. And the specialty involved would 23 then be contacted by both the manager and the chair of 24 the invited review oversight group and each specialty 25 had a specific lead and at that time, that was Page 20

1 an eminent surgeon, Mr Richard Kerr, he would have been 2 involved and once the Invited Review Oversight Group had 3 decided to accept the review, and terms of reference had 4 been drawn up by the trust involved and the manager and 5 of the Invited Review Mechanism, then the chair of the 6 invited review and the lead for the particular specialty 7 would confer to produce a list of potential reviewers 8 that could be invited to undertake that review. 9 Q. And as the review then progressed beyond that stage, 10 would the oversight group have any further role or would 11 it just be in relation to the set-up and acceptance of 12 the remit? 13 A. Certainly at this time, and I have no reason to think it 14 was any different when Dame Clare Marx, who was the 15 chair of the Invited Review Mechanism at that time, the 16 chair reviews all correspondence as it comes in and it 17 quality assures any correspondence going out, making 18 sure that any correspondence from the colleges make it 19 back to the trust. 20 Q. There is mention of quality assurance in the statement 21 and that's a function that the chair undertakes at every 22 stage; is that correct? 23 A. Yes, that's correct. 24 Q. Thank you. You mention in the statement that it would 25 be possible -- and given that it's a private contractual Page 21	1 that the healthcare provider feels that it needs some 2 sort of assistance with resolving the problem? 3 A. I think that's, you know, a correct perception. It may 4 be that the individual healthcare provider is not quite 5 sure at what level a problem exists, for instance in 6 a systems-type review as you referred to. Or it may, as 7 in other reviews, have been responding to complaints 8 from the patient -- from patients or public that they 9 feel they need a response to and an independent 10 assessment of the underlying problem. So yes, that is 11 correct. 12 Q. Thank you. You've helpfully -- just for our purposes, 13 you've helpfully provided to us a set of regulations 14 I think were in place at the time. For our records it's 15 RCS-00012. I don't think I need to go to the 16 particulars. But one of the things you've already 17 mentioned in terms of the processes involved is that 18 part of the contractual arrangement, if you like, is 19 that there is a set of terms of reference fixed; is that 20 correct? 21 A. Yes, that is correct. 22 Q. I think you mentioned a moment ago part of the oversight 23 function is to be involved in that and that that would 24 be agreed with the -- is it the lead of the group that's 25 actually carrying out the review and the healthcare Page 23
1 arrangement this is perhaps not surprising -- for the 2 Royal College to, I think, the word used is to "decline" 3 to undertake a review. In what sorts of circumstances 4 might that happen, hypothetically? 5 A. Well, I can give you an example of an unnamed review 6 which we were solicited for recently. To put it quite 7 frankly, the workload would have just been unsustainable 8 by what is relatively a small organisation and that 9 review has to be undertaken by the NHS itself. 10 Q. And would it be fair to say, based on your experience of 11 the system, that when an invited review is commissioned 12 from the Royal College by a healthcare provider, that 13 the circumstances tend to be quite serious? 14 A. That would be the perception. There's always something 15 that stimulates concern, otherwise an invited review 16 would not be requested. It may be as simple as a single 17 case that has caused concern within an institution who 18 feels that they wanted an external review, or it may be 19 perceived to be a specific problem. So the very request 20 of an invited review tends to suggest that the 21 organisation is aware of a potential problem which it 22 wants resolved, or at least clarified. 23 Q. And given the fact that the purpose of seeking the 24 review is to seek the expert advisory independent 25 assistance of the Royal College, does it tend to suggest Page 22	1 provider? 2 A. Yes. The way it would work usually -- for instance 3 I have a number of functions in the college, so I don't 4 get involved in setting up the terms of the review or 5 negotiating directly with the chief executive or medical 6 director of the trust. The invited review manager whose 7 sole role in the college is to deal with invited reviews 8 and has a great deal of experience would meet with the 9 medical director or the chief executive, and they would 10 form a concise framework of the terms of reference into 11 what the invited reviewers would investigate. 12 They would not stray outside those terms of 13 reference. It's really important that because reviews 14 usually take place over two or three days, that there is 15 a very concise framework and that the questions 16 perceived to be really important to the trust or the 17 board are dealt with, and that can only be done through 18 a concise framework rather than, if you like, 19 a meandering through a variety of other circumstances 20 that the college has not been informed about. 21 Q. I see, so the process then, in case there was 22 a misconception about what agreement of the terms of 23 reference means, effectively it is getting the 24 healthcare provider to be clear about the questions that 25 are being asked, is that right, in the first instance? Page 24

1 A. Yes, absolutely. 2 Q. But beyond that, it's not for the Royal College to say: 3 well, perhaps you should ask some other questions. It's 4 for the Royal College to say: yes, that looks acceptable 5 to us? 6 A. The college says: that looks acceptable. They may add 7 a clause that if concerns arise during the course of the 8 review that, if the trust wishes to, the remit of that 9 review could be extended. And I think that happened in 10 this particular review, there was some mention of the 11 potential to extend a certain part of the review if 12 necessary. But usually the terms are fairly concise. 13 And obviously if anything relating to patient concerns 14 arises during the review, that's communicated to the 15 director and then the trust can commission further work 16 if that's necessary. 17 Q. I see. So if the initial material suggested that there 18 were patient concerns beyond the preliminary or initial 19 remit, it might be that the college would suggest this 20 mechanism whereby further work could be commissioned, 21 because those concerns look like they perhaps should 22 also be addressed; is that correct? 23 A. That's correct. 24 Q. Thank you. I think actually it would be helpful to look 25 at some of the components of RCS-00012, please. Could Page 25	1 reviewers, the Chief Executive or Medical Director is 2 asked to ensure that, in the interests of fairness, the 3 surgeon being reviewed has the opportunity to comment on 4 the list before it is submitted to the reviewers. If, 5 within reason, the surgeon believes that there are other 6 members of the clinical team that should be part of the 7 review, he/she must inform the hospital which will, in 8 turn, inform the reviewers. If the surgeon concerned 9 has any strong objections to any person on the list, 10 he/she will be asked to explain the nature of the 11 objection." 12 So there is a mechanism whereby the surgeon can 13 become involved, the surgeon who is under investigation 14 or under review can become involved, but it would appear 15 to a relatively limited extent; is that correct? 16 A. It's as it states in the paragraph, you're quite right. 17 Q. Yes, and as far as -- there is then, it says at 18 paragraph 3.6.3, after that opportunity for the surgeon 19 to produce any comments on matters in particular in 20 relation to whether other members of the clinical team 21 should be part of the review, it says: 22 "In finalising the terms of reference for the review 23 with the hospital, the reviewers will have the 24 opportunity to request from the hospital or from the 25 surgeon being reviewed additional information they Page 27
1 we have that up. Page 6, paragraph 3.6 which relates to 2 terms of reference and supporting documentation. 3 A. I'm sorry, if you could just -- this is in the 4 bundle ...? 5 Q. It is. 6 A. Which page would that be? 7 Q. I'm on page 6 at paragraph 3.6.2. 8 A. Thank you very much, I'll find that. No, in my bundle 9 I have the General Medical Council's "Good Medical 10 Practice" document. So it may be that -- sorry, I'm not 11 going to the document you've referenced, first of all. 12 Which document was that? 13 Q. This is the document of the regulations that were in 14 place at the time. I can read you out the passage, if 15 you like? 16 A. Yes, if you could, that would be very helpful. 17 Q. The passage that I'm talking about, this is in a section 18 of the regulations that were applicable at the time. 19 You provided us with a number of different versions but 20 we think this is the one that was applicable at the 21 time. 22 A. Right. 23 Q. This is the section which deals with terms of reference 24 and supporting documentation. Paragraph 3.6.2 says: 25 "When identifying the personnel to be seen by the Page 26	1 believe necessary to further the review process." 2 And it says that: 3 "The Chief Executive or Medical Director of the 4 hospital is required to make available all relevant 5 documentation relating to the terms of reference for the 6 review and the questions the reviewers are asked to 7 consider, subject to compliance with its obligations on 8 patient confidentiality and any other obligations of 9 confidence and obligations under the Data Protection 10 Act, 1998." 11 So, in effect, the terms of reference are finalised 12 after the surgeon has this limited opportunity to input; 13 is that correct? 14 A. Yes, that's correct. 15 Q. And then beyond that, which one can understand is 16 important, it is not in general terms for the hospital 17 or the healthcare provider to determine what materials 18 should be provided because what requires to be provided 19 is all available relevant documentation, subject to the 20 patient confidentiality and data protection issues, is 21 that right? 22 A. Yes, all available relevant documents. 23 Q. Yes. That's obviously important to enable the reviewers 24 to be able to conduct as thorough a review as possible? 25 A. That's correct. Page 28

1 Q. And I think also, you've mentioned already in your 2 evidence, Professor, that there can be travelling 3 involved in being a reviewer and they can take 4 a few days. There is a mechanism whereby effectively 5 what lawyers might call oral testimony can be adduced 6 and people involved or connected to the matter and the 7 terms of reference can be interviewed. Does that happen 8 in every case or is that a matter for the reviewers to 9 determine? 10 A. Almost in every review that I've had any dealings with 11 there are some face-to-face interviews. 12 Q. Why is it deemed important that face-to-face interviews 13 like that take place? 14 A. It's important to ensure that a full range of views, 15 concerning either the system or the individual being 16 investigated, are solicited. I think it's part of 17 fairness, and it's part of an equitable approach to 18 gaining all the data necessary to get a picture of 19 either an individual or a system. 20 Q. Thank you. And as far as which individuals might be 21 interviewed or involved in that way. Obviously the 22 reviewers will not know who the individuals in 23 a particular hospital might be and so who decides, 24 effectively, who gets on to the list? 25 A. The trust itself would have responsibility for compiling Page 29	1 A. No, in my experience, it always happens. 2 Q. I suppose that would be in connection with 3 considerations of comprehensiveness of evidence but also 4 fairness to the surgeon? 5 A. Absolutely. 6 Q. To be able to give an explanation or a point of view? 7 A. And indeed, the reports reflect both aspects of 8 commentary on a particular surgeon, those positive and 9 those that are not perceived to be positive. 10 Q. For either administrative or procedural reasons, is it 11 normal in the reviews for an attempt to be made, first 12 of all, for people to be interviewed where they work, if 13 you like, within the hospital? 14 A. It would almost inevitably take place in a hospital but 15 to my knowledge, the reviewers don't usually move 16 around. The trust is asked to provide an environment in 17 which they can confidentially meet those that they are 18 interviewing, so it would usually take place within 19 a hospital. 20 Q. So because it might be important that in order to be 21 able to provide explanation or an account of things, it 22 could be useful to do it in the very environment in 23 which work was delivered, I would imagine? 24 A. Yes, and although in this case it doesn't happen, 25 occasionally of course somebody is away because of Page 31
1 a list of all of those engaged -- let's say, we're 2 talking for this purpose of an individual, all of those 3 engaged with or having practice relevant around that 4 individual, usually members of the team, members who 5 work with the individual, managers for instance who are 6 involved with the individual, and right down to theatre 7 staff, to other professionals within the hospital who 8 have a professional role that would have been concerned 9 with the individual's role. 10 Q. But in the same way as the reviewers are entitled, under 11 the contractual relationship, to have access to all 12 available relevant documentation, would it be expected 13 that the reviewers would be able to have access to all 14 available relevant individuals, perhaps not knowing them 15 who they are personally, but the type of individual if 16 you like, colleagues you've mentioned, that sort of 17 thing? 18 A. Yes, that's correct and indeed, often there's quite 19 an extensive list of people who will be interviewed by 20 the reviewers. 21 Q. What about the practice or protocol around interviewing, 22 in the type of case we're talking about where 23 an individual is involved, the individual surgeon 24 themselves? Would that always happen or is that, again, 25 a sort of discretionary matter? Page 30	1 annual leave or they're indisposed and then, if 2 considered necessary by the reviewers, a further 3 interview can be undertaken, either on a face-to-face 4 basis but nowadays occasionally virtually. 5 Q. As we'll probably touch on, we'll get into the details 6 of the particular review, of course, in a moment. But 7 one thing that might be useful just to clarify at this 8 stage is the documentation that's been available to you 9 in connection with this. You, of course, were not 10 personally involved in the review in 2013, were you? 11 A. No, I was not and indeed, in terms of my statement today 12 and the only document that I had seen, with the 13 exception of the two bits of correspondence that I have 14 been provided with this morning, has been the original 15 review report. Because, as you well know and I'm sure 16 you will touch upon, all other documentation, once 17 a report has been completed and given to the trust or 18 the board concerned, is subsequently destroyed within 19 a set timeframe that appears within the handbook of both 20 the 2013 period and subsequently in the 2014 and later 21 period. 22 Q. Indeed. So the position is I think it's actually the 23 case from your statement that you've been asked by 24 various different agencies, including the police at one 25 stage, for access to any additional documentation you Page 32

1 might have beyond the report itself, is that right? 2 A. Yes, that is correct. 3 Q. And over the timeframe in which these requests have been 4 made, your consistent position, as it is today, has been 5 that the only piece of paper that the college retained, 6 as in accordance with its practices, was the report 7 itself, is that right? 8 A. That's absolutely correct. You will have the email 9 trail I think between the college and the police. 10 Q. We do. 11 A. And the original request for information. The 12 handbook -- both the 2013/14 and '18 handbooks, and 13 I have dug that up, looks at a specific paragraph on 14 data retention, which states: 15 "There are no legal requirements regarding the 16 minimum period of time that college and reviewers should 17 retain documents related to invited reviews. The 18 college will normally retain documents relating to 19 a review for four years, after which they will be 20 confidentially destroyed." (As read) 21 I think the review in question took place in 2013. 22 So I don't know when these documents were destroyed and 23 indeed, I can't find records of that and we don't have 24 records of that. But I believe the four-year period 25 would have been around 2017 to 2018 and that would have Page 33	1 review available to any organisation or individual that 2 it thought appropriate to make it available to; is that 3 correct? 4 A. That's correct and indeed to anybody investigated in the 5 review themselves. 6 Q. Yes. So for example, in the case we're looking at, 7 NHS Tayside, or the medical director of NHS Tayside who 8 requested the review, could have made the review 9 findings available to, say, Scottish Government? 10 A. That's correct. 11 Q. Could have made it available to other members of staff 12 who were involved in the review who may be touched upon 13 by matters concerned with it? 14 A. I -- I would have to enquire of the organisation itself 15 as to -- my understanding is they would only make the 16 report available to those for whom it had direct 17 implications in improving safety standards. 18 Q. So it could've been made available to the General 19 Medical Council, for example? 20 A. Indeed, if necessary, that would be the advice that it 21 should be and that would be done through the General 22 Medical Council liaison officers who liaise with 23 individual trusts. 24 Q. Yes, thank you. And therefore, I suppose within that 25 definition, would also be bodies like Healthcare Page 35
1 been prior to any notification by the police that they 2 wished to access records. 3 Q. Thank you, that's very clear. Just while we're still on 4 the subject of the documents, the review is conducted 5 under the rules, as I understand it, under rules of 6 confidentiality broadly, is that right? 7 A. That's correct, yes. 8 Q. But although it is the case that in almost all 9 circumstances the college will be bound by 10 confidentiality in that it won't reveal any of the 11 contents of the review or the review itself to anyone, 12 the opposite does not apply to the healthcare provider, 13 does it? 14 A. I'd have to look at the precise terms but there's 15 certainly advice in the handbook that advises the 16 healthcare regulator of the board, the trust, that full 17 confidentiality should be maintained within that 18 organisation, where appropriate and necessary. 19 Q. But as far as -- I think you say in the statement that 20 at the end of the review the materials and the report 21 become the property of the healthcare provider, is that 22 right? 23 A. Absolutely correct. 24 Q. So if we're to take the circumstances we're in here, it 25 would be perfectly open to a health board to make the Page 34	1 Improvement Scotland who have an important role in that? 2 A. Yes. 3 Q. Thank you. So on a particular general point, again the 4 rules -- I'll just read them out to you, again, 5 relate -- this is from the regulations in place at the 6 time. This is to do with the subject of the extent to 7 which it would be possible for -- in any circumstances, 8 for the college itself to divulge any of the contents of 9 the information to anyone. It says: 10 "The College ..." 11 This is paragraph 3.7.8 of the document I was 12 looking at before which is RCS-00012. It says there: 13 "The College, the Association and/or the reviewers 14 reserve to themselves the right to disclose in the 15 public interest but still in confidence to a regulatory 16 body such as the General Medical Council, the National 17 Patient Safety Agency or the Care Quality Commission or 18 any other appropriate recipient, the results of any 19 investigation and/or of any advice or recommendation 20 made by the College, the Association and/or the 21 reviewers to the hospital. The College will only 22 disclose this information on rare occasions, when it is 23 apparent that the hospital has not taken appropriate 24 action following receipt of the report. 25 "The hospital must within six months of receipt of Page 36

1 the report provide feedback to the College on the 2 progress made on implementing the recommendations from 3 the report." 4 So the position is -- at least at that time, the 5 position was that it was possible in the public interest 6 on rare occasions for the outcome of a review to be made 7 available to the General Medical Council or other bodies 8 involved in healthcare improvement and safety, but that 9 that would only happen effectively at the end of the 10 process when the report had been received; is that 11 correct? 12 A. That's correct. 13 Q. I suppose one might ask the question, as to how that 14 sits with the obligations of the college and bodies and 15 members of it with regard to reporting matters of 16 concern to the General Medical Council when they are, 17 themselves, subject to its jurisdiction. Could you 18 explain to me how that is resolved? Presumably the 19 private arrangement says something different to that but 20 there are those obligations which one might suggest 21 would mean that things might have to be divulged during 22 the course of an investigation, for example? 23 A. Well, as you say, it's a private contract between the 24 Royal College of Surgeons and the trust. However, of 25 course, when there is an immediate concern of potential Page 37	1 nature of reviews, because the trust or board had 2 concerns in the interim one, would hope that they would 3 act on that and indeed the college seeks evidence that 4 they will act on that. They follow up at feedback 5 shortly after the review and then subsequently at 6 six-month periods until they remove themselves from the 7 review process. 8 But rarely would we be in a position in which 9 allowing somebody, for instance as an example practice 10 for another 24 hours, would necessitate some sort of 11 induction or cessation of the practice instigated by the 12 GMC. 13 Q. Thank you. 14 A. I'm sorry if that was a little convoluted. 15 THE CHAIR: Mr Dawson, could I just ask a point of 16 clarification which -- Professor, the paragraph that we 17 just looked at, I'm not sure if you have it in front of 18 you but it's the one that's concerned with feedback: the 19 hospital must, within six months of receipt of the 20 report, provide feedback to the college on the progress 21 made on implementing the recommendations in the report. 22 Can I take it from an answer that you gave just 23 a moment ago that it doesn't follow from that, that 24 a period of six months will elapse before the college 25 would receive any such feedback? Page 39
1 patient danger that has not been resolved or addressed 2 by other methods or other communication with the trust, 3 then there is the option for the Royal College of 4 Surgeons directly to contact the General Medical Council 5 as indeed there is for any individual or body where they 6 have concerns. 7 This is rarely invoked, indeed hardly ever invoked, 8 because the advice comes to the trust on completion of 9 the review at three different stages. When the review 10 is completed, and before the reviewers depart the 11 institution, we have a face-to-face meeting with whoever 12 commissioned the view, either the trust medical director 13 or the chief executive and their initial and immediate 14 advice is given at that stage. 15 There then follows an interim letter which comes 16 very shortly after the review has been completed and 17 that's to provide some paper guidance and then the full 18 review is completed, quality assured, before it goes 19 back to the trust and that may add further 20 recommendations. 21 So the college rarely would be in a situation where 22 they had not communicated their concerns to the medical 23 director and the chief executive and had assurances that 24 those individuals and the trust board itself would act 25 on those initial recommendations, and I think in the Page 38	1 A. No. 2 THE CHAIR: Because I think I understood you to suggest that 3 there may be communication within that period of time 4 and indeed potentially shortly after the report was 5 finalised? 6 A. Absolutely, sir. 7 THE CHAIR: Yes, thank you. 8 MR DAWSON: So the general position would be -- the normal 9 experience would be that at the end of the process the 10 concerns, if they had been found, would be communicated 11 and there would be a process whereby the healthcare 12 provider would provide an explanation to the Royal 13 College about what they intended to do about those 14 concerns and in most cases one would imagine that 15 undertakings given that certain steps will be taken 16 would be taken at face value and one would hope that 17 they would be satisfactory to address the concerns, 18 presumably often in line with what had been recommended? 19 A. Yes, and it would usually go further than just a verbal 20 assurance. We would expect to see a written action plan 21 and indeed, in the follow-ups we would expect to see 22 some sort of written evidence. Now specifically, again 23 I'm afraid within this case, I can't state what evidence 24 we did or didn't see at the time because I only have the 25 report to go by but it would be usual that it's not just Page 40

1 a verbal assurance, that we would want to see some 2 evidence of improvements and meeting minutes, for 3 instance, or those sort of things. 4 Q. Understood, thank you. The reason why I'm interested in 5 this area, Professor, is you mentioned a moment ago, 6 I think, that it's possible at the beginning of the 7 process for the Royal College to suggest that 8 a stipulation could be included within the terms of 9 reference that further work could be commissioned, in 10 particular where there were evidence of perhaps wider 11 patient concerns than was the focus of the necessarily 12 focused terms of reference. 13 What I wondered about was a situation in which 14 a review was undertaken but at the end of it, the 15 circumstances of the review gave rise to concern that 16 perhaps, given perhaps the gravity of the concerns or 17 the particular matters that had been reviewed, this 18 could perhaps be the tip of the iceberg and not be the 19 entirety, although the terms of reference said that this 20 was the entirety of what required to be looked at, may 21 not be the entirety of what in fact has been going on in 22 an individual's practice. 23 In fact, in circumstances where even the evidence 24 available may provide hints that there have been more 25 long-standing problems than the very focused nature of Page 41	1 A. And I believe it would be in the recommendations which 2 I will have to find. 3 Q. Yes. 4 A. And I will just mention that either I have frozen up 5 a couple of times or you have, so I hope that the 6 message is coming across clearly. 7 Q. Yes, absolutely. Thank you. 8 A. In my bundle it would be page 425, page 27 of the IRM 9 report. 10 Q. Yes. That, for us, just for our record is RCS-00014, 11 27. Just to put it up on the screen for everybody in 12 the room here. Page 27. 13 A. And I think it's under item 9, "Recommendations". 14 Q. Yes. 15 A. If I may just read from that report: 16 "It was also recommended that a review of 17 Mr Eljamel's ..." 18 THE CHAIR: Sorry, Professor, if you could just pause while 19 we get the document in front of us in a form that is 20 readable. Thank you. 21 MR DAWSON: We have that. Thank you, Professor. 22 A. So comes under recommendations provided immediately 23 following the review visit and it goes to the third 24 paragraph. There are three bullet points and then the 25 third paragraph: Page 43
1 the review on, say, certain cases, would it be open, at 2 least, for the college to make further investigations or 3 make further suggestions more proactively than would 4 normally be the case, given, of course, the overriding 5 importance of public interest in patient safety? 6 A. I think if there was an underlying concern of any 7 further risk or harm to patients that had not been 8 encountered within the specific cases, for instance 9 within a review, then that message would come across in 10 the recommendations of the report. And I think, if 11 you'll forgive me, in the context of this specific 12 report recommendations were made to investigate a wider 13 practice. 14 Q. Yes. I suppose what I might suggest is that the 15 recommendations could have, in fact, gone even further 16 than that and recommended an investigation into the full 17 practice of the individual involved. The focus, 18 I think, of the particular review here was on a number 19 of complaints predominantly in the area of spinal 20 surgery. But the report makes it clear, I think as we 21 know, that the surgeon concerned had a much wider 22 practice than just spinal surgery? 23 A. We could come to the report if -- 24 Q. Yes. Well, perhaps that would be useful at this stage. 25 The report is RCS-00014. Page 42	1 "It was also recommended that a review of 2 Professor Eljamel's spinal surgery cases be undertaken 3 to ensure there were no wrong site surgeries that have 4 gone unaddressed. An appropriate timescale for this 5 review would be for the past three years, unless 6 problems are found to have been evident for longer, in 7 which case the scope should be extended." 8 Q. Thank you. If you have the document there, Professor, 9 if we could look at page 4, just to give some context to 10 what I was telling you about earlier. It's page 402, 11 perhaps on -- 12 A. Yes, I have that. 13 Q. So this is the initial summary, broad summary, of the 14 circumstances, it comes just after the terms of 15 reference, where it tells you a little bit about 16 Professor Eljamel's -- it says "Professor Eljamel" on 17 the documents -- background and it says: 18 "His surgical sub-specialities include: spinal 19 surgery, neuro-oncology, skull base surgery and 20 functional neurosurgery." 21 And it says that: 22 "Since 2012, he [had] been the lead surgeon on the 23 Scottish Adult Neuro-oncology Network (SANON) board." 24 So, the matter I was raising, I entirely understand, 25 Professor, that you've helpfully analysed the only Page 44

1 document you had available to you to analyse and you are 2 telling us that one of the important recommendations 3 that was made was that there should be this wider review 4 as a result of what was found of his spinal cases. 5 There are other aspects, of course, other than just 6 technical flaws, if one could put it so crudely, in 7 Professor Eljamel, Mr Eljamel's, spinal surgical 8 techniques. Those tend to suggest in certain places 9 that there are other aspects, for example, that he had 10 perhaps not been as candid as he might have been with 11 colleagues in a more historic sense in relation to 12 undefined surgeries. 13 So, given what I understand in neurosurgical context 14 to be a particularly broad practice, I was simply asking 15 you earlier in theory -- whether it was appropriate in 16 this case or not, in theory, would it have been possible 17 for the college to have made wider recommendations based 18 on concerns that it might not just be in the spinal 19 surgery that concerns about the practice may have 20 impacted on the safety of patients? 21 A. Thank you, I think that's a very valid question. But 22 you have to remember the college was asked specifically 23 to comment on spinal surgery and many of the problems 24 that arose in the review cases were related specifically 25 to spinal surgery, particularly the case of the level of Page 45	1 respect to anatomical markers and locations. And having 2 marked the skin during the operation, it would be good 3 practice -- and indeed, there are recommendations, 4 I believe, from the neurosurgical organisations -- to 5 undertake some sort of imaging, either lateral 6 fluoroscopy or X-ray with a metal marker placed at the 7 site of the intended surgery. And nowadays it would be 8 good practice, even before continuing with surgery at 9 the specific level, to have a pause in theatre so that 10 the whole team could agree that the level of surgery was 11 the correct level of which this was undertaken. 12 I'm sorry if that's very specific but that's my 13 understanding as to why we haven't tried to broaden the 14 investigation with respect to, for instance, brain 15 tumours or anything else. 16 Q. That's very helpful. Thank you, Professor. We'll take 17 a break in a moment and we'll return to this after the 18 break but there's just one technical aspect of that 19 answer I'd like to follow up on. You mentioned the 20 specialist association which I think plays a part in the 21 Invited Review Mechanism which, in this case, I think 22 was the Society for British Neurological Surgeons; is 23 that correct? 24 A. That's correct. 25 Q. Could you explain, first of all, what the role of the Page 47
1 surgery. And I'm a vascular surgeon, I'm afraid, 2 I'm a plumber, so I don't see much neurosurgery. But 3 I have asked colleagues -- particularly experienced 4 colleagues, past, presidents of the Society of British 5 Neurosurgery -- about how spinal surgery levels are 6 determined during surgery. And a lot of the cases, 7 I think, that we were looking at here were particularly 8 to do with spinal surgery. 9 Q. Indeed. 10 A. We, and the college, has no remit nor access to 11 understand the full extent of Professor Eljamel's 12 surgery or indeed whether concerns had arisen about 13 other cases in his broader practice. Were we asked to 14 deal with that by the trust, then that's something, of 15 course, we could have done. But a lot of the cases that 16 were looked at in this specific review, as I understand, 17 were due specifically to problems with spinal surgery 18 and even more specifically the level at which this was 19 undertaken. 20 My colleagues in neurosurgery tell me that standards 21 in neurosurgery would involve firstly, interpreting 22 imaging to determine the level of the problem, for 23 instance with a spinal disc or a specific nerve route. 24 Then at surgery, you would be expected to mark the skin 25 to know that the level that you were working at with Page 46	1 specialist associations is in the mechanism and also 2 what the role of that body is with regard to, as this 3 was, a neurosurgical review? 4 A. There are ten surgical specialties, neurosurgery is one 5 of them. Every specialty has a specialty association; 6 mine is the Vascular Society of Great Britain and 7 Ireland. The Society of British Neurosurgery, the SBNS, 8 represents the neurosurgeons in the United Kingdom and 9 is their professional association, which all matters 10 pertaining to the practice of surgery, surgical science 11 and research are discussed. And indeed, they would -- 12 or members of that society would form a part of the 13 specialist advisory committees who determine the 14 curriculum and examinations within neurosurgery which 15 lead to professional qualifications. 16 In terms of an invited review, we would have liaised 17 with the president of the SBNS to determine 18 an appropriate senior reviewer to represent the SBNS on 19 the Invited Review Oversight Group and at that time that 20 was council member of the Royal College of Surgeons, 21 Mr Richard Kerr, who provided a very authoritative and 22 helpful service. 23 Q. Thank you. Just on the subject, while we're on it, of 24 a liaison with the president of the Society of British 25 Neurological Surgeons, you tell us in your report that Page 48

1 you, I think, very helpfully got in contact with the 2 current president of the organisation, who I think is 3 Professor Peter Hutchinson, in order to try to ascertain 4 whether, in light of your organisation having a single 5 document, whether they held anything further. But my 6 understanding is that unfortunately they held no 7 documentation at all relating to this review; is that 8 correct? 9 A. Yes, unfortunately or not unfortunately, because they 10 would have been advised by -- once a review is 11 concluded, the review manager will send out a missive to 12 all those involved to ensure that all documentation is 13 destroyed to prevent any inadvertent data lying around 14 on hospital or personal computers that could be accessed 15 and could breach the Data Protection Act. 16 Q. I see. So unfortunate for our investigative purposes 17 but fortunate for their data protection obligations? 18 A. Yes. 19 MR DAWSON: Right, okay. Sir, that would be a convenient 20 moment for a break. 21 THE CHAIR: Yes, Professor. Thank you very much. We're 22 going to take a 15-minute break now. To keep matters 23 regular, we do ask that you don't discuss your evidence 24 over that period of time. I have no concerns in that 25 regard and we'll aim to start again just after half past Page 49	1 review of Mr Eljamel's practice received from [Mr] 2 Andrew Russell, Medical Director at NHS Tayside. 3 "16-17 September 2013 -- Invited review visit at 4 NHS Tayside took place. The members of the invited 5 review team and those interviewed in the review are 6 detailed in the invited review report [which is 7 RCS-00014]. The review team consisted of 8 Mr Neil Kitchen, FRCS representing RCS England, 9 Mr Nicholas Phillips, FRCS representing SBNS (jointly 10 'the clinical reviewers') and Ms Helen Carter ('the lay 11 reviewer'). 12 "2 October 2013 -- Mr Eljamel was interviewed by the 13 invited review team. 14 "4 October 2013 -- An interim immediate advice 15 letter was issued to the Medical Director of 16 NHS Tayside, the details of which are summarised in the 17 report. 18 "6 December 2013 -- Invited review report issued to 19 NHS Tayside. 20 "28 January 2014 & 22 July 2014 -- Our review 21 tracking system indicates that updates on the 22 recommendations in the report were received from 23 NHS Tayside. 24 "[And] 20 November 2014 -- RCS England IRM's 25 involvement in the review concluded." Page 51
1 the hour. Thank you. 2 (11.18 am) 3 (A short break) 4 (11.33 am) 5 THE CHAIR: Right, if we could have the witness back, 6 please. Thank you, Professor. I think we're ready to 7 resume. 8 MR DAWSON: Hello, Professor. Can you hear me again? 9 A. Yes, I can. Thank you. 10 Q. We'd just started to talk about in some more detail, the 11 2013 invited review, and you have provided us, despite 12 the fact you were working only from the review report, 13 with some helpful evidence about exactly what you can 14 make out from it. In particular, although you've 15 provided more detailed evidence, at paragraph 18.1 of 16 your statement, you've provided a chronology of the 17 Royal College's involvement. If we could go to that, 18 please, RCS-00021 at page 14, paragraph 18.1. 19 A. Thank you I have that. 20 Q. Great, we're just putting it up on our screen. And you 21 tell us there that: 22 "A chronology of the involvement of RCS England 23 with, or knowledge of, the professional practice of 24 Mr Eljamel is as follows: 25 "26 June 2013 -- Request for an individual invited Page 50	1 Just on a couple of technical details, as far as 2 that second-last entry was concerned, you talk about 3 some information being available in relation to the 4 follow-up, if you like, on the recommendations from 5 something called your "review tracking system". What is 6 that and what information were you able to access there? 7 A. I'm not actually sure what the review tracking system 8 refers to. I understand, from discussions with our head 9 of invited reviews and our head of quality assurance, 10 that there is just a spreadsheet of dates of 11 correspondence. I have not seen that and I think the 12 major correspondence or the evidence arising from the 13 tracking system relates mainly to the correspondence 14 with CID Dundee and the RCS head of invited reviews. 15 Q. I see, yes. You subsequently tell us about the 16 correspondence that we've referred to already with 17 CID Dundee, but we'll focus on the correspondence and 18 actions related to the review itself. Another aspect of 19 the chronology which I wanted to ask you about was there 20 was obviously, as one can tell from the report, a really 21 quite extensive investigation interviewing of a number 22 of individuals within the hospital, as we discussed 23 earlier, who had obviously some sort of connection to 24 Mr Eljamel's practice between 16 and 17 September 2013. 25 But it's interesting to note that Mr Eljamel himself was Page 52

1 interviewed, not when everybody else, was but on 2 2 October 2013. Given what you said earlier, would it 3 be normal for there to be a separate interview or it's 4 not part of the process or anything that the surgeon is 5 reviewed separately, is it? 6 A. No, it isn't. You would expect the surgeon to be 7 interviewed at the same time. I have absolutely no 8 evidence I was informed that by head of quality 9 standards that Mr Eljamel was not available until 10 2 October and that that was why he was not interviewed 11 initially, but I don't have any evidence for that. 12 Q. And do you know anything about the interview that took 13 place on 2 October, other than aspects -- 14 A. I have no details at all, I'm afraid. I'm restricted to 15 the report. 16 Q. Yes. There are, of course, aspects of what one assumes 17 he must have said which are evident from the report but 18 there isn't a sort of summary of what happened on that 19 day or anything like that? 20 A. No. 21 Q. No. The other aspect that I just wanted to ask you 22 about, which we'll come on to in more detail in 23 a second, is what is an "interim immediate advice 24 letter"? 25 A. As I sort of iterated earlier on, there's the verbal Page 53	1 record for the individual trusts so they have something 2 to work to. 3 Q. One of the concepts that we lawyers are familiar with 4 when we talk about getting interim orders from courts -- 5 so what we'd call here something like an interim 6 interdict, or you might call an interim injunction -- is 7 the need to try to persuade a judge that an order should 8 be taken -- should be pronounced that would restrict 9 someone's otherwise available rights, usually on the 10 basis of limited information. And so usually, the means 11 by which one does that is to try to persuade a judge of 12 what's called a prima facie legal case and the second 13 hurdle is that the judge considers it to be, on the 14 balance of convenience, appropriate to grant the order. 15 Effectively meaning that the benefits of granting the 16 order in the interim would outweigh the downside of 17 doing so. 18 Is it possible, even theoretically, even when the 19 basic information is available to a Royal College before 20 an investigation is undertaken -- I'm talking 21 theoretically here -- that the prima facie information 22 might be so alarming that it would recommend that 23 something needs to be done immediately, as a judge might 24 do in the circumstances that I have described? 25 A. I would think, if the review team encountered anything Page 55
1 advice at the end of the inquiry and then as soon as the 2 team have left and have access to the review process and 3 management team, an interim advice letter goes out which 4 is quality assured by the head of invited review. So 5 for instance, if one were to go out for one being 6 undertaken at the moment, I would review that. Really 7 just to make sure that, you know, typographically it's 8 okay, it was constructed properly and that the essential 9 advice makes sense. 10 Q. And so there are -- as I understand it then, there are 11 two potential occasions in the normal process before 12 a final report is issued where some sort of interim 13 advice could be given, or immediate view or something, 14 that would be verbally at the end of the visit, is that 15 right? 16 A. Yes, that's correct. 17 Q. And the visit here would be the visit in September, 18 I'm assuming? 19 A. That's correct, yes. 20 Q. And then is it always the case that an interim advice 21 letter is issued or is it only in cases where there is 22 something to be said in the interim? 23 A. No, it's always the case that an interim letter would be 24 sent out just to put on paper. It really just amplifies 25 the initial advice given verbally and puts that on Page 54	1 that they felt was putting patients at risk at that 2 instant basically, then they would make those 3 recommendations -- and thank you very much for 4 clarifying interim with respect to its legal context. 5 I'm afraid we have a much looser context and it just 6 meant a letter that came out in between. 7 THE CHAIR: I thought the Professor was very succinct as 8 well. 9 A. But it was very informative, thank you. But I think the 10 interim letter was sent took into context what the trust 11 were already doing to protect patients from any further 12 harm and the final recommendations had to be worked out 13 and produced in the final letter, but the interim letter 14 covered the initial recommendations which were designed 15 to protect patients from any further harm within the 16 context of what was happening already. 17 I believe Professor Eljamel's practice had already 18 been placed under supervision by the trust which was 19 hopefully protecting patients and indeed, it's a matter 20 of complete conjecture and I have no idea but my hope 21 would be that no patients were subjected to further harm 22 under that period of supervision. And I'm not -- but 23 I have no evidence of that. 24 MR DAWSON: Thank you. The reason I ask, Professor, is we 25 because heard some evidence yesterday from the patient Page 56

1 safety commissioner for Scotland -- there's 2 an equivalent role I'm sure you're familiar with in 3 England -- and one of the dilemmas that she faced in her 4 role was she only looks at systemic issues rather than 5 at individual cases, so perhaps one of the two broad 6 types much review that could be invited in the college, 7 a similar sort of distinction. 8 But I asked her whether there would be circumstances 9 in which a systemic issue could become apparent as 10 a result of a single approach or a single patient case 11 and she thought that that could be the case and also, 12 I suggested to her that her remit might make it 13 difficult to act on things quickly enough to protect 14 patients. And the phrase she used to describe 15 circumstances in which things -- there needed to be 16 urgent action was a "now" issue. 17 Is it theoretically possible that there could be 18 enough evidence, as I say, even before an investigation 19 that is put before the Royal College that it could be 20 a "now" issue such that interim recommendations could be 21 made and I'm deliberately asking you before they even go 22 to do the visit? 23 A. I think the role of the college is to assess the 24 evidence and it's impossible to do that without 25 undertaking the review. Broad recommendations, with Page 57	1 the experts, if you like, would look at it and go: oh, 2 my goodness, this is a really very serious situation, 3 you perhaps don't realise how quite serious this is, 4 even on the written material we've seen, this is a "now" 5 issue, if I can use the phrase. I'm simply exploring 6 the theoretical possibility of that because obviously 7 you have not seen all of the documentation provided. 8 And indeed, even if you had seen it, you might not have 9 seen all of the documentation that might have been 10 provided. 11 So, I'm not asking you about the specific case, 12 I'm simply asking, in the generality, given the 13 dynamics, as to whether that is a possibility? 14 A. I'd go back to what I'd say really that our initial 15 documentation is the express letter of concern seeking 16 an invited review which does set out the concerns of the 17 trust themselves. Our own option really is then to 18 accept that invited review and to undertake that as 19 swiftly and efficiently as we could. I understand the 20 concept of the "now" scenario, but that isn't entirely 21 relevant, I think, to an invited review until the 22 evidence has been assessed. 23 Q. But of course, as you've made very clear in your 24 statement and you made very clear today, the ultimate 25 responsibility remains with the healthcare provider Page 59
1 respect to generalisations, are that the college will 2 always do whatever it could to protect patients. But in 3 this case you will understand the trust or the board had 4 an understanding of the practice of the individual 5 surgeon and it was -- the college has no statutory or 6 regulatory duties, but the trust does, of course, have 7 a duty through its responsible officer to act on any 8 concerns and if necessary to restrict practice 9 themselves. And that might happen before an invited 10 review took place. The invited review can only act on 11 the basis of the evidence that it sources. 12 Q. But the first evidence it receives is the written 13 evidence, isn't that right? 14 A. Yes. 15 Q. So what I'm contemplating is the possibility, given of 16 course the dynamic between the two bodies, as we 17 discussed earlier, I think you accepted that it would be 18 normal if a healthcare provider were seeking the counsel 19 of the college in this regard, he would be doing so 20 because the people who were dealing with the review in 21 the college would be very much more expert in the 22 specific area and perhaps might have access to greater 23 knowledge and expertise as to what to do about it. It 24 is therefore possible, in those circumstances, that the 25 healthcare provider might not know what to do and that Page 58	1 could who could treat it as a "now" issue irrespective 2 of what the invited review says or does, isn't that 3 right? 4 A. In response to that I think -- if I could take us back 5 to this case, I think the medical director had already 6 had meetings within the healthcare board to restrict the 7 practice of Mr Eljamel before the request for an invited 8 review was made. So there were already restrictions or 9 supervision arrangements in place when the invited 10 review was requested. 11 Q. Thank you. We may return to that momentarily. Could we 12 have a look, please, at NHST-00071. This is the letter 13 dated 4 October 2013, a copy of which you were sent this 14 morning, Professor. 15 A. Thank you. 16 Q. So this is a letter from the RCS -- is this the interim 17 letter that we discussed? 18 A. This is the 4 October letter. 19 Q. 4 October, that's correct. 20 A. And it's a two-page letter? 21 Q. That's correct. 22 A. This is the interim letter. 23 Q. The interim letter. We'll just go through it. This is 24 a letter from the Royal College from an individual 25 called Steven Wakeling, IRM manager, I think you Page 60

1 mentioned the role earlier, to Dr Andrew Russell, the 2 medical director at NHS Tayside, dated 4 October 2013. 3 It says: 4 "Private and confidential 5 "Dear Dr Russell 6 "I am writing to you regarding the individual review 7 of the clinical work of Professor Sam Eljamel, 8 a Consultant Neurosurgeon Surgeon at NHS Tayside. As 9 you are aware the review visit took place on 16 and 10 17 September, with the review team providing initial 11 feedback to you and Dr Phillip McLoughlin, Clinical 12 Director for Specialist Services. Following the 13 interview with Professor Eljamel, which was held on 14 2 October 2013, the review team would like to convey the 15 following points." 16 So, just to pause there, that indicates that there 17 was some initial feedback about the visit provided in 18 the September period, the September dates, 16 and 19 17 September; is that right? 20 A. Yes, there would have been oral feedback within the 21 review team left the hospital to the medical director. 22 This constitutes the interim letter which was sent 23 two days after the interview with Eljamel. 24 Q. Yes, I'm simply just using that as a means of confirming 25 that there was such oral advice in accordance with the Page 61	1 up any concerns. I think this interim letter probably 2 summarises -- and it's conjecture because I don't know 3 what the discussions were -- but to my mind, would be 4 a summary of the oral discussions that had already been 5 had. I think, having reviewed the notes and interviewed 6 the witnesses, the review team would have come to 7 an opinion already, it's my view -- again, as I say it's 8 conjecture -- and of course they would have listened to 9 Professor Eljamel's responses to the queries and if 10 necessary, altered their views. But my feeling, from 11 looking at all the correspondence and the final report, 12 is that they would probably have indicated to the trust 13 director, or board director, that -- much the same as 14 the contents of this interim letter. 15 Q. That's very helpful, thank you. And the letter goes on 16 to say, to look at the actual content: 17 "Based on all the information provided to the team, 18 there are concerns about Professor Eljamel's clinical 19 practice with regards to spinal surgery. A number of 20 wrong site surgeries have been carried out, which raise 21 concerns about Professor Eljamel's approach to 22 pre-operative marking and post-operative care. In 23 addition, for a number of cases where wrong level 24 surgery had been performed Professor Eljamel 25 acknowledged that he may not have been absolutely open Page 63
1 normal process provided and it was provided at 2 the September visit, is that right? 3 A. Yes, that is correct. 4 Q. The difficulty that I set out earlier, Professor, is 5 that we are trying to piece together what happened over 6 this very important period for a particular aspect of 7 our Terms of Reference, as you have helpfully done, by 8 looking at very limited amount of documentation. And it 9 is very helpful to us to have someone who is familiar 10 both with the review but a very experienced surgeon to 11 try to give us an impression of what, perhaps by 12 inference or reasonable inference, may have been going 13 on here. 14 One of the things obviously that we're interested to 15 try to resolve if we can, based on what evidence is 16 available, and any view that you might reasonably feel 17 you could provide, would be what the nature of that oral 18 advice might have been. Now, I think the first part of 19 that is, what is the nature of the oral advice that's 20 normally provided? Does that depend on what's been 21 found, or is it always in a sort of general area or 22 standard form? 23 A. It would be on the basis of what had been found, 24 discussed by the reviewers and felt to be relevant to 25 the practice of the individual surgeon and it would flag Page 62	1 with his colleagues about the outcomes of these 2 operations. Additionally, the review team could not be 3 sure if he had been open with patients who had undergone 4 wrong site procedures. 5 "The Trust will need to consider whether it feels 6 further action should be taken to review 7 Professor Eljamel's spinal surgery cases to ensure that 8 that there were no wrong site surgeries that have gone 9 unaddressed. 10 "The review team has been informed that supervision 11 of [Mr] Eljamel is in place. In order to ensure that 12 spinal surgery is undertaken safely it would be 13 appropriate for this supervision to ensure that; 14 Professor Eljamel follows departmental guidelines for 15 pre-operative marking, that all of Professor Eljamel's 16 spinal cases receive post-operative imaging to ensure 17 the procedure has been performed successfully and at the 18 right level and that Professor Eljamel's cases are 19 subsequently audited. 20 "We will now prepare the review report, which it is 21 anticipated will be completed within six to eight weeks. 22 If at any time would you like to contact me about the 23 production of the report, please do not hesitate to do 24 so." 25 So these sorts of issues that were raised in -- some Page 64

1 of these, of course, are followed through into the final 2 report which is much more detailed, but there are 3 a number of interim matters expressed. Could you help 4 us, please, with the -- although you're not 5 a neurosurgeon, with the pre-operative marking concept? 6 I think you told us a little about it earlier, but if 7 you could just clarify, that would be very helpful. 8 He's lost the connection? 9 A. Sorry, I have unmuted myself. I think I have to be 10 permitted to unmute, so my apologies. 11 It's my understanding, from discussions, as I said, 12 with my colleagues, that wrong-site surgery is a problem 13 across all surgery and it's one of the things we're 14 really concerned about. You would know that 15 a wrong-site or wrong-side operation is termed a "never 16 event" by NHS classifications. It should never happen. 17 They're inappropriately named because they do happen. 18 And all facilities that are available to avoid that 19 happening are really important. 20 Now, operating on the spine is characteristically 21 difficult, it's -- operating at the wrong level is 22 a recognised complication and one which I understand the 23 neurological spinal associations, both here and in the 24 United States and other parts of the world, have gone to 25 a great deal of trouble to try and eliminate. And there Page 65	1 a disc at the fourth lumbar level, L4, or a disc between 2 the L4 and L5 vertebrae. If there was a problem there 3 that needed to be resolved, it would be vital that the 4 correct disc was approached, not the disc, for instance, 5 at the L2/3 level, upon which, if there was a procedure 6 undertaken, that might complicate proceedings but also 7 would not resolve the problem about which the patient 8 was complaining. 9 The way I understand the neurosurgeons to do that is 10 to take a further image before any potentially damaging 11 surgery is carried out on the spinal column. And that 12 might involve placing a piece of metal, either a very 13 specific narrow retractor or even a hypodermic needle at 14 the level that the pathology is presumed to be at, 15 taking a further set of imaging to confirm the location 16 of the needle at the right level of the pathology before 17 undertaking a specific surgery which might be, for 18 instance, to remove a bit of bone, or to go in and 19 remove part of a damaged disc, potentially even to 20 insert a new disc, an artificial disc. That would be 21 a microdiscectomy or a procedure to remove a bit of bone 22 that might be compressing a nerve root would be 23 a laminectomy and these are all done through small 24 incisions. 25 So nowadays, a further level of safety would be, as Page 67
1 are sets of recommendations and as I said, I consulted 2 a previous past SBNS Chair, who had a practice in spinal 3 surgery even yesterday, and his advice was that even at 4 2013, recommended standard practice would be to mark, 5 with an indelible felt-tip pen, the approximate level of 6 spinal surgery, possibly the short incision that might 7 be needed, that might be a 2 to 3-centimetre incision. 8 If the symptoms or the surgical approach needed to be 9 lateralised to one particular side, they might have 10 placed an arrow towards the side and that would have 11 been confirmed by pre-operative -- by looking at 12 pre-operative imaging, either x-rays or lateral 13 fluoroscopy. 14 Lateral fluoroscopy refers to taking an x-ray from 15 the side of the patient -- and this is undertaken once 16 the patient is on the table as well -- which would, of 17 course, show the spine. Once the patient is 18 anaesthetised and has gone to sleep and the initial 19 incision has been undertaken, and before an approach to 20 the potentially very damaging procedure of interfering 21 with the spinal cord, or the spinal column, is 22 undertaken confirmation that that was being undertaken 23 at the correct site would be really important. For 24 instance, we talk about the lumbar vertebrae as the 25 L vertebrae and you might have a problem with, say, Page 66	1 I indicated earlier, to introduce a pause, to make sure 2 not only that the surgeon himself was happy but that his 3 assistants and everybody in theatre was happy that he or 4 she was going to approach the right level. So all of 5 these act to reduce the risk of inadvertent incorrect 6 level surgery which, as I said, is a significant 7 potential complication. 8 I'm sorry if that's drawn it out. 9 Q. No, that's extremely helpful. I think you mentioned 10 having had a discussion as recently as yesterday with 11 a former president of the SBNS. Could you tell us who 12 that was? 13 A. I'm not sure -- well, I can respond to that and he would 14 not -- that would be Mr Rick Nelson, FRCS, but that 15 advice was provided in an informal context and not as 16 specific advice and not on behalf of the Royal College 17 of Surgeons although he was also the chair of the 18 neurosurgery specialist advisory committee. 19 Q. Thank you, that's very clear, Professor. Another aspect 20 of the interim letter touches on a matter that we've 21 discussed before, I think. You mentioned before the 22 importance, in surgical practice, of being what 23 Professor Eljamel was found not to have been which was 24 absolutely open with his colleagues about the outcome of 25 these operations. Could you give some insight into the Page 68

1 sort of severity, if you like, of when one juxtaposes 2 the particular issues and the outcomes for those 3 operations that you have just been helpfully describing 4 and then not raising those matters candidly with 5 colleagues afterwards, the extent to which, I suppose, 6 the original error is compounded by the failure to raise 7 it. Could you give us some insight, from a surgical 8 perspective, as to how bad that is, if I can put it that 9 way? 10 A. Again, I can only really refer to the report and the 11 report doesn't describe in detail any complications -- 12 minor description of complications, but any 13 complications arriving from this. In broad context, my 14 understanding of problems with neurosurgery -- and 15 I understand the principal cause for operating would 16 frequently be pain, or incapacity, for instance impaired 17 leg function, and the people in the court will probably 18 understand that of, for instance, sciatic-type pain 19 radiating down the back of the leg because of 20 a prolapsed disc pressing on the nerves that run down to 21 the leg. 22 So the types of operations that neurosurgeons would 23 undertake might be to deal with prolapsed discs, to 24 remove the pressure on the nerves and that may mean 25 taking away part of the disc, could involve fusing the Page 69	1 instance, anaesthesia and potential specific 2 complications, which would include things like wound 3 infection, bleeding, causing haematomas, or fluid 4 accumulation, a serious leak, for instance. Then any 5 unnecessary operation puts patients at risk of that 6 complication. 7 It would be normal for any complicated surgery to be 8 discussed at a multidisciplinary team meeting or 9 a morbidity and mortality meeting and the aim of that, 10 of course, is to improve all approaches to making sure 11 that our patients are looked after properly. And often 12 nowadays we accept that we get a much better standard of 13 advice if a problem is discussed amongst a group of 14 professionals -- that's what a multidisciplinary team 15 meeting implies -- we might have -- for instance, in 16 a neurosurgical multidisciplinary team meeting you might 17 have the neurosurgeons who are there, say three or four 18 neurosurgeons, you would have neurosurgical 19 radiologists, the doctors who interpret the films, and 20 you may have a neurologist who is able to interpret the 21 symptoms that the patient is complaining of. And once 22 all of those experts come to concordance, then you're 23 much more likely to have a feasible and a safe treatment 24 plan. 25 If surgeons operate solely, those are obviously more Page 71
1 spine, I understand in some cases that spacers are 2 inserted, prostheses to maintain the integrity of the 3 spine. Or in some cases due to degenerative disease, by 4 that I mean arthritic-type disease in which a nerve is 5 emerging from the spinal column to run to the legs or, 6 in the cervical spine, in the neck to the arms. 7 Sometimes the degenerative process, the arthritis, 8 can narrow the space, the foramen through which a nerve 9 emerges, pressing on that nerve and causing either 10 problems with sensation -- and usually that would take 11 the form of pain -- or impaired motor activity, in other 12 words the nerve did not drive the muscles as it should 13 do. And that can result in weakness of a limb and 14 wasting. 15 Now, firstly, if you operate at the wrong level on 16 a disc that is potentially healthy and doesn't need 17 an operation, then potentially you are pre-disposing the 18 patient to a whole different set of symptoms, either 19 further pain in that region or further nerve impairment. 20 If you then find that the symptoms are not resolved, 21 as I understand from this report, and that requires 22 a further intervention, it may be that the surgeon has 23 to go back and operate for a second time at the correct 24 level. Now, of course, any operation involves a certain 25 amount of risk, there are the general risks of, for Page 70	1 potential for problem and it's entirely appropriate for 2 any complicated surgery, or any surgery giving rise to 3 complications, to be discussed so that everyone learns 4 from this. Complications do occur. You know, they can 5 occur, they are, to some extent, inevitable in surgical 6 practice but it's vital that everybody learns from 7 complications so that potential problems are avoided in 8 the future. And so not communicating is probably is -- 9 I would accept as part of the issue of probity, the word 10 you referred to at the very beginning of this session. 11 And again, that's quite a long exposition. I'm sorry 12 about that. 13 Q. Thank you. That's very helpful indeed. Of course, the 14 lack of communication. You focused there on the 15 importance of communicating that in a colleague to 16 colleague sense for the multiple reasons you set out but 17 also the suggestion set out here that the review team 18 could not be sure if he had been open with patients who 19 had undergone wrong-site procedures. You mentioned, 20 I think, a moment ago, the possibility one would have to 21 have a second procedure in these type of situations 22 which would expose a patient to the risks inherent in 23 surgery. 24 How would one go about doing that if the patient 25 didn't know that the reason was that the original Page 72

1 surgery had been done at the wrong site? One would need 2 to explain to some extent why the second surgery was 3 happening, wouldn't you? 4 A. Every surgeon has had complications and you, of course, 5 will know that the surgeon has a duty of candour in the 6 event of complications to have a full and frank 7 discussion with the patient to explain the situation, to 8 explain why a potential complication might have 9 occurred, and to have a fully informed consent process 10 to discuss with the patient any remedial action. 11 So, say I had undertaken an operation in which, 12 inadvertently, I had approached the surgery at a wrong 13 level, operating on a spine, and the patient's problems 14 were not resolved, they remained in pain and I felt that 15 the best thing to do would be to undertake a further 16 procedure, then I would have an absolute obligation to 17 discuss with the patient why their pain had not been 18 resolved, how, inadvertently, I had operated at the 19 wrong level, and indeed, what I would think would be the 20 resolution and indeed, to discuss with the patient 21 potentially whether they still had confidence in me or 22 would like to speak to somebody else about it, to obtain 23 a second opinion. Often that could be done within 24 a unit but the key to that, from the professional side, 25 would be that if I had this mistake I would be expected Page 73	1 certainly my feeling is that the surgery should have 2 been supervised itself. 3 Q. By -- 4 A. I had understood that this had been done. I'm not sure if 5 that's the case. 6 Q. By another suitably qualified professional colleague? 7 A. By a peer, a colleague. We, in complex surgery 8 nowadays, in many cases, we operate as dual consultant 9 roles so that we can assist, we can come to decisions 10 together and can undertake different parts of the 11 procedure together. That's not done, of course, in all 12 contexts but in complex surgery that's now a well-held 13 value within surgery. 14 Q. Thank you. Just a couple of technical questions about 15 the review, again, to get back to your role as the head 16 of the review. My understanding, just to get the 17 timeline here, is that I think the review which was 18 requested on 26 June then led to the visits on 16 and 19 17 September. In the period between those two dates, 20 I think we've covered this already, but there are 21 various things that need to happen, I think, including 22 the terms of reference being finalised and discussed in 23 accordance with the processes that we've put together. 24 There would need to be some initial discussion, one 25 would imagine, amongst the reviewers as to how they Page 75
1 to discuss this with my colleagues to bring it to 2 a multidisciplinary team or a morbidity and mortality 3 meeting and obtain consensus from the unit to proceed 4 with the patient's best outcome in mind. 5 Q. Thank you very much indeed. There are some references 6 in the passages that I have read out to -- which you 7 have mentioned yourself, to the understanding of the 8 reviewers that there was already a suspension -- there 9 was a -- there were clinical conditions in place 10 relating to Mr Eljamel's practice already and that 11 effectively he was under a sort of supervision, I think 12 is the word that's used. So my understanding from the 13 criticisms that are made here is that part of what's 14 being criticised not, all of what's being criticised, is 15 to do with the actual performance of the surgery. It 16 was done at the wrong site, rather than just being to do 17 with communication or what one deals with before, or 18 after or imaging, the actual surgery has been done 19 incorrectly. In those circumstances, would it be 20 thought to be appropriate, given that the risk is the 21 actual conduct, the technical operation itself, that the 22 supervision should involve supervision in the conduct of 23 any further surgeries itself, rather than other aspects 24 of clinical practice? 25 A. That is what I had understood by "supervision". It was Page 74	1 intended to approach matters. Organisational matters 2 such as arranging a visit would have to be put in place, 3 availability would have to be checked, travel and all 4 that kind of thing. 5 Are there any other aspects that I'm missing or is 6 that what happens in the period between effectively June 7 and September? 8 A. No, you've summarised that very well. I mean, the key 9 aspect is availability of evidence. So the trust would 10 have to identify, for instance, the index cases that 11 they wanted to review, they would have to identify all 12 the evidence associated with those cases, the case 13 notes, imaging, letters, that sort of thing. And of 14 course, they'd have to identify the witnesses they 15 wanted to appear before the review panel. And they 16 would, presumably, have to assure themselves of the 17 availability of those witnesses as well. So it's quite 18 a big logistical exercise and that would explain any 19 delay between the discussion of the initial terms of 20 reference and the date for the arranged review. 21 Q. And that might, perhaps particularly, be the case 22 because as we'll see in a moment when we look at the 23 actual report, there are a large number of individuals 24 interviewed and involved. It wasn't one, two colleagues 25 it was a huge list of different people, isn't that Page 76

1 right? 2 A. That's correct. 3 Q. One aspect, perhaps quite a technical aspect but it's 4 something that's been raised with me and it's of some 5 interest to some individuals who are part of our 6 participant group, is to do with -- you mentioned 7 earlier that there was perhaps some sort of system 8 whereby you could track certain things being done, 9 including I think particularly we were talking about the 10 recommendations, communication after the report had been 11 done. One of the things that I have been asked to 12 address is whether there are any records, perhaps as 13 part of that tracking system, as to how, in particular, 14 the interim letter and how the final report were 15 communicated. 16 We have the two letters, we'll go to the second one 17 in a moment, but do you know what the normal method of 18 communication at that time would be, just putting it in 19 the post, or would there be some record in the tracker 20 perhaps as to how that would work? It may be too 21 technical a matter for you to address just now. 22 A. Well, to be quite honest, with respect to the 23 tracking -- and I'm grateful to you -- but you've 24 provided me with those two letters this morning, we 25 didn't have access to those. They're not within our Page 77	1 THE CHAIR: Sorry, Mr Dawson, could I get the reference 2 again? 3 MR DAWSON: Certainly, it's NHST-01581. 4 THE CHAIR: Thank you. 5 MR DAWSON: Do you have that, Professor? 6 A. I do, 6 December. 7 Q. That's right: 8 "Please find enclosed the final signed report 9 prepared by Mr Neil Kitchen ... Mr Nicholas Philips ... 10 and Helen Carter ... who undertook the individual review 11 of the clinical work of Professor Sam Eljamel, 12 a Consultant Neurosurgeon Surgeon at the NHS Tayside, 13 under the Invited Review Mechanism. 14 "Please could you ensure that a copy of the report 15 is made available to and discussed with all those 16 directly involved in the review especially 17 Professor Eljamel at the earliest opportunity. 18 "As part of the Invited Review Mechanism process, 19 the college will send an evaluation form to the Trust 20 after the review has taken place. The purpose of this 21 exercise is to provide general feedback to the College 22 on the process and to ensure that the arrangements for 23 the Invited Review Mechanism are kept under review. 24 "I would be most grateful for any feedback you wish 25 to send to the College and I enclose an evaluation form Page 79
1 records and they've presumably come from the trust or 2 elsewhere. 3 Q. Yes, they have. 4 A. Whilst the letters are typed, they are of course, sent 5 by email so there's an instantaneous delivery as soon as 6 they've been produced. 7 Q. Right, so these letters, the ones that I gave you this 8 morning, 4 October and 6 December, although they are 9 letters, they would have been emailed and of course -- 10 A. They certainly would be now and I hope in 2013 we would 11 have had sufficient technology to be able to do that. 12 Q. And presumably, it would be logical that the 6 December 13 letter would also have had the report attached to it as 14 the letter narrates? 15 A. Yes, that would be -- 16 Q. By email? 17 A. I believe so, yes. 18 Q. Yes, thank you. So can we have a look at that just now. 19 It's NHST-01581. This is the 6 December letter which -- 20 again, this time it's been written by Ms Clare Marx, 21 whom you've mentioned, the chairman of the Invited 22 Review Mechanism, to Dr Andrew Russell. Again, strictly 23 private and confidential: 24 " ... Dr Russell 25 "Please find enclosed the ..." Page 78	1 for this purpose. I appreciate that you may wish to 2 comment confidentially and, of course, this will be 3 respected." 4 We do actually have access to correspondence where 5 a form is -- which includes a form, so there is the form 6 but unfortunately there's no completed copy, as far as 7 I'm aware. The aspect of this I just wanted to address 8 with you was, in particular, the significance of 9 "ensuring that a copy of the report is made available to 10 and discussed with all those directly involved in the 11 review especially Professor Eljamel at the earliest 12 opportunity" is that normal practice and why is it 13 important that all those directly involved in the review 14 are informed of its precise terms as soon as possible? 15 A. Well, I think it's in the interest of clarity and 16 openness within the trust that those who have 17 contributed to the review should be able to learn from 18 it. And, of course, it's only fair to the subject of 19 the review that that individual has complete access to 20 anything that's been written about them. And I believe, 21 of course, that might form the basis for further 22 discussions within the trust between the individual and 23 those in authority, the chief executive and medical 24 director. 25 Q. Because presumably, even beyond Mr Eljamel himself, Page 80

1 others who are involved may learn and their practice may 2 be improved by aspects of what's said, presumably that's 3 part of the purpose of it as well? 4 A. Yes. 5 Q. But it seems at that stage, given our earlier discussion 6 about the fact that it becomes the property at that 7 stage of the trust or the board, that at that point, 8 arrangements as regards the confidentiality rather fall 9 away, at least from one side, and what you're seeking to 10 do there is to promote promulgation of its contents, if 11 I can put it that way? 12 A. I think we would promote learning. It's vital to 13 preserve anonymity of patients and clinical material. 14 We'd always promote that aspect of learning and indeed, 15 the invited reviews form a significant part of the work 16 that we do to assure and develop quality assurance 17 processes. But as you have emphasised yourself, the 18 report becomes the property of the trust or the board. 19 In the handbook on invited reviews, I think there is 20 emphasis made that confidentiality is preserved where is 21 appropriate. But the whole point of an invited review 22 is that it is a learning process and an informative and 23 helpful, authoritative process. 24 Q. Thank you for that. If we might have a look at the 25 review report itself, at least certain aspects of it. Page 81	1 aspects wouldn't automatically be included in 2 an individual review but they have been specifically 3 requested by the board and presumably accepted by the 4 reviewers and the college that it would be appropriate 5 for them to be looked at and that they could look at 6 them usefully? 7 A. Within an individual review, there would always be terms 8 of reference, all -- whether a service clinical records 9 or an individual review, there would always be 10 a structured set of terms of reference which provides 11 a framework to work around. 12 Q. But would all of these components of Mr Eljamel's 13 practice necessarily be part of the review? 14 A. No. They're only as ones specified and agreed between 15 the board and the invited review manager. 16 Q. Understood. And as far as the terms of reference -- the 17 specific terms of reference are concerned, we can see 18 them there. A specific aspect that I wanted to raise 19 with you was, under (b), one can see under paragraph 2, 20 that there are various aspects which are a fuller 21 explanation of what we just talked about under (a) 22 relating to Professor Eljamel himself, but then, under 23 (b) it says: 24 "If applicable: NHS Tayside would be receptive to 25 recommendations in relation to wider aspects of service Page 83
1 For us, that's RCS-00014. 2 A. I have my paper copy. 3 Q. Thank you very much. I'm looking at page 3, in 4 particular. Thank you very much. The report is long 5 and detailed. I'm not going to go through -- it's not 6 necessary for our current relatively introductory 7 purposes to go through all of this. But you have 8 helpfully done so and reflected your views on its 9 contents and what they mean, helpfully, in the written 10 report. But the background to the review is narrated: 11 "On 26 June 2013, Dr Andrew Russell, Medical 12 Director at NHS Tayside wrote to the Chair of the 13 Invited Review Mechanism ... to request an invited 14 individual review of Professor Muftah Salem ('Sam') 15 Eljamel, consultant neurosurgeon, in particular to 16 review Professor Eljamel's clinical knowledge, technical 17 skills and judgment as well as his interpersonal skills. 18 This request was considered by the Chair of the RCS IRM 19 and a representative of the Society of British 20 Neurological Surgeons, where it was agreed that 21 an invited individual review would take place." 22 I just wanted to focus on the different aspects here 23 of "clinical knowledge, technical skills, judgement as 24 well as interpersonal skills". I'm assuming, given what 25 we've said about the terms of reference, that those Page 82	1 delivery and team cohesiveness within the Neurosurgery 2 Department that may emerge from the context of the 3 review." 4 And that at the bottom of the box one can see there, 5 skipping past (c) for the moment, it says: 6 "The reviewers will then make recommendations for 7 the consideration of the Chief Executive and Medical 8 Director of NHS Tayside as to: 9 "Whether there is a basis for concern about 10 Professor Sam Eljamel's practice in light of the 11 findings of the review; 12 "Possible courses of action which may be taken to 13 address any specific areas of concern which have been 14 identified." 15 So, there is, in section (a), specific terms of 16 reference relating to Professor Eljamel. Section (b) if 17 applicable, communications about the wider service 18 within NHS Tayside. But the recommendations that are 19 asked for only relate to Mr Eljamel and not to the 20 board. Is that an accurate interpretation of what this 21 says? 22 A. I interpret it as slightly differently, if I may, 23 because (b), as you say, says that NHS Tayside would be 24 receptive to recommendations with respect to the wider 25 aspects of service delivery. And I think if we go to Page 84

1 the conclusions of the report, and the recommendations, 2 you will see there were some specific recommendations 3 with respect to Mr Eljamel's practice but there were 4 also some broader recommendations with respect to the 5 trust and with respect to the conduct of neurosurgery. 6 Q. So, my understanding from the report is that you 7 explained earlier the different types of review one can 8 have and this was classed as an individual review, is 9 that right? 10 A. Yes. 11 Q. But it might -- rather than a service review? 12 A. Yes. 13 Q. But it might be: an individual review and if you happen 14 to find anything that would be useful to us to know 15 about the service, we'd be happy to know about that too? 16 A. Absolutely, and the trust, and of course the IRM 17 mechanism, would have been at liberty -- most of 18 these -- or the findings that gave rise to the 19 recommendations with respect to the service, which are 20 relatively limited, have arisen out of the direct 21 investigation of Mr Eljamel's practice and would have 22 come from the witness statements which have described 23 the practice of neurosurgery at NHS Tayside slightly 24 more broadly. 25 So, there are some recommendations with respect to Page 85	1 A. Yes. 2 Q. It could have requested a service review relating to the 3 adequacy of the suspension provisions? 4 A. Yes. 5 Q. It could have requested -- 6 A. If I may though, you'll have to -- you'll have to accept 7 that all of these would have had to have been agreed 8 between the two parties. 9 Q. Of course. 10 A. But those are all things that the Royal College of 11 Surgeons and the IRM mechanism would have had the 12 facility to investigate. 13 Q. I'm specifically asking you whether they could have 14 requested these things, of course, because the college 15 would have had to have agreed to it, but I want to be 16 sure what could have been included in the service 17 review. 18 A. All of those could have been requested. 19 Q. Could it have requested -- could they have requested 20 a review relating to the systems they had for clinical 21 supervision, as we've mentioned already? 22 A. Yes, and that would very much form part of a review 23 process for a specific, for instance, directorate or 24 specialty. 25 Q. Yes, because of the fact that, as we know, this was Page 87
1 the practice of neurosurgery. Had the trust and the IRM 2 wished to take that further, it would have been within 3 the capacity of the trust to request a formal service 4 review but that was not undertaken at that stage. 5 Q. Yes, so that was the choice of the trust, to have this 6 individual review with this sort of slight add-on, if 7 you like? 8 A. Yes. I think some of the problems had been flagged up 9 and the hope -- and indeed, I'm sure the correspondence, 10 although I have not seen the correspondence, would -- in 11 terms of the follow-up, would have looked at the changes 12 that the trust was instituting. 13 Q. So, a service review -- the board could have requested 14 a service review which could have requested that there 15 be a review of clinical governance procedures within the 16 trust; is that correct? 17 A. Yes. 18 Q. It could have requested a service review that included 19 a review of its professional governance processes? 20 A. Yes. 21 Q. It could have requested a review that included a request 22 that the reviewers look at questions relating to issues 23 pertaining to document management? 24 A. That's correct. 25 Q. Record-keeping? Page 86	1 underpinned by a significant number and an increasing 2 number of patient complaints, could it have requested 3 a review into the complaint system? 4 A. Yes, yes, it could have done, with respect to the 5 specific things they were concerned about. 6 Q. Yes and particularly, also perhaps, a review into how 7 the complaints had been handled and responded to by the 8 trust or Mr Eljamel or others? 9 A. Yes. 10 Q. That might particularly be the sort of thing that the 11 college could help with? 12 A. Yes. 13 Q. Because it's about professional improvement and 14 improvement of service and improvement of patient care? 15 A. Yes and we do, of course -- if I may just add, the 16 trainees and resident doctors are, of course, 17 a particular focus for all the Royal College of 18 Surgeons. They're the future of British surgery and we 19 have to ensure their working conditions and their 20 training is appropriate and satisfactory. 21 Q. You definitely haven't seen my list in advance, but 22 I was going to ask you whether the review could have 23 requested -- I think you've already confirmed -- 24 an analysis of the training regime of surgeons in 25 training? Page 88

1 A. Yes. 2 Q. And it, perhaps in the particular, could have requested 3 the way a review of Mr Eljamel's treatment of and 4 interaction with his trainees? 5 A. Yes, and my feeling is that some of that has been 6 covered in the report and that was part of the concerns 7 that were flagged up. 8 Q. That might be actually quite a good example of where 9 you've looked at Mr Eljamel particularly but then some 10 systemic elements have been shaken out of that, if you 11 like, that they have looked at, is that right? 12 A. Yes. 13 Q. And just on one final aspect as to whether the review 14 could have included it, I wanted to know whether the 15 review could have included the reviewers commenting on 16 the system operated by NHS Tayside as to their 17 communication and getting involvement of the GMC? 18 A. That could have been undertaken. It's not something, as 19 you would expect, that is carried out in most invited 20 reviews but had the reviewers been asked to investigate 21 that, they should have had the facility to be able to do 22 that. 23 Q. Because one of the things that does come out of this is 24 suggestions to do with the GMC and what I'm focusing on 25 is it's possible, isn't it, that it might be a systemic Page 89	1 interviewees, it seems entirely appropriate that there 2 were the senior medical administrators, medical 3 director, clinical director. There were trainees, there 4 were anaesthetists who worked with the neurosurgical 5 practice, the senior nurses, who of course, have 6 an important role to play in theatre, associated 7 specialties, ENT surgery which sometimes works with 8 neurosurgery, psychiatry, which is involved with 9 outcomes and dealing with potential psychiatric 10 conditions, neurosurgery, radiologists and then some of 11 the administrative managers. 12 So it's a fairly comprehensive group of people but 13 all of those people would provide evidence that would 14 allow the review team to build up a comprehensive view 15 of the practice of Mr Eljamel and indeed, the 16 neurosurgical service. 17 Q. I'm just wondering -- that's very helpful, but you 18 mentioned doctors in training. Does it include any 19 trainee doctors? 20 A. Yes, it does. Those termed "specialist registrar in 21 neurosurgery" are trainees -- 22 Q. Thank you. On the previous page where it sets out the 23 broad number of staff, it talks about four middle-grade 24 staff, including one clinical fellow at specialist 25 registrar etc. So there is that -- that's covered off Page 91
1 failure within a board or a trust that leads to issues 2 not being forwarded on to the GMC in the way that they 3 should, such that it might be possible for 4 an independent reviewer to come in and say: well, the 5 problem here is the system rather than the individuals 6 within the system. And so that's something that could 7 have arisen in this context and on which NHS Tayside 8 could have requested a review? 9 A. That is the case. 10 Q. Thank you. I just wanted to ask you, if we could go 11 over the page on to page 5, please. I have mentioned 12 this already but there does seem to be a very large 13 number of people interviewed over a two-day period. Is 14 that normal in a review, that this number of people 15 would be spoken to? 16 A. It is, yes. 17 Q. Right. And it does seem -- is the number of people that 18 are selected from -- presumably a list provided by the 19 board as we discussed earlier in accordance with the 20 sorts of people that the reviewers would want to speak 21 to, is the list finally decided upon based on how many 22 people they think they will need to speak to to be able 23 to answer the review comprehensively? 24 A. I mean, I think the answer is that the review team need 25 to gather broad evidence and looking down this list of Page 90	1 as well in the list. 2 As I say, Professor, I don't intend to go through 3 the full content of the conclusions here and you have 4 reflected, I think, the key themes in your report. One 5 aspect that I did -- and indeed, we've touched on 6 aspects of the ultimate findings which were reflected in 7 the interim letter about Mr Eljamel's own practice. 8 There are a couple of aspects that I wanted to raise 9 with you that I thought would be worth bringing up. The 10 first is at page 18, which is at page 416. 11 A. Yes, I have that, thank you. 12 Q. This -- going down to the bottom, please, on our screen. 13 Thank you. This is where -- you mentioned this earlier 14 that having dealt with, for numerous pages, Mr Eljamel's 15 review, if one can put it that way, there's a section 16 here to do with clinical governance, where it says: 17 "Through the course of this individual review 18 a number of issues came to light regarding the clinical 19 governance within the Neurosurgery department and the 20 surgical directorate as a whole. 21 "During the interviews it was heard that there had 22 been problems with Professor Eljamel's performance in 23 the past but that these had been dealt with informally. 24 It was stated that no documented concerns or formal 25 complaints from other staff about Professor Eljamel's Page 92

1 behaviour had been submitted. The reason given for this 2 was that there were concerns about the possibility of 3 a re-structuring of neurosurgical services in Scotland 4 and that any unrest within the department might [be] 5 put ... at risk." 6 So the conclusion that they appear to have drawn 7 from the ancillary aspects of the visit was that there 8 had been problems with Mr Eljamel's performance in the 9 past but these had been dealt with informally, that 10 they -- there were no concerns or complaints within the 11 formal system about his behaviour, but that the reason 12 for the fact that there had not been any formal 13 complaints were their concerns about the possibility 14 that any unrest within the department might put the 15 neurosurgical department at risk. I wonder if you have 16 any reflections on that passage as regards whether that 17 constitutes a responsible way to run a neurosurgical 18 unit? 19 A. I'm afraid, I can't take that into context. I have no 20 idea about the structuring of neurosurgical services in 21 Scotland but this was obviously a topic that had arisen 22 in some of the witnesses' commentary, otherwise the 23 reviewers wouldn't have mentioned that. 24 There are two aspects. There's the informal 25 treatment of potential complaints but in the absence of Page 93	1 concerns of an individual's behaviour. 2 Q. Thank you. One aspect of this report -- I just wondered 3 if this would be the norm, perhaps this is slightly 4 historic based on your involvement as the chair, but one 5 thing that is, certainly for a lawyer, quite frustrating 6 is that we have this very interesting list of people at 7 the beginning and then a commentary of the factual 8 evidence without any attribution as to who actually said 9 any of these things. Is that normal? Because there 10 might be reasons as to why that's done deliberately. 11 A. That's completely normal and in view of the fact this 12 report goes back to the trust, unless an individual 13 specifically wants to be attributed with comments, which 14 sometimes happens, then, in order to preserve the 15 anonymity of the people who have contributed, then the 16 comments are often taken as correct but we don't 17 attribute them to individuals. 18 Q. Thank you. Just further down that page there's one 19 other aspect of this which I wonder if you might be able 20 to help us with. It's under "job planning", just that 21 first paragraph. It says -- this again, is under the 22 "clinical governance" section: 23 "There were also a number of issues relating to the 24 Consultant Neurosurgeons' job plans which were raised 25 during the course of the interviews. The review team Page 95
1 specific evidence in this report, it's difficult to 2 comment on that in any detail. There are always -- or 3 a consistent thing, I have to say throughout many of the 4 reports we deal with, are that all services have areas 5 of weakness and sometimes an individual review will 6 bring out those areas of weakness. Certainly 7 restructuring of services generally can be a cause for 8 concern and it's happened across many specialties. As 9 we try to improve the NHS, it's vital that we do 10 restructure services but that can cause concern to both 11 individuals and departments as well, who may not always 12 perceive their role in any future re-organisation. 13 Q. But surely the systems that exist for complaints or 14 concerns being raised about colleagues' behaviour is 15 designed for patient safety reasons ultimately and that 16 although I would accept that the concerns about the 17 viability of the service would be unsettling, those 18 should never stop someone raising a concern or it being 19 made formal because otherwise patient safety would be 20 put at risk? 21 A. Well, my information here, I'm afraid, is that paragraph 22 is so conjecturing as to what specifically these witness 23 statements were concerned about is difficult to do. And 24 I was just trying to put that in terms of generality. 25 Of course, patient safety should promote feedback about Page 94	1 heard that the department had taken on a lot of 2 degenerative spinal cases from East Fife, which had 3 added to the surgeons' workload and changed their scope 4 of practice to being predominantly spinal work. 5 Professor Eljamel stated that he felt that his workload 6 was too high and that he had been pressurised to take on 7 more patients and that he now undertook additional 8 evening clinics of six to seven patients all of which 9 were spinal cases." 10 Just in the generality, without going into 11 specifics, of course, because you don't have a lot of 12 information about that, but I suppose that that might be 13 a phenomenon that one encounters in the modern world in 14 any part of medicine, that the pressures on hospitals 15 and the need -- perhaps the diminution of services 16 elsewhere and the need to take in extra areas that 17 weren't previously covered and the pressures on 18 individuals. The key thing I wanted to ask you was 19 whether, given the fact that although not inevitable, 20 it's entirely possible that that might happen in the 21 modern world, there should be systems to try to make 22 sure that individual surgeons like Mr Eljamel and others 23 are not put under undue workload pressures in order to 24 maintain patient safety? 25 A. Of course there should be and you're reflecting on Page 96

1 an ideal situation and you've summarised the problem 2 very succinctly. But I think this is a generalised 3 problem across the whole of the health service and it's 4 really beyond the scope of my response to talk about 5 philosophy of funding of health services and 6 re-organisations. But, yes, of course, increased 7 workload always potentially puts stress on people. 8 I have to say, if you do extra clinics, then usually 9 that's with the agreement of the individual involved. 10 Nobody would be forced to do extra clinics. It might 11 well be suggested and discussed with hospital 12 management. But increased workload, particularly in 13 a sphere which I think it's commented on, that he did 14 not particularly want to undertake, might have induced 15 some stress. 16 Having said that, if I may just as a generalised 17 comment, every surgeon is bound to do the best for their 18 patients and despite stresses, the bottom line is that 19 you organise those stresses to try and manage the best 20 outcome for your patients and if necessary, have the 21 discussions with management that look at 22 a re-organisation for the patient's benefit. 23 Q. Thank you very much. Just one final passage, I wonder 24 if I could take you to, which is on page 24. Just at 25 the bottom under "Recent changes". Page 97	1 practice. This included undertaking his own clinics, 2 personally consenting his patients during ward rounds, 3 conducting his own procedures and making entries into 4 patient records himself. He also stated that he would 5 now bring any wrong site cases to the M&M meeting for 6 discussion." 7 Our, at least initial, interpretation is that pretty 8 much all of those things, if not all of those things, 9 are things he should have been doing anyway, possibly 10 with the exception of conducting his own procedures in 11 circumstances where they had been delegated 12 appropriately to a junior surgeon. Would that be fair? 13 A. All of those things would have been, or are regarded, as 14 part of normal clinical practice. 15 Q. Thank you very much. I wonder if I could, momentarily, 16 sir, a couple of minor matters just as the Professor has 17 very helpfully helped us with some conclusions and 18 reflections at the end of his report. So if I could go 19 back to the report please, RCS-00021. 20 You've helpfully provided us, Professor, with 21 a couple of interesting reflections on surgical practice 22 which are certainly of interest to us. I'm at page 31, 23 paragraph 39.1, right at the bottom of the page. 24 A. I have that, thank you. 25 Q. Thank you. And you were asking here whether there were Page 99
1 A. Yes, I have that. 2 Q. Thank you. This is a particular passage relating to 3 Professor Eljamel again: 4 "In response to the concerns that had been raised 5 the Trust put in place supervision of 6 Professor Eljamel's practice, which consisted of joint 7 ward round and subsequent discussion with the clinical 8 lead for neurosurgery." 9 First of all, when we discussed this supervision 10 earlier my understanding of your evidence was that that 11 would be expected, in the circumstances, to cover the 12 actual technical performance of the surgery itself 13 rather than just joint ward round and subsequent 14 discussion with the clinical need for neurosurgery. Am 15 I understanding correctly what your evidence was, that 16 that is different? 17 A. My understanding of "joint supervision" would be that 18 the operative procedures were also supervised. 19 I'm unable to tell, from that particular paragraph, as 20 to whether operative supervision fell into this remit 21 but I believe it was the intention of the review team to 22 make sure that was the case. 23 Q. Thank you. It then goes on to say: 24 "Professor Eljamel stated that the concerns had also 25 prompted him to make a number of changes to his Page 98	1 any reflections on the work that you had done and you 2 helpfully told us that: 3 "Although NHS clinical governance processes and 4 wider systems safety processes have substantially 5 improved during my time as an NHS consultant surgeon, it 6 remains the case that responses to potential and actual 7 patient concerns across [over the page] the NHS and 8 wider healthcare could substantially improve. 9 RCS England is committed to working with all relevant 10 advisory and regulatory bodies as part of this process 11 and to achieve our core aim of excellent surgical care 12 for everyone who needs it. Our invited reviews, which 13 are advisory, enable expert teams, including 14 a lay person representing the patient and public 15 interest, to determine whether there is cause for 16 concern about surgical practice or a surgical service, 17 and/or individual episodes of care, and to make 18 recommendations for improvement. Our unwavering 19 commitment to patient care is why we offer healthcare 20 organisations an invited review service." 21 So your position is that there has been a general 22 improvement but an area where one might, on the report 23 card, say "must do better" is in relation to the 24 important matter of responding to potential and actual 25 patient concerns. Could you tell us a little bit more Page 100

1 about why that is something where you think more 2 improvement is required? 3 A. Well, as indicated, I think there has been a general 4 ethos to try and improve healthcare across the 5 United Kingdom and that was stimulated largely by, as we 6 heard, index events such as the Bristol Children's 7 Cardiac Inquiry and the recognition of the deficiencies 8 there. 9 We recognise in many areas that there are still 10 deficiencies and that is probably reflected by the 11 number of invited reviews we undertake, for instance 12 in '25 to '26, six reviews have been undertaken, nine 13 reports issued and ten are still in the planning 14 process. And even between 2008 to 2017, we undertook 15 240 invited reviews and produced a document entitled 16 "Learning from invited reviews" which looked at 17 100 selected reviews and tried to bring out the key 18 issues. 19 Now, NHS England patient safety will be 20 concentrating on that. A number of other areas that 21 patient safety -- the government reviews, for instance, 22 into "never events" and the work of the Centre for 23 Perioperative Care, the work of the National Patient 24 Safety Response panel, all of those areas and 25 organisations are working together to try to improve Page 101	1 or certainly not, and we hear from surgeons, but it's 2 important to try to understand things from a surgical 3 perspective. 4 The review that you've undertaken of the limited 5 materials available to you, are you able to give us 6 an indication, based on what you have seen in the report 7 conducted by colleagues of yours, effectively, and based 8 on your experience of looking at many, many other cases 9 as you've just outlined, as to how bad the review of 10 Mr Eljamel is? Does it stand out as something that you 11 think that's a really enormous issue, or is that the 12 sort of thing one unfortunately sees quite often? 13 A. I would certainly hope it isn't something one sees quite 14 often. Every procedure has an acknowledged risk rate. 15 I would defer to my colleagues, for instance the spinal 16 surgeons, to tell you what an appropriate risk of 17 inadvertent surgery at the wrong level is, but to be 18 presented with four cases out of 14 and acknowledgement 19 by Professor Eljamel that in a further 70 cases he may 20 have had -- he acknowledges that he may have had four or 21 five other cases of wrong-site surgery -- is 22 an excessive number of complications. And my belief and 23 my hope is that across the wide area of surgery in the 24 United Kingdom, that standards are much higher and those 25 standards are held to and that we are trying to improve Page 103
1 patient safety. And it's beholden on the college to do 2 that. We have produced guidance -- guidance which 3 mirrors "Good Medical Practice" produced by the GMC, 4 "Good Surgical Practice" of the Royal College of 5 Surgeons, we run periodic workshops for medical 6 directors and clinical directors, to share learning and 7 a lot of that is done at multiple specialty conferences. 8 We've produced good practice guides, things that -- 9 they are entitled things like "High performing surgical 10 team", "Surgical leadership", "Managing disruptive 11 behaviours", "The duty of candour and consent". 12 So not us alone, all the Royal Colleges are pursuing 13 a patient safety agenda. I believe NHS Scotland, 14 NHS England and the healthcare systems in all the 15 devolved nations recognise that there's still more to do 16 and this particular are, the case you've been working on 17 assiduously over this period is just illustrative of the 18 fact that we need to improve standards. 19 Q. Thank you very much, Professor. One final question 20 I have for you is that you, very helpfully on the basis 21 of only the report itself and the couple of letters 22 you've seen, reviewed this case and obviously you are 23 the chair of the Invited Review Mechanism and a very 24 experienced surgeon yourself. It is difficult, I think, 25 for us to get an understanding as we are not surgeons, Page 102	1 them across all specialties all the time. 2 Q. Thank you very much indeed. That concludes my 3 questioning, other than to ask you, Professor, whether 4 you have anything else you feel you would like to add in 5 addition to what you have already told us? 6 A. I don't. When we have these inquiries -- this is the 7 first Inquiry I have appeared at, but I'm very much 8 aware that there will be a number of patients and 9 relatives who have been profoundly affected by this and 10 my sympathy goes out to them. 11 Q. Thank you very much. We'll take a very short break now 12 in order to try and see whether our core participants 13 have any questions for you. 14 THE CHAIR: Yes, indeed. Professor, we normally have 15 a short break just in case there are any other questions 16 that will be proposed. So if I could ask for your 17 indulgence and not leave us quite yet. We'll take 18 a few minutes break, if you don't go too far, we'll let 19 he know when we're ready to resume. 20 A. No, I will stay here. 21 THE CHAIR: Thank you. 22 (12.49 pm) 23 (A short break) 24 (1.03 pm) 25 MR DAWSON: Thank you, sir. There are a couple of Page 104

1 questions. 2 THE CHAIR: Can we have the witness back, please. 3 Thank you, Professor. There are, I think, one or 4 two more questions. Mr Dawson, when you're ready. 5 MR DAWSON: Thank you, sir. Can you hear me okay, 6 Professor? 7 A. Yes, I can. 8 Q. Great. I have just a couple of questions for you. 9 I wonder whether we can have the statement up again, 10 RCS-00021 at page 25. I'm looking, this time, at 11 paragraph 27.1. 12 A. Thank you, I have that. 13 Q. This was in response to a specific question that the 14 Inquiry had asked you in relation to the 2013 review as 15 to whether evidence from the point of view of former 16 patients of Mr Eljamel or their relatives were taken 17 into account in the 2013 review and if not, why not. 18 Again, of course, recognising that you were working from 19 the report and the two letters and nothing more, you 20 said: 21 "No patients were interviewed in the 2013 review. 22 Patients are not routinely interviewed in invited 23 reviews because invited reviews are peer reviews of 24 surgeons and/or surgical services and/or episodes of 25 patient care by surgeons. Patient perspectives are Page 105	1 of the IRM process which looked very specifically at the 2 evidence from clinical records and direct witness 3 statements. 4 Q. Yes, and in the circumstances of this case, you've 5 helpfully pointed out on your review that because 6 patient complaints were part of it, there was, I suppose 7 albeit indirectly, an aspect of the patient voice that 8 was heard in the analysis? 9 A. Absolutely, and indeed our inclusion of a lay reviewer 10 is in effect to look and evaluate the evidence but from 11 a patient and public perspective as well. 12 Q. I suppose that provision of having a lay reviewer seeks 13 to negate the possibility that surgeons looking at other 14 surgeons might miss things that might be important to 15 patients completely innocently perhaps but they would 16 still be deemed to be important? 17 A. It provides a global perspective and a balance I think, 18 yes. 19 Q. Thank you. If I could just go over to the next page, 20 please, paragraph 28.2. This was in response to 21 a question as to what extent was the 2013 review 22 undermined by a lack of available documents or 23 reasonably accurate written information. This is 24 a specific part of the Inquiry's Terms of Reference to 25 look at that issue. And you explain that you have gone Page 107
1 considered in an invited review according to a review's 2 terms of reference. In this 2013 review patient 3 complaints were reviewed as per the terms of reference 4 and as listed in the documents reviewed as set out on 5 page 6 and 7 of the report." 6 So I suppose there's a number of components to that 7 and the subject of whether patients have been or should 8 be consulted. Obviously, as we've said already, the 9 ultimate objective here is to try to promote patient 10 care, isn't that right? 11 A. Correct. 12 Q. And as far as the particular circumstances here are 13 concerned, or I suppose, in the generality, it's open to 14 a healthcare provider to specify that they would like 15 patient perspectives or any particular material to be 16 taken into account and if that's agreed to, then that 17 would be part of the assessment; isn't that right? 18 A. Yes, if that was agreed to as part of the terms of 19 reference. 20 Q. Yes, and presumably, given the interest in promoting 21 patient care, it would be agreed to. As long as it 22 wasn't an excessive or unusual amount of material, that 23 presumably would be if it were asked for? 24 A. If it was asked for, we would do that. As had been 25 indicated in this paragraph, that isn't routinely part Page 106	1 through the process of analysing the limited material 2 and you very helpfully provided both a report and 3 reflections on the report in your oral evidence today. 4 You say that you did not seek input and advice from the 5 invited review team in relation to the issue as you did 6 not consider it will assist the Inquiry. 7 Are you able to tell us whether members of the 8 invited review team are at least theoretically, could 9 they still be contacted by the Inquiry in case they had 10 any reflections or memories, given in particular the 11 paucity of document that appears to be available? 12 A. I don't think that that would be helpful at this time. 13 I don't know either of the clinical invited reviewers. 14 I'm not sure where they are now at this specific time. 15 The report is a summary of our evidence at the time and 16 I feel that -- I will be, to be blunt, the part of 17 getting people to undertake this process in the initial 18 you know circumstances is the feeling that somebody will 19 represent them and represent their opinions further down 20 the line, and I happen to be that person on this 21 occasion, and I hope I have provided a fair 22 representation of their views. I do not think that 23 anything further would be gleaned by asking them to 24 appear. 25 Q. Thank you very much indeed and thank you for your Page 108

1 evidence, it's very much appreciated. 2 A. Thank you. 3 THE CHAIR: Professor Smith, just before you go I hope you 4 will allow me to extend the thanks of the Inquiry for 5 your very considerable assistance, and I mean that not 6 just by reference to the statement that was produced and 7 the ancillary materials to which it relates but also 8 your interesting and helpful reflections and insights 9 which you've provided to us over what has been quite 10 a long session this morning and early this afternoon. 11 So, in telling you now that you are free to go, you 12 leave also with my very personal thanks for your efforts 13 on behalf of the Inquiry, so thank you. 14 A. Thank you very much indeed, sir, and goodbye to 15 everybody. 16 THE CHAIR: Would 2 o'clock be convenient, Mr Dawson? 17 MR DAWSON: It would indeed. Thank you, sir. 18 THE CHAIR: Thank you. 19 (1.10 pm) 20 (The short adjournment) 21 (2.07 pm) 22 THE CHAIR: Yes, Mr Dawson. 23 MR DAWSON: The next witness, sir, is Tracey Gillies. 24 THE CHAIR: Thank you. 25 Page 109	1 director of NHS Lothian, I understand? 2 A. Yes. 3 Q. And you have been in that position since 4 1 February 2017? 5 A. Yes. 6 Q. By way of qualifications, you hold MBChB from the 7 University of Bristol and a fellowship of the Royal 8 College of Surgeons; is that correct? 9 A. Yes. 10 Q. One of the aspects of your evidence in which we're 11 interested is to try and understand a little bit more 12 about what medical directors do. One of the roles which 13 seems to go along with being a medical director, or part 14 of it, is being a responsible officer for a health 15 board. 16 A. Yes. 17 Q. Could you tell us a little bit about what that means? 18 A. So the role of the responsible officer is about creating 19 a system that allows doctors to practice safely and with 20 participation in the expectations of the GMC around 21 appraisal which supports their revalidation. So those 22 are two important separate aspects but they are linked 23 together. 24 Q. So just to tease that out, there's the creation of 25 a system within which doctors are able to fulfil their Page 111
1 MS TRACEY GILLIES (sworn) 2 Questions by COUNSEL TO THE INQUIRY 3 MR DAWSON: Good afternoon, Ms Gillies. 4 A. Good afternoon. 5 Q. As I say to all the witnesses, could you just try to 6 speak into those microphones as best you can so everyone 7 can pick up everything you say. Thank you very much. 8 You are Tracey Gillies? 9 A. I am. 10 Q. And you have provided the Inquiry with a statement on 11 behalf of NHS Lothian? 12 A. Yes. 13 Q. Could we have up, please, document NHSL-00088. 14 Is that your statement? 15 A. It is. 16 Q. And it's, on the front, dated 25 February 2026. If we 17 could go to page 16, please. Have you signed it there? 18 A. I have. 19 Q. In fact, the date of the signature is 27 February 2026, 20 is that right? 21 A. Yes. 22 Q. And can you confirm the contents of this statement are 23 true as far as you're concerned? 24 A. Yes. 25 Q. Thank you very much. You are the executive medical Page 110	1 revalidation requirements, are those the two parts? 2 A. No, the two parts -- so people tend to think about the 3 responsible officer role as just overseeing 4 participation in appraisal because the GMC has 5 an expectation of doctors to participate in appraisal 6 annually and once every five years in the cycle, to 7 undertake feedback from colleagues and from patients. 8 But just as important is that there is an adequate 9 system of clinical governance in place which allows 10 concerns about a doctor's practice to be identified and 11 acted on and the role of the responsible officer really 12 pertains to both those parts and to bringing those 13 together and undertaking appropriate actions. 14 Q. Thank you. So within that then there's 15 a responsibility, as the responsible officer, towards 16 the high performance, or good performance of the 17 clinical governance system, but a particular component 18 of that is overseeing and being responsible for the 19 appraisal system that I think you've told us is required 20 by the GMC, is that right? 21 A. Yes. 22 Q. We've seen the phrase "medical revalidation and 23 appraisal", is that the same as appraisal, or -- 24 A. It is, yes. It was -- I think I have said in my 25 statement when the responsible officer regulations were Page 112

1 introduced, appraisal was in place some years before 2 that, and the action of the GMC was to then say that 3 once every five years, the responsible officer made 4 a recommendation that the doctor's licence should be 5 renewed but quite important within that system is that 6 one doesn't wait for the date of revalidation before 7 acting on any concerns. Concerns should be acted on as 8 they are raised. 9 Q. Yes, so that by the time one reaches the five years, 10 everything is satisfactory and any concerns have been 11 addressed, I assume? 12 A. Yes, exactly. 13 Q. Thank you. Are the doctors who work for the health 14 board NHS Lothian accountable to you then? 15 A. They are accountable to me in the sense that that's that 16 professional line of governance around the behaviours of 17 a doctor in line with the expectations of the GMC. 18 Q. I understood from a witness we heard from yesterday that 19 perhaps when one has, within a health board, resident 20 doctors in training, their medical director is 21 a different medical director who works within 22 an organisation called NHS Education for Scotland which 23 is now Public Services Delivery Scotland; is that 24 correct? 25 A. Yes. Page 113	1 Q. Thank you. NHS Lothian is a health board which is part 2 of the overall operation of NHS Scotland; is that 3 correct? 4 A. Yes. 5 Q. And NHS Scotland is effectively, as I understand it, 6 a bit of a delivery system of healthcare, and is the 7 means by which the Scottish Government exercises its 8 responsibility for promoting the health of the nation? 9 A. Yes. 10 Q. And ultimately, health boards are responsible to the 11 Scottish Government? 12 A. Yes. 13 Q. And specifically, does that mean that they report in to 14 the directorate for Health and Social Care? 15 A. I suppose, I would just wonder what you mean by "report 16 in". In terms of the chief executive, that would be the 17 most obvious reporting line. In terms of my own 18 professional supporting line, my responsible officer is 19 the chief medical officer in Scotland. 20 Q. Right, but I suppose the chief executive would report 21 into the directorate of Health and Social Care more 22 directly? 23 A. Absolutely. 24 Q. Yes, but you are nevertheless, as is the case with all 25 medical directors, accountable to the chief medical Page 115
1 Q. So, insofar as I'm asking you about doctors being 2 accountable, it's the other doctors that -- 3 A. It's the doctors that are employed by Lothian, yes. 4 Q. Yes, and it was also suggested that it might be possible 5 for certain doctors who work with a health board to have 6 different conditions of employment in terms of their 7 accountability to the medical officer. Is that 8 a phenomenon you recognise or is that not something 9 you've seen? 10 A. The only doctors that I could think of that that might 11 apply to might be those employed by the military. So we 12 do have a small number of doctors who are employed by 13 the Ministry of Defence but who are placed to work with 14 us and their responsible officer is somebody within that 15 military system. But there's a regular exchange of 16 information and if we appraise the doctor, the doctor 17 would provide the documentation about that appraisal 18 back into the military system. If they were appraised 19 in the military system, we would get that information 20 back. 21 Q. Thank you, but one might say, putting that to one side, 22 in the general run of things, doctors are accountable to 23 use the medical directorate; that's the way the system 24 works? 25 A. Yes. Page 114	1 officer; is that correct? 2 A. Professionally, they are my responsible officer but in 3 terms of my employment as a medical director, 4 I'm accountable to the chief executive. 5 Q. Okay and health boards are, as I have said, in the 6 business of improvement of health and the provision of 7 healthcare for their local area, is that right? 8 A. Yes. 9 Q. And do health boards, given that system, collaborate 10 with each other in order to try to raise the overall 11 standard of health within Scotland? 12 A. I would think that -- yes, I would agree with that. 13 Q. Yes, there presumably are initiatives that exist to try 14 to share information and to try to improve things where 15 there might be learning that could be passed around 16 within NHS Scotland as a whole, would that be right? 17 A. Yes, yes, that's definitely true. 18 Q. I mean, on a personal level or a professional level, do 19 you collaborate with other medical directors in order to 20 try to achieve those aims? 21 A. Yes. 22 Q. Is there a formal mechanism by which that's done? 23 A. There is an Association of Medical Directors in Scotland 24 which -- the membership of is slightly broader than just 25 the executive medical directors, and there are Page 116

1 important, I guess, connections that are made in that 2 that allow one to understand who might be facing similar 3 problems, who might have dealt with something else that 4 was similar in the past, as well as for us to work 5 collectively to say how could we approach a particular 6 problem. 7 Q. Understood, thank you. And just in terms of your 8 career, I think your statement tells us that you were 9 appointed as a consultant general surgeon at NHS Lothian 10 in 2004; is that correct? 11 A. Yes. 12 Q. And that you left Lothian in 2014 to take up the post of 13 executive medical director in NHS Forth Valley? 14 A. Yes. 15 Q. And you were there until 2017, is that right? 16 A. Yes. 17 Q. When you took up your current post? 18 A. Yes. 19 Q. Can you just tell us what a general surgeon does? 20 A. I can. I think a general surgeon. 21 Q. As succinctly as possible. 22 A. Of course, of course. The term has changed a bit over 23 time but it really means surgeons who deal, most 24 commonly now, with diseases in the abdominal cavity. 25 Q. Okay. You didn't provide us with a CV. You didn't have Page 117	1 help from some people. 2 I wondered whether -- if you could tell us why it 3 was determined that you should provide the response that 4 the Inquiry sent to NHS Lothian? 5 A. I suppose because a piece of work that was done that led 6 to me being incorporated into the Inquiry's Terms of 7 Reference was done within NHS Lothian's time and in my 8 role as NHS Lothian's Medical Director, but really, 9 I wouldn't say that there was any involvement from 10 anybody else within NHS Lothian in producing the report 11 that I did and therefore, when you asked those questions 12 I sought information and help from a number of people in 13 NHS Lothian to try to answer the questions. The 14 timescale of the Inquiry's Terms of Reference obviously 15 pre-dates me as a consultant and then as a more senior 16 member of staff. Therefore, I didn't have detailed 17 knowledge about some of the things that were in the 18 earlier timescale. 19 Q. Yes, thank you. As I say, you point out in the 20 statement in certainly at least one place that you got 21 some help with someone on the complaints policy, I think 22 at one stage. I presume you got some people to help 23 gathering in policies and documents that you sent, 24 through administrative services or something like that? 25 A. Yes, a board secretary helpfully gathered the documents Page 119
1 to, we asked you whether you would like to. Where did 2 you do your undergraduate degree? 3 A. In Bristol. 4 Q. And where did you train before you became a consultant 5 general surgeon in 2004? 6 A. So I spent five years training in Bristol. Once I had 7 graduated, so I did what my were then pre-registration 8 House Officer jobs in Bristol. I taught anatomy for 9 a year and I did two and a half years as a Senior House 10 Officer there and then I moved to Edinburgh and 11 undertook my -- a period of time in research and then my 12 higher surgical training in Edinburgh. 13 Q. Thank you. We asked you, as we ask everyone, whether 14 you had any involvement in the provision of services in 15 NHS Tayside, in particular Ninewells Hospital and 16 I think you told us you don't have any such experience? 17 A. I have never worked in Ninewells. 18 Q. Thank you. We asked you some questions about how 19 various systems work within NHS Lothian to try to 20 improve our understanding of the way things work within 21 the NHS more generally and in your response you've given 22 us a number of documents and in some places you've been 23 able to provide enlightenment based on your own 24 experience but in some other places you, I think, don't 25 know enough about it and in some others you've sought Page 118	1 that were available. 2 Q. Thank you very much. If I could have a look at your 3 statement, please, it's NHSL-00088. Again, there's some 4 aspects of your evidence about the way that the systems 5 work that are of interest to us and very helpfully 6 explained. Paragraph 3.2 please, page 2. One aspect of 7 the way that healthcare has developed, you helpfully set 8 out, at 3.2, a kind of historical narrative which does 9 pre-date your time, I think, but it's useful for us to 10 get our minds around at this stage. You say: 11 "The concept of NHS Trusts was introduced in the NHS 12 Community Care Act 1990. This gave power to create 13 Trusts, and to devolve functions of Health Boards to 14 Trusts. Trusts were autonomous organisations, with 15 their own Boards reporting to the Scottish Executive (as 16 then called). Health Boards were responsible for 17 commissioning services from Trusts public health, health 18 promotions, service co-ordinations and strategic 19 planning. The Trusts were responsible for implementing 20 the strategic plans of the Health Board by organising 21 and providing healthcare services, under the direction 22 of Trust Management Team. The Trusts were operationally 23 responsible for the delivery of healthcare services." 24 And then you go on, in paragraph 3.4 over the page, 25 to tell us that: Page 120

1 "In 2003 national guidance was issued via the Health 2 Department Letter ... with the intention to bring this 3 diverse model of health provisions to an end and replace 4 it with a single system of health provision. This 5 resulted in the dissolution of Trusts and staff, 6 property, rights and liabilities transferred back to the 7 Health Board. This essentially created the model of 8 delivery of healthcare similar to what we see today of 9 a Health Board responsible for the strategic planning, 10 governance, performance management, and operational 11 responsibility for the delivery of healthcare." 12 Then you tell us how that manifested itself in 13 Lothian. It's the generality of that that interests us 14 because obviously the period, as you've said, that we 15 are looking at goes back quite far to 1995. So do 16 I understand it from that, that there was a period, 17 which ended in 2003, in which rather than health boards 18 delivering operational healthcare services, there were 19 things called "trusts"? 20 A. Yes. Yes, there were and the trusts did the delivery 21 and what was called the health board at the time was the 22 overarching, more strategic commissioner. 23 Q. Yes, and is that -- we will come across this in the 24 Tayside context in the coming days so it's useful 25 context to us, if this is an area that you have some Page 121	1 we'll become familiar with later at paragraph 5.1, 2 page 5. This is in the context of telling us about the 3 way in which services and structures around neurosurgery 4 were delivered in Lothian, but you say, about halfway 5 through: 6 "Care of neurosurgical patients would be on a case 7 by case basis but could include the following associated 8 disciplines of neurology, neuroradiology, interventional 9 neuroradiology, neuro-anaesthesia and critical care 10 within medicine and from professional groups including 11 nurses, allied health professionals, radiographers and 12 physiologists." 13 In considering the question about how neurosurgical 14 care was delivered, you're making the helpful 15 observation that there are actually a number of other 16 medical disciplines that tend to be associated with 17 neurosurgery but also need to be delivered within 18 a health board to provide all the different aspects of 19 care that are required? 20 A. I think I am trying to say that, yes. 21 Q. Yes, and you've helpfully pointed out for us some of the 22 disciplines that would be most closely associated, 23 perhaps, with neurosurgery. I wonder if you could 24 broadly just tell us what these different types of 25 services are. So if we start with neurology? Page 123
1 understanding of. Effectively -- the services of the 2 trusts were effectively commissioned by the board to 3 deliver the healthcare operations, whereas as you say, 4 strategic and financial directions still stayed with the 5 trust, is that broadly the pattern? 6 A. That is my understanding. It does pre-date my time as 7 a consultant, so my understanding would be more limited, 8 I would say. 9 Q. Yes, but you've obviously helpfully done a little bit of 10 research here which is helpful to us to provide some 11 context. 12 THE CHAIR: Sorry, just to allow me absolute clarity on what 13 can, to some, seem like a complex arrangement. At its 14 most basic level, the trusts employed the doctors and 15 nurses and the health boards, effectively commissioned 16 their services? 17 A. Yes. So the trusts employed the doctors and nurses and 18 were independently, essentially, delivering those 19 services according to what the health board was asking 20 them to do. 21 THE CHAIR: Right. Thank you. 22 MR DAWSON: Thank you very much. Yes, you were asked some 23 questions about the way in which neurosurgical care was 24 delivered in the period in the Lothian area and in doing 25 so you've provided us some interesting concepts that Page 122	1 A. Yes, so neurology would be the medical specials about 2 neurological diseases, so a sort of partner specialty to 3 neurosurgery, where there's a consideration of surgical 4 interventions for those diseases. Neuroradiology is 5 a specialised area looking at particularly 6 cross-sectional imaging related to the brain and the 7 spine. Interventional neuroradiology is a subset of 8 that and involves, in particular -- so the 9 interventional part is usually delivered by a catheter 10 into a blood vessel to access vessels within the brain. 11 That can be to deal with a small -- a bleb on a blood 12 vessel which is at risk of causing bleeding. It can be 13 to deal with arteriovenous malformations that occur 14 within the very small blood vessels within the brain and 15 more recently has extended to mechanical thrombectomy to 16 remove clots which are not amenable to dissolution with 17 drugs, that are present early in the onset of a stroke, 18 which lead to significant improvement in the patient's 19 symptoms. 20 Q. Sorry to interrupt, but just on that, that would then be 21 a situation in which those types of interventions that 22 you've mentioned would be done by the neuroradiologist 23 rather than by another type of medical professional, is 24 that right? 25 A. Yes. Categorically, yes. Page 124

1 Q. Right. Sorry, neuro-anaesthesia? 2 A. Neuro-anaesthesia is, as the title says, it's 3 a provision of anaesthesia to patients undergoing 4 neurosurgical procedures. It's particularly important 5 to think about control of blood pressure and positioning 6 of the patient in that and then critical care, as 7 a separate discipline, is looking after patients who 8 require that enhanced level of physiological support. 9 Q. Thank you very much. And as far as the structures were 10 concerned, you also tell us in this section, 11 paragraph 5.2 that the paediatric epilepsy service has 12 been provided on a nationally commissioned basis for 13 Scotland by NHS Lothian since 2012. So that remains the 14 position, does it? 15 A. Yes. 16 Q. You were answering that question in the context of being 17 asked about your surgical services, so paediatric 18 epilepsy is something that would be associated again 19 with neurosurgery but what you're telling us, I think, 20 is that the service for that is delivered from a central 21 hub rather than in each health board, is that right? 22 A. So a small number of highly specialised services are 23 delivered for the whole population of Scotland and that, 24 within neurosurgery, is the only nationally commissioned 25 service that we would have. Page 125	1 rather than just looking internally. 2 Q. Okay, thank you. We'll come on to, perhaps, some other 3 specific aspects you mention in a moment. One might 4 have expected, perhaps from a patient's perspective, 5 that those type of systems would have been in place for 6 a lot longer than the period you have suggested they 7 have come in, in the late 1990s. The fact that this has 8 come in suggested there was something different before. 9 What is the history before that? Were these things 10 delivered in a different way, or were they simply in the 11 part of the way that medicine was approached? 12 A. I think they were probably less formalised and less 13 reported on. Many people would consider the inquiry 14 into the Bristol cardiac surgery events as really the 15 start of a more formalised process around clinical 16 governance. 17 Q. You may not realise this, but you're the second witness 18 from Bristol today and the second witness to mention 19 that particular inquiry. So the particular aspect that 20 you go on to mention, as an innovation within clinical 21 governance at paragraph 7.3, is: 22 "[The] protection of whistle blowers came in in 1999 23 [as a result of] the Public Interest Disclosure Act 1998 24 with the further developments in Scotland as detailed 25 below." Page 127
1 Q. Okay, and that does remain the position to this day? 2 A. Yes. 3 Q. Thank you. Could I ask you, please, to go to page 8 of 4 the report, paragraph 7.2. Right at the bottom of the 5 page, thank you very much. You were asked there whether 6 you could give an indication about the broad systems of 7 clinical governance in place in NHS Lothian over the 8 relevant period. And you tell us that: 9 "Clinical governance, both conceptually and in 10 demonstration has changed significantly between 1995 and 11 2015. It is generally taken to have developed in the 12 late 1990s." 13 I wondered whether you could tell us how, broadly 14 speaking, given that clinical governance is 15 a responsibility of yours as the medical director, what 16 the key developments in clinical governance have been 17 over that period since it developed in the late 1990s? 18 A. I think one would summarise those as a greater level of 19 involvement of other disciplines. So considering 20 clinical governance events in a multi-disciplinary way 21 rather than only within single professional groups, 22 being more open and transparent with patients about 23 events that have gone on and a greater focus within 24 thinking about effectiveness in benchmarking information 25 with other delivery units providing similar services Page 126	1 And you suggest that a "PIN Whistleblowing Policy" 2 came in, in 2011. What was the PIN whistleblowing 3 policy? 4 A. These are policies that -- sorry, I have gone blank as 5 to what "PIN" stands for. It commonly refers to 6 policies that are delivered within Scotland where 7 essentially there's a desire to have policies that are 8 the same for all employees within Scotland. They're 9 developed in partnership -- I have a sense that the "P" 10 may relate to being developed in partnership. I suppose 11 the purpose of those policies is to provide appropriate 12 protection to those who raise concerns where they fear 13 there may be detriment to them through raising concerns. 14 But the evolution of the policies really relate to that 15 really broader need to hear where there are concerns and 16 understand what those concerns are and to look at those 17 concerns appropriately and to act on the findings. 18 Q. And then you say in 2015 there was another invasion in 19 the appointment of "whistleblowing champions". Is that 20 a concept that you could explain to us? 21 A. My understanding is this was a Scottish Government 22 proposal that there was a non-executive member of the 23 board who really led -- or oversaw rather than lead, 24 oversaw the processes relating to whistleblowing and 25 prior to that, the whistleblowing champions within Page 128

1 boards were individuals who were highlighted as 2 appropriate people who could be approached with 3 a concern where that wasn't being listened to and 4 understood within any staff member's normal mechanisms 5 for raising concern, which would be with their line 6 manager. 7 Q. Okay, thank you. 8 THE CHAIR: What sort of people are we talking about who 9 could occupy that? 10 A. In terms of the whistleblowing champions? 11 THE CHAIR: Yes. 12 A. So it was usually reasonably senior members of staff, 13 who could be -- 14 THE CHAIR: Medical staff? 15 A. All different types of members of staff actually, not 16 just medical staff, but nursing staff, colleagues in 17 general management roles, as identified as people who 18 concerns could be brought to. 19 THE CHAIR: Okay, thank you. 20 MR DAWSON: Is it correct to say that, as you say, the 21 protection of whistleblowers seems to have started in 22 1999 but the policy that you've mentioned there as being 23 a significant landmark in Scotland didn't come in until 24 2011. There seems to be something of a gap there. Is 25 there any reason for that or any significance in it? Page 129	1 a new consultant contract in 2004 seems to be something 2 of a milestone. Could you give us some indication as to 3 what that involved? 4 A. I can try. I was not employed as a consultant before 5 2004 so I was not one of the people who moved from the 6 old contract to the new contract. 7 Q. I was just checking you, in fact, became a consultant in 8 2004? 9 A. That's right, so I did not have something that was 10 a contract under the old contract, but my recollection 11 is that the old contract involved 11 sessions and those 12 were distributed differently across the days of the 13 week. The new contract -- 14 Q. Just to pause there, sorry. You mentioned sessions. 15 What would a session be? 16 A. It would normally be a half day. So 11 sessions would 17 be -- and obviously some people would choose not to take 18 up all 11 sessions. 19 Q. Right. 20 A. But I am working on recall, rather than factual -- 21 Q. Does that mean one required to work 11 half days in 22 a week? 23 A. One could, if one had a full-time contract, work 24 11 half days in a week because obviously the way teams 25 were structured then, it was much more common for Page 131
1 A. I don't have any knowledge of that. 2 Q. Right, it does also seem that, even over the later 3 period, that the key landmarks that you've pointed out 4 show perhaps a slow evolution of that aspect of clinical 5 governance; would that be a fair impression? 6 A. I see the gaps in the timeline, so I understand why 7 you're pointing that out. The INWO, the officer is the 8 same as the Public Services Ombudsman, they are the same 9 individual and I don't really have any knowledge about 10 what discussion there was behind the scenes that led to 11 that post being created. 12 Q. I see, thank you. You also were asked and give us 13 a view in paragraph 7.4 on professional governance and 14 that touches on the matters we discussed earlier about 15 the introduction of the responsible officer and the 16 appraisal process that we discussed. Paragraph 7.5, you 17 were asked about, again within NHS Lothian, systems 18 about patterns and rule to do with work. An aspect of 19 your response which is just interesting to us is that 20 you suggested that job planning was introduced as part 21 of a new consultant contract in 2004, the formal job 22 planning framework was only developed in 2013 and you 23 say you can't recall what formal documentation and 24 arrangements were prior to that. 25 Again, the introduction of job planning as part of Page 130	1 consultants to come in to see their own patients at 2 weekends. 3 Q. Okay, and does that include what we now call "on-call 4 obligations" or does that not? 5 A. That does -- well, I did not ever have anything on the 6 old contract, so I couldn't answer for sure. 7 Q. Understood. But in terms of the changes, what you did 8 experience what the new contract. So what did that look 9 like? 10 A. So the new contract set out normal working hours, was 11 based on ten sessions and the new contract specifies 12 some time that are -- some times between 8 am and 8 pm 13 that are considered normal working times and what are 14 called "PAs", the time-block of four hours are fitted 15 into those days. So some people might work 16 a three-session day that would be from 8 am till 8 pm. 17 That would be unusual but it does happen. 18 Q. I see, so is that what you mean by "job planning" as 19 being the innovation? 20 A. So job planning as part of that contract, my 21 understanding of the change of the contract there was 22 greater visibility of where consultants were and what 23 they were doing on a day-by-day and week-to-week basis. 24 Q. I see. 25 A. And a -- more formalisation around providing Page 132

1 an identified individual who was available in the 2 out-of-hours period. 3 Q. I see, so something more akin to a rota that you might 4 see somewhere else, you would know that a certain person 5 would be in at a certain time, doing certain tasks? 6 A. Yes. 7 Q. Whereas before, one committed to doing a certain number 8 of sessions but when one did that was one's own 9 responsibility, is that right? 10 A. I suppose the old contract had been in evolution for 11 some time. I don't know when it came in, I'm afraid. 12 So I imagine that there was a change over time. 13 Q. Yes, but the move was more towards there being more 14 visibility when people were working at any given time, 15 as opposed to a freer system, perhaps? 16 A. That's exactly right, yes. 17 Q. That's very helpful, thank you. 18 THE CHAIR: And howsoever that was arranged, or whether 19 when, during the working week, at again, it's most basic 20 level, we're looking at a 40-hour week, are we? 21 A. Yes. 22 THE CHAIR: So 10 times four hours? Yes. 23 MR DAWSON: You were also asked -- this was the area 24 I touched on earlier -- about what complaints systems 25 might have looked like in NHS Lothian over the relevant Page 133	1 someone with a similar level of responsibility, maybe 2 a site lead nurse, but they should be signed off at 3 a senior level. 4 Q. Another aspect of that which comes up in other places is 5 "Datix"; what's that? 6 A. It's a system by which we manage complaints. It also 7 holds information about adverse events and about 8 litigation cases. 9 Q. Excellent, thank you very much. Is that used across all 10 health boards in Scotland, as far as you're aware? 11 A. I think not all. I think nearly all, but not all. 12 Q. So it's one that's available, you can take it up if you 13 want to, but you don't have to? 14 A. Yes, and then obviously all these systems -- there's 15 a level of individual configuration. So how one board 16 use as system might differ from how another board uses 17 that system. 18 Q. I think Datix is something -- you sometimes see it in 19 the context of "a Datix" or something is referred to as 20 something where something has gone wrong or there's 21 been, as you say, an adverse event. Effectively, what 22 that means is it's been logged on the Datix system; is 23 that right? 24 A. Yes. 25 Q. Paragraph 7.12. Again, you were asked questions about Page 135
1 period which I think we defined as 1995 to 2015. And 2 this was the area where you got some help from 3 NHS Lothian's head of patient experience which, you say, 4 was in line with your own experience anyway, where you 5 say: 6 "All staff are encouraged to deal with complaints 7 and these should be investigated and responded to (where 8 possible) within 20 working days. The NHS Lothian 9 Complaints Policy, sets out roles and responsibilities 10 for all staff who are involved in complaints handling, 11 encourages team to learn [them to learn, I think 12 probably] from complaints and the policy also offers 13 advocacy services to support people to make complaints. 14 DATIX is the complaints document management system. The 15 NHS Lothian Complaints Team offered a 'single point of 16 contact' to make it easier for the public to contact the 17 organisation and this could be either in writing, face 18 to face or by telephone." 19 So in that, you tell us that was a certain 20 expectation that where complaints came in, they would be 21 responded to by the staff member to which they related, 22 or would be responded to by NHS Lothian? 23 A. They should be responded to by a senior member from 24 NHS Lothian, that's who would ordinarily sign off the 25 complaint. Ordinarily, that would be a site director or Page 134	1 the systems in place regarding investigations into the 2 professional practice of consultants and you referred 3 us, in particular, to: 4 "Policies regarding the investigation and 5 disciplinary action against a doctor are set out in NHS 6 Circular (1990) 8 with amendments in NHS Circular (1990) 7 32." 8 So would those have been documents issued by the 9 government setting out the expectations as to how 10 disciplinary matters and the investigation of them 11 should be handled? 12 A. Yes. 13 Q. So there would be expected to have been a consistency in 14 that regard across Scotland? 15 A. Yes. 16 Q. Thank you. You were also asked what policies may exist 17 relating to particular facets of neurosurgical 18 practice -- we get quite specific there, by the time we 19 get to page 12. In paragraph 8.1, you told us that: 20 "[You weren't] aware of the policy to assess 21 Neurosurgeons' technical surgical skills in NHS Lothian 22 between 1995 and 2015." 23 But you do tell us that: 24 "During this time period, the systems in place 25 within all areas of surgical practice were principally Page 136

1 local morbidity and mortality meetings. A clearer 2 organisational approach to these meetings in NHS Lothian 3 was not developed before 2015. The Scottish Audit of 4 Surgical Mortality ran from 1994 to 2015 and included 5 neurosurgery. NHS Lothian participated in this. ISD 6 Scotland now Public Health Scotland [managed] the 7 Scottish Audit of Surgical Mortality and are better 8 placed to provide further information to the Inquiry. 9 "NHS Lothian currently works as part of the 10 Neurosurgical MSN who audit outcomes against agreed 11 standards ..." 12 So there's various components there, all parts of 13 the system, as far as I can make out. 14 You say, in relation to the maintenance or the 15 monitoring and the promotion of technical surgical 16 skills, there were, over this period, local morbidity 17 and mortality meetings but certainly, at NHS Lothian, 18 the organisational structure of those may have been 19 clarified at the end of the period we were looking at. 20 When you say "local morbidity and mortality meetings" 21 first of all, what do you mean by "local" and secondly, 22 how did these meetings contribute towards trying to 23 promote surgeons' technical skills? 24 A. So when I say "local", I really mean, in the main, 25 within a particular team. So a team within general Page 137	1 technical -- not necessarily skill, but to choices that 2 have been made maybe around a particular approach, or 3 a way something has been undertaken and that is the 4 opportunity for the surgeon to try to articulate why 5 they did what they did, and to hear views from other 6 colleagues that might involve a different approach. 7 Q. So certainly, in surgery, where I think you said this 8 concept started before it became applied more widely, 9 this was an important component of the way surgical 10 services were delivered, is that right? 11 A. It is. It's also important that that's how, if you were 12 discussing wound infections, you, as a team you might 13 pick up that there was a particular issues emerging 14 about wound infections. That would make the team 15 consider what was the interoperative practice, whether 16 things related to any antibiotics that were being given, 17 before procedures that needed to be changed, were there 18 any elements of post-operative care that needed to be 19 changed. 20 Q. Okay, thank you. And I think what you're telling us is 21 that after, from about 2015, there was more 22 organisational structure about how these meetings were 23 organised but before that, they were more local, in the 24 sense of being organised within a particular team. 25 Different teams might have them, but they might run them Page 139
1 surgery working within one hospital. On occasions, 2 there can be meetings that are held to consider a longer 3 time period between different -- involving more than one 4 team. And they really are looking at complications that 5 have occurred and some teams will look at those on 6 a weekly basis. It is something that has come from 7 a surgical discipline of practice but is now 8 incorporated into other areas. So in particular, within 9 interventional areas of practice, it's very important 10 and tends to happen more frequently than within more 11 medically-based specialties such as medicine of the 12 elderly, where there are still important complications 13 and poor experiences to discuss and learn from, but the 14 way those cases are selected might be different. That 15 really is the piece of work that I'm referring to that 16 comes after 2015 but we have attempted to introduce 17 a clearer structure around expectations within the 18 organisation. 19 Q. So first of all, these meetings were, in the period that 20 we are looking at, an important component of trying to 21 discuss matters within a team and to promote the 22 standard of surgery and technical skill; is that 23 correct? 24 A. Well, that is where a complication would be discussed. 25 And some complications may be attributable to Page 138	1 slightly different ways, would that be fair? 2 A. I think that is still actually likely to be the case. 3 Different teams will still run those meetings 4 differently because actually, this is a process that 5 needs to be owned at a local level. It can't really be 6 imposed from on high within the organisation, if you 7 want to think of it like that. The actual team who are 8 looking after the patients need to participate 9 meaningfully in the process. 10 Q. Thank you and you then, in this paragraph that I read 11 out, talk about some audits of surgical mortality that 12 took place. What was the relevance of those to the 13 question relating to policies about the promotion of 14 surgical skill and quality? 15 A. Well, they are -- my recall of that system was that it 16 didn't involve peer review. It only looked at cases 17 where the individual had died, but there was a form that 18 was completed by the surgeon, and that was then sent off 19 for peer review, and that peer review had the potential 20 to identify whether there was any technical shortcoming 21 that was obvious to a peer from within that discipline. 22 Q. I see. And that took place between 1994 and 2015 so 23 very much the period that we were looking at. And as 24 far as peer review is concerned, would that be a peer 25 within the same team or the same health board or someone Page 140

1 outside? 2 A. No, I think it was outside. I think it was outside the 3 health board. It was organised through the College of 4 Surgeons in Edinburgh, they had an office who 5 administered the allocation to reviewers. 6 Q. And would that cover oral surgical mortality? 7 A. I can't recall whether there are any particular surgical 8 disciplines which were excluded, but it did -- I'm as 9 sure as I can be, to put it in my statement -- cover 10 neurosurgery. 11 Q. That's very helpful, thank you. You then go on to say 12 that: 13 "NHS Lothian currently works as part of the 14 Neurosurgical MSN who audits outcomes against agreed 15 standards ..." 16 This is something that I've mentioned earlier in the 17 week is the Managed Service Network for neurosurgery, as 18 I understand it. Could you tell us broadly what that is 19 and if you know, how long it's been around? 20 A. I think the document that is referred to, or the 21 following document, does reference the creation of the 22 MSN, which -- the reason why I mention it in this 23 paragraph is they do undertake benchmarking about 24 individual neurosurgery consultant outcomes. So that 25 information is -- that's why I was trying to point that Page 141	1 so I do think that is exactly what the MSN is trying to 2 achieve in this and that is to understand, from the 3 outcomes that they look at, which may be limited, that: 4 do you get comparable results between Edinburgh and 5 Dundee, or Edinburgh and Aberdeen. 6 THE CHAIR: I don't want to distract you too far from your 7 script, but when you're talking about outcomes, one 8 example might be readmission after surgery; is that the 9 sort of thing that one is looking at? 10 A. Yes, that type of thing. 11 THE CHAIR: Yes, right. Thank you. 12 MR DAWSON: And other set matters being monitored? 13 A. Well, the MSN set the standards that they monitor to. 14 Q. So you might include -- things like mortality, might be 15 included in it? 16 A. You might. I think the important thing will be to be 17 sure that you were clear about the definition of what 18 you were measuring, so that you are measuring the same 19 thing across organisations. 20 Q. Yes, to meet the benchmarking of value, at the end of 21 the day? 22 A. Yes. 23 Q. You mentioned, I think, that as a medical director you 24 would want to see that. Obviously it would provide 25 useful data to try to, as I think you said, point out Page 143
1 out as something -- although it's not an in-theatre 2 assessment of a technical surgical skill, if there was 3 an outlier in terms of their outcomes, that's where, as 4 a medical director, I would expect to see that. 5 Q. And would that apply to all neurosurgeons? 6 A. In Scotland, yes. 7 Q. In Scotland, yes. And this, I think, as I understand 8 the Managed Service Network, it was a system that came 9 in to try to create more consistency and improve 10 standards Scotland-wide, that would then filter down 11 into individual the individual -- I think were delivered 12 from four different places in Scotland. Is that broadly 13 the pattern? 14 A. Yes. 15 THE CHAIR: Sorry, Mr Dawson, I wonder if I could just ask 16 about the term "benchmarking" that you've used and it's 17 cropped up a number of times. And you may have an idea 18 as to what it means and I think your reference to 19 an outlier might hint at what it means, but can you just 20 make it clear to us what "benchmarking" is and what it 21 achieves in the context of this organisation? 22 A. Yes. So by "benchmarking" we would normally mean we're 23 trying to compare the same thing between different 24 organisations to see whether the same, broadly speaking, 25 outcomes within an acceptable range are achieved. And Page 142	1 whether any outliers or any patterns or issues that 2 might require your attention. But is it the case that 3 that can't be everything you look at to try to determine 4 whether a service is being delivered to an appropriate 5 standard, would that be fair? 6 A. Yes, that's fair. 7 Q. So what are the limitations of just looking at the data 8 and not considering other aspects of the care that's 9 being provided? 10 A. So obviously it sort of refers to the earlier comment 11 really. That type of benchmark data is looking at 12 a very small number of clearly measurable outcomes and 13 that does not include things like experience, it doesn't 14 usually include measures that might pertain to safety. 15 It's really about the effectiveness or otherwise of 16 interventions. There are a number of these type of 17 measures that are well developed, so I could give you 18 an example from transplant services where, for both 19 liver and kidney transplant services at a UK level, 20 there are particular measures that are monitored. But 21 if one's own organisation comes up as an outlier within 22 that monitoring, you very much need to look and 23 understand why that has happened, what is going on. And 24 it is almost always related to the whole team function 25 rather than the individual surgical intervention from Page 144

1 the surgeon. That's why the delivery of the services is 2 very much a function of the whole team, not just the one 3 individual. 4 Q. Okay. Did you say that it doesn't measure safety? 5 A. It doesn't measure some of the more processed measures 6 around safety that we would think about. So are 7 antibiotics given on time? Do we have an appropriate 8 bundle around looking after both peripheral and central 9 lines? Some of those more processed matters. 10 Q. I'm just trying to think if it can be possible to sort 11 of hypothesise an example because I think something I've 12 seen in benchmarking in some surgical contexts would 13 involve a situation where one of the matters that would 14 be being monitored would be the amount of time that 15 might -- or the number of people or the amount of time 16 that might elapse for people who have to come back for 17 further surgery, in a surgical context that. That might 18 be a metric that would tell you something statistical, 19 but it might not tell you very much about the reasons 20 why that was happening. Would that be the sort of idea 21 that it's not really telling you very much about safety; 22 would that be correct? 23 A. Possibly. Maybe I phrased that poorly. 24 Q. This is an interesting phenomenon because it is -- 25 benchmarking does come up quite a lot and it seems to Page 145	1 expectations of the GMC for all doctors for revalidation 2 purposes from 2012 onwards." 3 You say that before that, over the page: 4 "... a questionnaire developed by the MSN from 2009 5 was used for out patients. Neurosurgical MSN may be 6 able to provide this information to the Inquiry." 7 So just to understand, would that -- would a patient 8 satisfaction questionnaire be expected to be given to 9 every patient? 10 A. That's why I have referred, in my statement, to the MSN 11 because I don't really have any more detailed 12 information than that. The reference about patient 13 satisfaction questionnaires more broadly relates to the 14 expectations of the GMC, as I've said, but I did check 15 with a neurosurgery colleague and that's where I got the 16 information from that they were -- there was actually 17 some testing of patients' experience of receiving care 18 within neurosurgery before that. 19 Q. But as far as the general situation was concerned, from 20 2012, there was an expectation that patients would be 21 sent patient satisfaction questionnaires. Is that all 22 patients? 23 A. No it's not all patients. No. No. It's -- the GMC's 24 expectation is that the views of about 25 patients are 25 sought. Now, that is a very arbitrary number. It is Page 147
1 be -- would it be wrong, put it this way, to look at 2 these benchmarking data and think, for example, as 3 a medical director: that's all I need to look at and 4 everything seems to be within the parameters, so 5 everything is being delivered safely? 6 A. Yes, that would be far too limited. One needs to take 7 into account many more things in understanding how well, 8 or otherwise, a particular service or team or system is 9 functioning. 10 Q. It's not irrelevant to that question but it is merely 11 a part of a much bigger data set or information set one 12 would need to look at; is that correct? 13 A. Yes. 14 Q. Thank you very much. And one other aspect that you 15 mentioned helpfully here -- not something I have come 16 across before, but I wondered if you could tell us 17 something more about, if we're not stretching your 18 neurosurgical understanding too far -- is in 19 paragraph 8.2 where you tell us that: 20 "[You are] not aware of a policy to assess 21 neurosurgeons' patient care including communication with 22 patients in NHS Lothian ..." 23 Over the relevant period. But you do tell us that: 24 "Neurosurgeons in NHS Lothian used patient 25 satisfaction questionnaires in line with the Page 146	1 quite difficult to apply within small teams sometimes, 2 where a patient may see many different team members and 3 so we -- I think, as a responsible officer, I wouldn't 4 be too fixated on the number. What is important to me 5 is that the individual doctor has made an effort to 6 understand how patients experience care coming from 7 them, preferably directly rather than as part of 8 a team, and they've reflected on the findings of that to 9 think about are there any things that they could or 10 should do differently. 11 Q. Okay, thank you for that. 12 THE CHAIR: Is that a representative example across a period 13 of, what, a year? 14 A. No, it's usually done in a shorter time period than that 15 but sometimes it can be done over a few weeks depending 16 on how many individuals a patient sees. 17 THE CHAIR: I see, but is this part of a process of 18 reporting to the GMC that is regular and, if so, how 19 regular? 20 A. The GMC has an expectation that it happens once in each 21 five-year cycle. 22 THE CHAIR: That's what I heard you say earlier, I wondered 23 if it was part of that timescale? 24 A. So. 25 THE CHAIR: I'm trying to put into context the relevance or Page 148

1 importance of the sampling of 25 patients in the 2 questionnaires. 3 A. I think what I'm trying to say is that 25 is a rather 4 arbitrary number and some doctors will see hundreds of 5 patients in a year and other doctors will see far fewer. 6 THE CHAIR: But this is per doctor? 7 A. Yes. Yes. 8 THE CHAIR: Okay. All right, I'll leave it there. 9 MR DAWSON: But that's linked into regulatory requirements 10 on doctors rather than it being something that's 11 delivered through the sort of more service side of 12 a hospital? 13 A. Yes. 14 Q. That's interest. Thank you. Obviously we have a number 15 of questions for you about the 2018 report which is 16 I think the reason why you told us you were nominated to 17 answer the Rule 8 requests that were sent to the board. 18 If we could go please to paragraph 9.1 of the report 19 which is at page 13. You were commissioned, I think in 20 2018, in your capacity as Executive Medical Director of 21 NHS Lothian, to write a report about matters relating 22 to -- broadly relating to the position with 23 Mr Sam Eljamel who was a consultant neurosurgeon in 24 NHS Tayside, is that right? 25 A. Yes. Page 149	1 attending in my capacity as Chair of Medical Directors. 2 Q. You say you were approached by them following a meeting, 3 does that mean they spoke to you in the corridor or 4 something or was there a more formal approach? 5 A. That would be basically it. 6 Q. Yes, okay. So they made an informal approach to you, 7 saying that, in that context, they were interested in 8 asking you to do this piece of work? 9 A. Yes. 10 Q. And I think you told us this already actually, but 11 I think you said that the work was done sort of on 12 NHS Lothian's time, if I could put it that way, very 13 much in your capacity as the Medical Director of 14 NHS Lothian; is that right? 15 A. Yes. 16 Q. Is this something you've ever been asked to do before or 17 since? 18 A. I don't think I'd been asked to do it before. 19 I actually would need to think quite carefully whether 20 I have done -- I have never done anything that's sort of 21 had the ramifications that this has had before or since, 22 but it would be not uncommon, as a medical director, to 23 be asked to, say, review a situation or participate in 24 a broader group of people who were doing something. 25 Q. And so there's no formal system or anything like that Page 151
1 Q. And in this paragraph, you tell us how that commission 2 came about. You tell us that: 3 "The report was commissioned by Malcolm Wright and 4 Annie Ingram (the then NHS Tayside Chief Executive and 5 depute Chief Executive respectively). I was approached 6 by them following a meeting in September 2018 and asked 7 to review how NHS Tayside had learnt from the concerns. 8 The request was to me as a current Medical Director 9 without any expectation of the involvement of any other 10 reviewer ... the emphasis in the conversation was on the 11 approach taken by NHS Tayside and whether there were any 12 opportunities to improve that. There was no 13 instructions provided to me beyond the Terms of 14 Reference [letter of] 19 November 2018." 15 How did it come to be, as you understood it, that 16 they approached you in particular to undertake this 17 task? 18 A. Well, I was the Chair of the Scottish Association of 19 Medical Directors at the time. So I'm not clear whether 20 it was in that capacity or whether it was because I was 21 a medical director of a board that involved neurosurgery 22 or that I had a surgical background myself. 23 Q. Okay and there's mention here of there having been 24 a meeting in September 2018, is that right? 25 A. That was a board Chief Executives meeting that I was Page 150	1 for one health board in Scotland to approach the medical 2 director of another health board to say: would you have 3 a look at something that's happened and -- within our 4 work and could you tell us what you think? 5 A. Well, there are medical director participants in groups 6 looking at areas of service provision. Looking at areas 7 where things have gone wrong or not happened in the way 8 that's intended, I'm not aware of any formal system to 9 identify somebody. But there may be a mechanism through 10 Scottish Government to suggest people. 11 Q. And you mentioned earlier the possibility that -- 12 I think you're speculating but it's possible they might 13 have approached you because you're the medical director 14 of a board which had neurosurgery within it and I think 15 not all do because there's the four neurosurgical 16 centres, so there are some places that do not offer 17 surgery neurosurgery. But what was the significance of 18 that, in light of what, at least in these initial 19 stages, you understood they were going to ask you about? 20 Because essentially they were, as I understand it, 21 asking you to talk about really more of a clinical 22 governance function, if you like, so how had they 23 handled it? 24 A. My understanding of what they were asking me to do was 25 to be quite specific about whether there were Page 152

1 opportunities that, at a senior level, Tayside could 2 have done things differently, and to consider whether 3 there was any learning that they needed to take from the 4 way things had been handled. 5 Q. Are you aware of there being any other mechanisms by 6 which a review of that nature could be instructed other 7 than this slightly unusual approach? 8 A. So I'm obviously aware of the Royal College of Surgeons' 9 invited review that was undertaken that was more 10 specifically into areas of clinical practice. 11 Q. For example, I'm touching on something that's associated 12 to that. We actually heard this morning in fact the 13 review that was done, which I know you're aware of, in 14 2013, was an individual review, so as you say, it was 15 more clinical in nature. But the Royal College of 16 Surgeons also offers a different type of review which is 17 called a "service review" which is more systemic, which 18 I think would be more akin to the sort of thing they 19 were suggesting that you should look into. 20 So, would that have been an appropriate mechanism 21 for this sort of thing to be looked into? 22 A. So I am aware of that mechanism that the College of 23 Surgeons in England now have because I have commissioned 24 one of those myself, but whether that was available in 25 2013, I actually don't know. And I don't think that the Page 153	1 Q. When you say "somebody from our side" -- 2 A. Somebody from outside, sorry. 3 Q. Sorry, that's quite an important distinction. 4 A. Yes. 5 Q. So did you understand that the mission, as it were, was 6 to try to assist them in that task of being able to 7 demonstrate to the board what had happened? 8 A. I understood that I was being asked to look at what had 9 happened with fresh eyes. I did not really detect that 10 it was to -- there wasn't really any sense of constraint 11 over what I could say. It didn't have to be helpful in 12 terms of assisting. 13 Q. So did you feel -- or did you understand that what they 14 were commissioning was an independent report? 15 A. Well, as an independent, I am from within NHS Scotland. 16 I'm not -- so within that sense, I'm aware that the word 17 "independent" has a number of connotations. 18 Q. Well, that's very interesting you should say that 19 because as a result of you understanding that context, 20 coming out of a meeting, I think, with other medical 21 directors from other health boards all from NHS 22 Scotland, I think you told us, would it really have been 23 possible for you to give a properly independent report, 24 if I can put it that way, such as one might have got 25 from an external agency with no contact from within NHS Page 155
1 review that I was asked to do was as extensive as that. 2 I would expect that to be. 3 Q. Was there any payment made at all in connection with the 4 review that you did, to you or the board? 5 A. No. No. 6 Q. You say in the statement, the way -- the words you use 7 are that the contemplated review that you were told 8 about was to review "how NHS Tayside had learnt from the 9 concerns". What did you take that to mean at that 10 stage? 11 A. I took that to mean what they -- whether they had any 12 understanding of the way events had played out and what 13 they had changed as a result of that. 14 Q. Right. Were you aware, at this time or any time, 15 whether there had been any particular trigger or reason 16 for this being asked for at that particular period? 17 A. In 2018? 18 Q. Yes, as opposed to earlier, for example? 19 A. No, I was not and I don't know whether it related -- 20 I don't know when Malcolm Wright started in that post, 21 whether that related to him starting and wanting to be 22 able to -- my recall of the words that were used is that 23 they wanted to be able to demonstrate to the board that 24 there had been consideration from somebody from outside 25 about the way things were handled. Page 154	1 Scotland? 2 A. So, no. Not if you look at it from outside like that. 3 I suppose they knew what they were -- they knew who they 4 were asking. I was not unknown to them. So I think 5 it's -- the independence that I understood that they 6 were seeking was somebody who was not part of 7 NHS Tayside and not part of neurosurgery, rather than 8 somebody from outside NHS Scotland altogether. 9 Q. I understand. And by this point in time, did you have 10 an existing awareness of Mr Eljamel, what had happened, 11 the current state of, sort of, political activity around 12 the treatment he had given to his patients, anything 13 like that? 14 A. Only from press coverage. 15 Q. And what was your understanding between the period you 16 were originally approached and you took up 17 the commission, about what the position was in that 18 regard? 19 A. That it was extremely difficult. That there were 20 a large number of patients who had had treatment that 21 was not as they understood it had been, and that there 22 were a large number of complaints that were coming 23 forward. 24 Q. And did -- were you aware of certain key elements of 25 Mr Eljamel's story, in the sense that were you aware of Page 156

1 the fact that he had been under a period of clinical 2 supervision, for example? 3 A. Until I received the documentation that I was sent, no. 4 Q. And even more broad than that, were you aware of the 5 fact he no longer worked at NHS Tayside, for example? 6 A. I think I was aware of, yes. 7 Q. Yes, okay. Were you aware of the fact that, for 8 periods, on certain accounts some years before this, 9 campaigners had been trying to push to have a public 10 inquiry into matters relating to Mr Eljamel's 11 professional practice? 12 A. In the time between the events I was asked to look at 13 and that -- 14 Q. In the time period between the events that took place up 15 to 2013, '14, '15 and the time you were being 16 commissioned, there had been calls for a public inquiry. 17 Were you aware of that? 18 A. I'm not sure that I know that there was cause for 19 a public inquiry. I do know that there was a lot of 20 press coverage around really significant levels of 21 concern. 22 Q. I see, amongst patients? 23 A. Yes. 24 Q. And did you join the two together and think that perhaps 25 it was that public concern that they were asking you to Page 157	1 A. Yes. 2 Q. By Dr Annie Ingram, is that right? 3 A. Yes. 4 Q. Just scroll back a bit further. It says here: 5 "Hi there. 6 "Further to the recent enquiries regarding 7 neurosurgery, the Chief Executive has confirmed that 8 NHS Tayside need to ensure that there is 9 organisation-wide learning from this case. To that end 10 he has asked Miss Tracey Gillies, Executive Medical 11 Director of NHS Lothian to review the process and 12 decision-making in this case to determine if there are 13 improvements that we could make going forward and if 14 there is learning for the Board." 15 So this is being forwarded on to you, but I assume 16 it's also providing you with a bit more information as 17 to what it is they're looking for. Is that perhaps the 18 purpose of it being forwarded to you? 19 A. I presume so, yes. 20 Q. Yes, because by this point, you have a kind of vague 21 idea what it's about, but this is providing a bit more 22 information? 23 A. Yeah. 24 Q. The principal intention, it would appear to be, was to 25 try to ensure organisational learning; is that right? Page 159
1 provide a report in response to? 2 A. No, I did not have any understanding. That's not what 3 I understand I was being asked to look at. 4 Q. I understand, but there was no other reason proffered, 5 I think you said at any time as to what the trigger was, 6 if there was one, other than this need to show something 7 to the board? 8 A. That was the only reason that was given to me. 9 Q. Understood. Sir, that would be a convenient moment for 10 a break. 11 THE CHAIR: We're going to take a 15-minute break at this 12 point. Ms Miller will just take you back to the witness 13 room. If I could ask you, just for the sake of good 14 order, not to discuss your evidence. We'll resume again 15 in about 15 minutes time. Thank you. 16 (3.13 pm) 17 (A short break) 18 (3.25 pm) 19 THE CHAIR: Thank you, Mr Dawson. 20 MR DAWSON: Thank you, sir. Ms Gillies, we were looking at 21 and talking about the circumstances of your instructions 22 to conduct the 2018 review. Could we look, please, at 23 NHSL-00006, please. I think this is an email that was 24 forwarded to you for your information on 25 12 September 2018, is that right? Page 158	1 Certainly expressed here? 2 A. Yes. That's what I understood, yeah. 3 Q. Indicating perhaps that there was some level of 4 acceptance that things hadn't gone, in a clinical 5 governance sense, quite as they should have, is that 6 right? 7 A. I think it may have been broader than just the clinical 8 governance aspects. 9 Q. The thing is that, by this stage of course, as we'll 10 come on to see, and you were sent, there has been the 11 Royal College of Surgeons' review. But what we know 12 about that was it was principally an individual review 13 into clinical matters relating to Mr Eljamel's practice, 14 although there was some commentary on the clinical 15 governance side. 16 A. Yes. 17 Q. So what I'm trying to investigate is perhaps whether 18 what's happening here is they're trying to -- they've 19 taken some time to realise that there may be clinical 20 governance implications of this and that the original 21 review they asked for someone else to do was more 22 clinically focused and that perhaps that was the 23 thinking behind this. Was that your impression or 24 perhaps I'm reading too much into it? 25 A. That wasn't really the impression that I had. The Page 160

1 impression that I had was that they wanted me to look at 2 whether, as a board -- ie a senior management team, 3 really was how I interpreted the word "board" in that 4 context -- they could and should have handled things 5 differently related to the significant concerns related 6 to Mr Eljamel's practice. 7 Q. Right, okay, but I suppose there are, out of that -- 8 that's a very general position and out of that, there 9 are, as you came to understand, multiple different 10 components to the Eljamel situation that the board could 11 perhaps have had a role in. So at this stage, it 12 doesn't seem to be being defined with any clarity as to: 13 you're to look at all of those, or some of those, or 14 which ones, or why; is that fair? 15 A. I think that is fair and my recollection is that I asked 16 for a terms of reference. 17 Q. Yes, indeed. We'll get to that in a second, but at this 18 point, it then goes on to say: 19 "In a short meeting this morning with 20 Peter Stonebridge, Lorna Wiggin and Alison Moss, 21 I confirmed Malcolm's that Malcolm has asked me to 22 co-ordinate our response and we agreed the following: 23 "Peter would speak with Lee Jordan to oversee the 24 timeline being prepared by Tracey Passway, linking with 25 the work previously undertaken by Audrey Warden and Page 161	1 Q. Yes, and David Mowle was one of the other consultant 2 surgeons who had worked in the other unit as 3 Professor Eljamel, I think, yes; is that right? 4 A. Yes. 5 Q. Could we look, please, at the terms of reference that 6 you just mentioned. They're, I think, most clearly set 7 out -- I think there's a letter where they're not set 8 out very clearly, there's a sentence cut off or 9 something like that. But I think they're probably most 10 clearly set out in the report itself. So if we can go 11 to that, it's NHSL-00012. And I think there it says 12 that you're to: 13 "... undertake a desktop review of NHS Tayside's 14 handling of the case involving Professor El-Jamel to 15 determine whether the action taken by the Board was 16 reasonable, timely and appropriate." 17 What did you understand that to mean in terms of, as 18 I said earlier, which aspects of the case involving 19 Professor Eljamel you should be considering? 20 A. So I understood it to involve the actions taken related 21 to concerns being raised, addressed and then the exit of 22 Professor Eljamel from NHS Tayside. 23 Q. Right, and insofar as particular components arose from 24 the paperwork, you could address them as you thought 25 appropriate, perhaps? Page 163
1 David Mowle; with the complaints and legal claims team 2 and with Christopher Smith in relation to HR matters; to 3 develop a full description of events, including the 4 patient complaints, trigger points, key decisions made 5 and the circumstances of [Professor] Eljamel's 6 suspension and retirement. This [would] provide 7 a complete timeline and is required by the end 8 of October 2018." 9 So efforts were ongoing, I think involving someone 10 called Lee Jordan, who would be bringing forward a lot 11 of information that presumably would then be given to 12 you, to give you the material from which you could work, 13 is that right? 14 A. Yes. Yes. 15 Q. Who is Lee Jordan? 16 A. So, my understanding, he was an associate medical 17 director within the NHS Tayside structure. 18 Q. Okay. And there appear to have been -- and there were 19 a number of other people involved there who have 20 contributed, it appears in some way, to this process 21 that he seems to be overseeing, including Audrey Warden 22 and David Mowle. Did you know who they were, at this 23 stage? 24 A. At that stage, no, but I obviously spoke to them, as is 25 set out in my review. Page 162	1 A. Yes. 2 Q. For example, there isn't -- you mentioned the exit of 3 Professor Eljamel. There isn't a mention there of the 4 exit of Professor Eljamel. It is something you looked 5 at, but ...? 6 A. Well, I tried to. 7 Q. Yes, but the -- it's quite a general remit? Put it that 8 way. 9 A. It is. 10 Q. And then it said that it: 11 "... should include a review of the timeline of 12 events; a review of the Board's handling of complaints 13 and the action taken." 14 And is the timeline effectively what we were talking 15 about before, ie the material that was put together to 16 show you what had happened, it was part of the material 17 that you had been given? 18 A. That was what I understood, yes. 19 Q. Okay. And it said: 20 "The Review should identify any questions to address 21 as a consequence and/or establish if any further data 22 should be sought and should identify areas for 23 improvement." 24 What did you take the reference to "further data" to 25 mean? Page 164

1 A. I guess, "data" in its broader sense, further 2 information, rather than necessarily numerical data. 3 Q. Yes. So does that mean they're saying: is there 4 anything that you might need to see in addition to what 5 you've already been given that would assist you, or how 6 did you take that? 7 A. Well, I took that to say anything that was maybe missing 8 that wasn't considered or wasn't available. 9 Q. I see, right. So does that sit well with the words "if 10 any further data should be sought", it's suggesting in 11 the present that something could be sought. You 12 interpreted it as meaning whether something more should 13 have been looked at, at the time? 14 A. Yes. 15 Q. Okay. And then, of course as had been indicated before, 16 you should identify areas of improvement. Could we have 17 a look, please -- we'll come back to this document, but 18 could we have a look, please, at NHST-01656. Now, this 19 is a document which you did not produce but has been 20 produced by NHS Tayside which, I think, has been sent to 21 you in a bundle of documents. And we've been trying to 22 work out, as have others, what precisely was made 23 available to you. There is a list, as we'll see, of 24 things that were made available to you but defining, in 25 particular, precisely what -- the timeline and other Page 165	1 16 November is that there's been a further attempt to 2 answer some of the questions which are marked and it may 3 have originally been in a different colour, but they 4 were not a different colour when I got them. But 5 they're marked and then it says "response" and they 6 mainly appear in brackets. 7 Q. Okay. Without, at this stage, getting into the details 8 of this, was the information with which you were 9 provided sufficient for you to carry out the task that 10 you understood you had been asked to do? 11 A. The information was limited and I've tried to be very 12 clear in my report, that's why I set out what I had been 13 given so there was no ambiguity about that. I did 14 not -- there is discussion about whether or not I should 15 be provided with details about individual patient 16 circumstances. So the only way that I was able to use 17 the larger spreadsheet of patient complaints was in 18 trying to map the time of the patient's original episode 19 of care to the time when the complaint was raised, in 20 order to try to frame that against when the concerns 21 began to be acted on -- about Mr Eljamel's practice, if 22 that makes sense. 23 Q. Okay, and one of the aspects of the materials that 24 you've been -- you were provided with, indeed in this 25 letter and indeed, you express a view on, relates to the Page 167
1 materials made available by Mr Jordan, it's difficult to 2 work that out because there are a number of different 3 versions. So there appear, to us, to be two drafts of 4 an initial version of an involving timeline, if I can 5 put it that way, and there is this document which seems 6 much fuller and perhaps represents what it was you were 7 given. So what we'd be interested to know is whether 8 you think this represents what you were given which was 9 the product of the work which Lee Jordan had been asked 10 to do? 11 A. So I was given both documents from Lee Jordan, at the 12 time. There's one that is referenced there on the 13 fourth line dated 26 October and then this one, from 14 16 November, because there are questions contained 15 within the text of the document which appear to have 16 been answered. In terms of the bundle of documents 17 provided as part of the Inquiry, I don't think 18 I received the one with the tracked changes from 19 Annie Ingram on it but I did receive the 26 October and 20 the 16 November documents from Lee Jordan which are 21 subtly different. 22 Q. That is helpful, thank you very much. You say they are 23 subtly different. Are there important aspects to the 24 subtle differences? 25 A. I think what has happened between 26 October and Page 166	1 period of clinical suspension -- sorry, the period of 2 clinical supervision which Mr Eljamel had in 2013. And 3 without, at the moment, going into the detail of what 4 material you did have about that, would it have been 5 possible for you to try to speak to those who had been 6 involved in the supervision process to try to understand 7 more about what actually happened, what didn't, what the 8 thinking was behind, how that had worked? Was that 9 option available to you, to try to seek more -- to 10 interview people, effectively, if I can put it that way? 11 A. So that's what I asked to do. So I went up and spoke to 12 four people and I have set that out, who I spoke to on 13 the day. The people that I spoke to were identified by 14 NHS Tayside. I asked to speak to somebody who could 15 tell me about educational governance, somebody who could 16 tell me about clinical governance. And so they 17 identified the people for me to speak to. So, the 18 limited review that I did was significantly augmented by 19 going to speak to people. 20 Q. Yes, okay. And who did you speak to? 21 A. So I spoke to Audrey Warden, I spoke to Tracey Passway, 22 I spoke to David Mowle and I spoke to Eric Ballantyne. 23 Q. Okay. Mr Ballantyne was one of the other consultant 24 neurosurgeons, I think? 25 A. Yes. Page 168

1 Q. Were these the people that you chose to speak to? 2 A. No, I asked to speak to somebody who could tell me about 3 clinical governance, so Tayside provided those names. 4 Q. Right. So when you said: these are the sorts of things 5 it looks to me I would like to know more about, you were 6 given a list of the individuals and that didn't include 7 someone who could speak to educational governance? 8 A. It did. That was Mr Ballantyne. 9 Q. All right, okay. Why did you think it was important to 10 speak to someone about that aspect of things? 11 A. Because, for any consultant, a significant part of their 12 practice involves working with doctors in training and 13 understanding whether there were concerns that had been 14 raised from those doctors in training. And their 15 participation in that would be an important way to 16 understand what was going on. 17 Q. The issue here though, is it not, that you're speaking 18 to a small group of people who may be able to explain 19 something to you, but you're not speaking to all of the 20 people that might have been able to explain to you their 21 various perspectives? So if we were to take that as 22 an example, that particular one, you spoke to 23 Mr Ballantyne who was one of the consultants, but in 24 light of the fact there were some concerns in the 25 paperwork that you were looking at about the way in Page 169	1 speak to, to answer the remit of the review. 2 Your position, I think, is that was not the sort of 3 review that one person could undertake? 4 A. It is, and that review had already been done by the 5 Royal College of Surgeons, and I was, in what I thought 6 I was being asked to do, trying not to repeat, or to 7 re-explore things that had been done already. 8 Q. So I'm not quite sure I follow that. You said had 9 already been done but your remit was not to explore 10 things that had already been done, is that right? 11 A. So the College of Surgeons had spoken to a large number 12 of people and I did not understand that my remit was to 13 reinvestigate the aspects that they had investigated. 14 My remit, I understood to be very narrow and to consider 15 how NHS Tayside, thinking of that as the senior 16 management team, had reacted to the concerns as they 17 were raised and the actions that had been taken. So 18 it -- 19 Q. Okay, but to put aside the question of the remit, at one 20 stage there's a question of what material you have 21 available to be able to conduct the remit. So for 22 example, you didn't have access, did you, to any of the 23 statements that had been taken by the review mechanism 24 which might have contained narratives that would be 25 relevant to the issues you were talking about? You Page 171
1 which Mr Eljamel had organised and interacted with 2 trainee surgeons, it would be more logical, would it 3 not, to try and understand what their perspective on 4 matters was, rather than another consultant who didn't 5 necessarily work within that close unit? 6 A. So I understand that point. I think that would be part 7 of something that was much, much broader than I had been 8 asked to do. And I would not -- that's not something 9 that can be done by one person. That would need a team 10 and an infrastructure to do that. 11 Q. So, one of the things that I know you've looked at 12 because it was one of the documents that was sent to you 13 was the report from 2013 where we know that the team -- 14 the reviewing team from the Royal College of Surgeons 15 attended in September 2013 over two days and spoke with 16 a vast array of people. 17 A. Yes. 18 Q. And we understood, from the evidence of Professor Smith 19 who is in charge of -- now in charge of that Invited 20 Review Mechanism this morning, that the names of the 21 people would have been a part of the dialogue were the 22 sorts of people someone wanted to speak to would be 23 proposed, names would be put forward and there would be 24 an agreed list. And effectively, the Royal College 25 would get to speak to whoever it was they wanted to Page 170	1 didn't have that, did you? 2 A. No, I did not. 3 Q. Nor did you have any facility to be able to gain any 4 such factual material from individuals who had 5 a perspective or an involvement in matters that you were 6 looking at, other than the small group that you 7 described? 8 A. Yes, and that's why I have been very careful to set out 9 the very limited nature of what I did. 10 Q. Absolutely. 11 A. So that what -- I was trying to make it as clear as 12 possible that what I did was limited and I was really 13 trying to focus on that one question. 14 Q. I understand and accept that. That's very much 15 appreciated that you've taken the care that you have in 16 that regard. What I'm trying to understand is -- what 17 the Chair of the Inquiry will ultimately have to decide 18 upon is what this review is all about, what its purpose 19 was, why it was that it was approached this way. And 20 you've explained, you've given your evidence about why 21 you might have been approached as an appropriate person 22 to provide a report like this. But as regards what 23 exactly it is or was set to achieve, what you could 24 achieve by this was very much limited by the fact that 25 you were just one person; is that correct? Page 172

1 A. Yes. 2 Q. And the fact that you had access to information which 3 predominantly, albeit through different routes, in 4 writing and through the interviews that you were able to 5 have with certain individuals, effectively emanated from 6 effectively the executive body that you were 7 investigating, if I can put it that way? 8 A. Yes, I understand that. 9 Q. Is that -- do you accept that? 10 A. Yes. Yes, I do. 11 Q. Thank you. And in light of that, I understand your 12 position, because you have been very clear and you've 13 accepted in your statement that this was limited, but 14 you did the best that you could, is your position, on 15 the basis of the information that you had in order it 16 try to assist; I think that was your motivation? 17 A. What was why I have tried to frame my observations and 18 recommendations in a way that outlined things that 19 Tayside could and should consider. Either they may 20 already have changed but to make sure -- to test those 21 out and make sure those were in place. 22 Q. Thank you. One of the passages in your statement that 23 I just wanted to ask you about was at paragraph 12.3 24 which is on page 15 if we could just jump back to that. 25 So this is in the context of you explaining what the Page 173	1 their recollections as best they could. It was clear 2 that there'd been a number of previous questions asked 3 to various individuals that couldn't necessarily recall 4 exactly who said, but the sense came over quite strongly 5 was that this was ground that had been rehearsed several 6 times before. And that -- 7 Q. Was that just Mr Mowle, or was that across the board? 8 A. No, that's what I'm trying to say. My impression -- and 9 it's probably more impressionistic than something that 10 I wrote down at the time, was that people had been asked 11 a number of questions. I was trying to be as clear as 12 I could in my recommendation about the burden of work, 13 in particular, that was placed on Mr Mowle and 14 Audrey Warden in terms of the patient recall exercise. 15 And having -- the lack of organisational infrastructure 16 support to support that. 17 Q. I see, but in terms of -- that was to do with their 18 involvement in reviewing some of Mr Eljamel's cases 19 after the event, if you like? 20 A. Yes, it was. 21 Q. Which was one of the steps that was taken, to try to 22 look back and work out the extent of what had gone 23 wrong, as I understand it? 24 A. Yes. 25 Q. But as far as their reflections or positions in relation Page 175
1 main findings, conclusions, recommendations of the 2 report were, which you set out under reference to the 3 report itself. Then you say: 4 "Additionally, in speaking to individuals within 5 Tayside, it was very evident that there remained 6 considerable distress about actions taken or not taken 7 to the discernible impact onto individuals' health still 8 some time later." 9 What did you understand that to mean? 10 A. So I was trying to say, in appropriate language for this 11 type of setting, that actually in speaking to those four 12 people, it was very clear that they were carrying a very 13 significant burden of guilt and concern about the way 14 they had not identified things earlier. 15 Q. And was that evident by their manner or in what they 16 said, or did they accept failings, or what was the 17 position? 18 A. Yes, there was a level of emotional distress within 19 actually all four of the conversations. 20 Q. Well, I mean, if we look at the roles that were played 21 by the four, I think you talked about, David Mowle 22 obviously was another consultant. What was his approach 23 to these questions in terms of telling you his 24 recollections and reflections on matters? 25 A. So I found everyone to be straightforward and to give me Page 174	1 to the events themselves, rather than the burdens of the 2 aftermath, which of course is not irrelevant, but the 3 events relating to Mr Eljamel and what happened in that 4 period, were the reflections on that what caused the 5 distress that you describe? 6 A. I think there was a natural questioning about why 7 concerns had not been identified previously. 8 Q. Yes, questioning of themselves, perhaps? 9 A. Yes. Questioning of themselves, yes. 10 Q. And when they asked those questions of themselves, did 11 they tell you what answers they'd found? 12 A. So I think the answer that I would draw out relates to 13 the honesty, it relates to honesty with patients because 14 obviously what became apparent related to patient 15 concerns that were raised is that they hadn't had 16 a straight -- you know, they had not been given 17 an honest account of what had happened to them. It 18 related to honesty with colleagues. So within morbidity 19 and mortality meetings, that there had not been honesty 20 from Mr Eljamel about events that had happened. And 21 then, I guess, my indirect observation would be that for 22 all surgeons honesty with oneself is incredibly 23 important about things that one could and should do 24 differently. 25 Q. But was there reflection, then, on their own roles in Page 176

1 how they had involved themselves and they were perhaps 2 reflecting in the way that you have suggested, that they 3 were wondering whether they could have done more? 4 A. Yes. 5 Q. And had they come to any conclusions as to whether they 6 felt they could? 7 A. I don't know that it would be fair for me to speak for 8 them. I didn't ask that question absolutely explicitly 9 and therefore, I don't think I could or should speak for 10 them. 11 Q. But I'm not asking you to do that today, I'm asking you 12 whether there were reflections expressed to you at the 13 time in that regard. Because obviously that is all 14 part, is it not, of the system that you were looking at 15 because, you know for example, if there were meant to be 16 parts of the system involving other consultants -- 17 completely hypothetically, taking a more proactive role 18 in trying to find out what was going on and there was 19 a reflection in that regard, that would be part of 20 a provisional governance system, would it not, that 21 would, in theory, be designed to try to prevent this 22 sort of thing happening? 23 A. Are you referring to the supervision? 24 Q. No, I'm not talking about the supervision, I'm just 25 talking about generally relating to his practice. Page 177	1 heard at the time and that influenced the methodology 2 and the findings that you reached in the report. 3 Because that's of incredible value to understanding, in 4 this Inquiry, what went on. 5 A. So, I'm sorry, I hadn't understood it in that context. 6 So when I'm saying the College of Surgeons review, 7 I mean there are phrases that I used within that review 8 that have obviously been drawn from the statements about 9 experience as a colleague which were very similar to the 10 phrases that were used with me. So there was a mixed 11 picture that in some ways what was described was someone 12 who was a colleague who was in some ways a good 13 colleague, open to swapping on-call aspects but who had 14 a difficult manner, both in terms of communicating with 15 the broader team and in a rather hierarchical and 16 autocratic manner, particularly in which they perceived 17 and reacted to challenge. 18 And in particular, thinking about a very small team 19 of neurosurgeons, the impression that I took was that 20 there was a level of adjustment to an individual's 21 behaviour that occurred over time and that there was 22 a level of reflection and guilt that that manner had not 23 been challenged more easily. 24 In particular, there was a description from 25 Mr Mowle, who would have worked most closely, that their Page 179
1 I'm trying to tease out from you really what the 2 information is because we don't know what it is that you 3 were told, that's the problem. We don't know what 4 information you worked on, other than certain written 5 materials. These interviews, it would seem from your 6 testimony today, are an important part of you gaining 7 an understanding of what the corporate situation was. 8 So I'm trying to tease out from you what it is that you 9 were told in that regard and what learning you took from 10 it? 11 A. So I was essentially told about their experience of 12 Mr Eljamel as a colleague which I would say is entirely 13 in line with the statements in the College of Surgeons 14 review about peoples' experience of him as a colleague. 15 Q. Could I just point something out is that nobody has 16 access to the statements in the college review. All we 17 have access to is material indicating, in a broad sense, 18 what they might have contained. You had access to 19 individuals who did effectively give you statements, if 20 you like, or they explained their position to you. So 21 it's of value to this Inquiry to understand. Because 22 it's highly likely that we will never see those 23 statements because they've been destroyed. We can 24 deduce what they contain in a broad sense, but 25 I'm interested in the particular reflections that you Page 178	1 job plans were opposite. So they were not usually in 2 the same place at the same time other than on a Friday. 3 And there was no sense that I took, from what was 4 explained to me at the time, that they had any concept 5 of the lack of probity that -- or lack of honesty that 6 had been involved. So that was not something that -- as 7 best as I could, in teasing out in terms of that 8 experience up to June 2013, and then in particular 9 from June 2013 onwards, that there had been 10 an understanding prior to that about a lack of honesty. 11 Q. Okay, and I think -- I think your report, in 12 paragraph 1, it does talk about this hierarchical 13 manner. And I think it effectively talks about both of 14 the neurosurgeons speaking about -- describing the same 15 sort of thing, I think that's right? 16 A. Yes. 17 Q. And as far as -- so you attended interviews with these 18 individuals. Did you record what they said? I don't 19 mean on a tape recorder, but did you write notes? 20 A. I did, yes. 21 Q. Do you still have those? 22 A. I do. 23 Q. And those notes, I assume, can be made available to the 24 Inquiry? 25 A. Yes, they could. Page 180

1 Q. Thank you. And as far as this impression of this 2 hierarchical manner, and perhaps opportunities that 3 might have been taken not being taken to be able to find 4 out more about that and perhaps even more in 5 a supportive sense than in an oversight sense, was that 6 ascribed to any particular period of time, or was that 7 something that should have existed throughout the 8 working relationship with Professor Eljamel? 9 A. I didn't get a particular sense that it had changed. 10 I think that what was described were some periods where 11 that behaviours – if we just generalise, in that 12 sense – may have deteriorated and then if there was any 13 level of feedback provided, that that improved for 14 a while but it was difficult to maintain that 15 improvement. 16 Q. Right, so this had been -- when you talk about the 17 period of improvement, had that been very latterly? 18 I'm thinking of the possibility that -- we looked at 19 a passage in the 2013 report reflecting Mr Eljamel's own 20 position which suggested he had tried to make things 21 better latterly in his career, but are you talking about 22 a particular time period for that improvement, or -- 23 A. No, I'm -- without actually looking at my summary of the 24 things that were said to me -- but I have a sense that 25 there was a period that was referred to of -- before Page 181	1 assist. I think that was the broad position, is that 2 right? 3 A. Yes. 4 Q. And so, in number 3, you said: 5 "Professor [Eljamel] had a defined role of the Chair 6 of the Clinical Governance Committee, and this 7 influenced Board reporting, and allowed him to 8 promulgate his own views. Additionally I note that 9 Professor El-Jamel attended the Significant Adverse 10 Review into the wrong site surgery of [a certain] 11 patient ... It is clear from comments made that this 12 influenced the direction of the discussion, and may have 13 weakened the findings the SAER." 14 Your recommendation was that: 15 "NHS Tayside should consider its SAE policy and 16 whether there are opportunities to strengthen this, and 17 to consider the effect on the investigation of 18 participation of individuals responsible for the care of 19 the patient in a roundtable type approach." 20 In looking at that, you focused in on your 21 recommendation on the specific SAE aspect of it. But 22 there are, presumably, wider concerns about someone like 23 Professor Eljamel having a role on an important body 24 like the chair of the clinical governance committee. 25 Would that not be a concern one would have in these Page 183
1 that, where there was, you know, potential to change 2 behaviour -- not potential to change behaviour, that 3 would be the wrong way to phrase it, that there was 4 feedback provided and a minor correction in behaviour. 5 Q. Thank you. And you provide -- in your report, you 6 address some specific issues that I would quite like to 7 look at with you. There won't be the capacity at this 8 stage, Ms Gillies, to get into the details of these 9 aspects but we'll certainly be interested in getting 10 more evidence for you about the particular details that 11 you know about and the testimony that you had, in the 12 context that I described, that there are other places 13 where such evidence used to exist but it doesn't exist 14 any more, and if you have access to that, that will be 15 incredibly valuable to our understanding of what 16 happened and indeed, what reflections there were on that 17 in the period thereafter. So if I can take you to the 18 report, this is again NHSL-00012. 19 And again, I'm looking at page 3 and one aspect of 20 this which is of some interest to us is the fact that 21 one of the issues which as -- I don't know whether we 22 got to agreement on this, but I think the position, as 23 I understand it, is you had a broad remit and you teased 24 out issues from the materials available to you that 25 seemed to be pertinent in relation to which you could Page 182	1 circumstances? 2 A. Yes. 3 Q. The clinical governance committee is a very important 4 aspect of the way that the health board is run, isn't 5 that right? 6 A. Yes. Can I just clarify that I may have described the 7 chair of the clinical governance committee as -- with 8 that being a management committee rather than a board 9 formal sub-committee. 10 Q. I see, yes. I didn't mean that either in that sense. 11 I just meant in the delivery of healthcare, a clinical 12 governance committee is an important committee because 13 it's a committee which is involved in trying to promote 14 high standards of healthcare through the clinical 15 governance mechanisms that we've discussed in the 16 evidence already? 17 A. Yes, and that's also replicated at a more local level, 18 that -- that really was part of my point earlier about 19 local morbidity and mortality meetings. They do need to 20 be places of appropriate, constructive challenge. But 21 the tone is very important in enabling that discussion 22 to remain constructive and so that people are not afraid 23 to surface different views because those may well be 24 appropriately different views. 25 Q. Yes, thank you. The next section is one that we touched Page 184

1 on before in discussions that you had covered which is 2 to do with interactions with trainees. You make the 3 important observation in the first sense that: 4 "Professor El-Jamel had significant opportunity to 5 influence the career directions and development of 6 trainees and had an expectation that he would always be 7 provided with a more senior trainee when on-call." 8 That's a point we've come across in the evidence 9 before which is to do with, in that role and in others, 10 the capacity that Mr Eljamel's position had to be able 11 to have a very wide-reaching effect on a lot of people, 12 on a lot of patients, ultimately. Because it's not just 13 about the patients he was treating himself, it was 14 about the way in which he was educating others and if 15 there had been deficiencies in that, those mistakes or 16 issues could have been replicated many, many times over. 17 Is that what you mean in that sentence? 18 A. I think -- so, I accept that point. I think what I mean 19 is something broader than that and that is that, 20 actually there's -- that the implication that was -- 21 that I drew from what was said to me was of a rather 22 unhealthy dynamic with individuals who were in training 23 positions being expected to do things for him, to 24 facilitate his way of working, including, you know, his 25 expectation about always having a more senior trainee Page 185	1 Q. All these various experiences that seem to be the 2 examples were given of trainees covering, it would 3 appear, different aspects of the relationship between 4 Professor Eljamel and his trainees? 5 A. So, the part about the feedback, about trainees being 6 fearful of causing offence, that came from those 7 interviews with neurosurgical colleagues. The part that 8 says, "Neurosurgery is a small specialty at a UK level", 9 that is my observation added in on top of that. 10 Q. Yes, I was just meaning the sort of specific, on the 11 ground -- it came from the other consultants? 12 A. It did. 13 Q. So it's sort of a second-hand, anecdotal -- but you do 14 recognise that you've: 15 "... not undertaken detailed examination of any 16 focus groups held with trainees, or individual pieces of 17 feedback." (As read) 18 But you go on to recommend that: 19 "NHS Tayside has a clear system in place to ensure 20 that any adverse or concerning comments identified by 21 trainees regarding an individual consultant's behaviour 22 in any speciality have a level of visibility within the 23 organisation rather than solely within an educational 24 line." (As read) 25 That aspect of things was -- there was a resonance Page 187
1 when on-call. The implication of that is that he would 2 be less likely to attend the hospital out of hours 3 himself. 4 Q. I see, because that more senior trainee would be able to 5 cover more complicated presentations? 6 A. Correct. 7 Q. Thank you. The narration goes on. Halfway through, it 8 says: 9 "Examples were given of trainees expected to 10 undertake additional on-call [and] an informal basis to 11 over more junior trainees. Various pieces of feedback 12 were given to Deanery colleagues regarding training 13 opportunities and behaviours but given 14 Professor El-Jamel's academic influence, trainees were 15 fearful of causing offence. Neurosurgery is a small 16 specialty at a UK level. Additionally, at various times 17 there have been considerations about the number of 18 neurosurgery units required in Scotland, and the 19 viability of individual units is influenced by trainee 20 experience and reports." 21 So there are a number of different elements there. 22 The first question I wondered about is what was the 23 source of evidence that you had about this, where did 24 that come from? 25 A. So, you mean the whole of that section of the paragraph? Page 186	1 in that with some evidence we've heard before about the 2 importance of there being a close interaction between 3 educational governance and clinical governance. Is that 4 the area that you're getting into there, that it should 5 not be seen as something to be dealt with just in the 6 educational side, but should perhaps indicate wider -- 7 should be looked at in a wider context? 8 A. So the concept that trainees will often be amongst the 9 first people to identify when there are concerns is, 10 I think, quite well understood. The way to make sure 11 that -- within an organisation, that there's 12 a visibility of that feedback from trainees is to make 13 sure that reports from the deanery are circulated, but 14 also that there is an exchange of information about 15 feedback that is coming from those educational routes 16 with the -- broadly speaking, the hospital management 17 system. It shouldn't just sit as a doctor thing. 18 Q. Right, okay. Thank you. The deanery, in that sense, 19 would be people within the medical education within the 20 hospital? 21 A. Yes. The "deanery" is a bit of an old-fashioned term 22 for that. 23 Q. Yes, we've already been through deans with somebody else 24 and they seem to crop up in various places. On page 5, 25 you provide a narrative about the RCS report, Page 188

1 specifically. A bit further down, paragraph 7, thank 2 you very much. You give a narrative of circumstances 3 were familiar, and you say: 4 "It is not clear to me whether any verbal feedback 5 was provided on the day but they did not speak to 6 Professor El-Jamel himself until the 2nd October 2013." 7 We understand from this morning that it's likely 8 that they did provide verbal feedback on the day. We've 9 also seen a copy of the interim recommendation letter. 10 Did you have that? 11 A. I did. 12 Q. And what was suggested by the chair of the current 13 Invited Review Mechanism was he thought it likely that 14 what had been said would be what was in the interim 15 letter, which were components of the final report. So, 16 in relation to the phrase, "They did not speak to 17 Professor El-Jamel himself until the 2nd October", were 18 you trying to make something of that point, or was it 19 just a factual observation? 20 A. No, I was really trying to, I guess, provide some 21 context to the fact they may not have provided verbal 22 feedback on the day relating to -- ordinarily, what 23 would happen in any type of review is if there are 24 important things that need to be acted on immediately, 25 they will be given as verbal feedback at the end of the Page 189	1 was suspended on 10th December 2013, I am not aware of 2 any Occupational Health status that said he was not fit 3 for an investigation to continue. Whilst the GMC had 4 imposed interim conditions on his registration, once 5 voluntary erasure proceeded, unopposed by NHS Tayside, 6 the GMC has no legitimate locus to continue with 7 a Fitness to Practice Hearing. The reasons why 8 NHS Tayside did not oppose Professor El-Jamel's 9 application for voluntary erasure are unclear as this 10 could have been done when he subsequently indicated that 11 he intended to apply for early retirement. There has 12 been a significant change in personnel at NHS Tayside, 13 and one would expect this level of decision to be made 14 at an Executive level. The role of the Chair in any 15 discussion is also not clear as he has been written to 16 in a university capacity rather than as the Chair of the 17 Board. The GMC have also reinforced their processes and 18 if they are investigating concerns through their own 19 processes, they will not process an application for 20 voluntary erasure." 21 You say: 22 "The Responsible Officer in NHS Tayside is notified 23 when any doctor connected to them applies for voluntary 24 erasure through current processes and there is a short 25 period (ten days) to indicate to the GMC that there are Page 191
1 day. And so it was -- I actually -- I did mean I didn't 2 know whether they did it or not because they may have 3 wanted to wait until they had spoken to him. 4 Q. Yes. It appears that they didn't. 5 A. Right. 6 Q. They didn't wait, I mean they didn't wait. 7 A. Right. 8 Q. And also you say, in relation to that, that the point 9 that you draw out for your recommendation is that: 10 "There was no verbal communication of the interim 11 letter with its explicit recommendations to the clinical 12 lead in the unit or the General Manager." 13 And I think that's something you say should happen? 14 A. Yes. 15 Q. On -- point 8 is one that we haven't dwelt on with many 16 other witnesses so far, so I'll read this out. It says: 17 "Voluntary Erasure from the GMC Register and 18 Cessation of the Internal Investigation. 19 "I have not been able to speak to 20 Professor Russell ..." 21 Who was then the medical director of NHS Tayside: 22 "... and therefore it is difficult to know exactly 23 in what order decisions were made. Whilst it can be 24 difficult to complete a difficult internal investigation 25 when an employee is not at work, and Professor El-Jamel Page 190	1 concerns under investigation to ensure that voluntary 2 erasure does not proceed. I recommend that the RO 3 reviews internal processes to ensure that any necessary 4 action to communicate with the GMC can be taken within 5 the short timeline." 6 So this relates to another aspect of our Terms of 7 Reference which is the circumstances in which Mr Eljamel 8 was able, voluntarily, to remove his name from the GMC 9 medical register. And the aspect of this in which we're 10 particularly interested is the extent to which -- the 11 role of NHS Tayside in that. And I think it's fair to 12 say that your ability to understand precisely what 13 happened you explain as being hampered by the fact that 14 you didn't have access at that time to the medical 15 director whom you understood could have given you more 16 information, is that right? 17 A. Yes. 18 Q. But is it fair to say that your impression is that you 19 didn't have any evidence to suggest that there was any 20 reason why the formal investigation against him could 21 not have continued, you didn't have any evidence? 22 A. I didn't have any evidence, yes. Yes. 23 Q. And what then on -- you may not be able to say this 24 because you don't think you have enough evidence, but 25 what -- I take that to mean that you consider it Page 192

1 important that health boards should make their views 2 known or make their understanding of a situation known 3 when they're notified about the possibility that 4 a doctor is wishing to have voluntary removal from the 5 GMC medical register; is at least that fact correct, do 6 you consider it important? 7 A. It is important, yes, and it's the responsible officer 8 specifically who is notified rather than the health 9 board. 10 Q. Yes, okay. But in this circumstance you talk about it 11 being somebody else. Or in a different capacity, no? 12 A. No. 13 Q. No. So the position here is that they were given -- 14 they would have been given an opportunity to do that but 15 they did not; is that correct? 16 A. That's my understanding. I accept I have been 17 extremely -- well, not extremely, but I have been quite 18 clear in what I think happens and then set out. 19 Q. Yes. So again, I was interested to know because we know 20 that there was a lot of evidence lacking in this area, 21 or potential evidence. Where did you get the evidence 22 upon which you based that understanding, those simple 23 facts that they didn't take the opportunity that was 24 given to them? 25 A. So it's the absence of any evidence that they had and Page 193	1 Q. No, no. But the main point here is you would have 2 expected, based on the information that you had seen and 3 was available by that time, that this would be a case 4 where it would be almost a sort of archetypal case 5 where -- would it, for where a health board would 6 intervene to express its position on it? 7 A. Yes. 8 Q. Yes, thank you. As I've said, Ms Gillies, it will be 9 necessary I think for us to collect some more detailed 10 evidence from you on certain aspects of this, but that's 11 a very helpful summary of at least your overall position 12 on some of the key aspects. In those circumstances 13 I don't have any further questions, sir. At this stage 14 I offer the witness the opportunity to say anything that 15 they would like to say and I'd like to invite to you do 16 that? 17 A. Thank you. So I am -- I am sorry in a way that my 18 report is so concise. I tried to write a very concise 19 report because I wanted to indicate that the piece of 20 work that I had done was extremely limited and in 21 particular that I could have put in, with appropriate 22 checks on the individuals concerned, more detail about 23 the evidence that I had drawn my observations from. 24 I was quite thoughtful about individuals' 25 confidentiality given the very small number of people Page 195
1 that's why I have caveated by saying that I was not able 2 to speak to the responsible officer, who is the medical 3 director. Because he may have been able to tell me that 4 actually there had been a verbal discussion, or 5 something else. So it was the absence of any evidence, 6 but with that caveat that I had not been able to speak 7 to him. 8 Q. But in the circumstances of this case, given what you 9 did know about it, albeit with perhaps limited 10 information, were you surprised that a health board or 11 the responsible officer wouldn't intervene in these 12 circumstances? 13 A. Yes. 14 Q. Why? 15 A. Because one would expect that at least there would have 16 been a lodging of the significant amount of concern in 17 order to at least set out the position of the 18 responsible officer who is acting on behalf of the 19 health board that voluntary erasure in their view would 20 have -- would not be considered -- I'm trying to avoid 21 saying "appropriate". It would be interpreted in a very 22 adverse way by those who had still ongoing very 23 legitimate concerns, ie patients. 24 Q. Yes, indeed. 25 A. Sorry, that was clumsily phrased. Page 194	1 that I had spoken to. But that that's the reason why it 2 was so concise. 3 My understanding of the request was to really put 4 myself in the position of: if I had been part of that 5 health board what would I have expected to see and do? 6 And so that's why I have tried to be clear in my 7 recommendations for constructive action. 8 MR DAWSON: Thank you very much. I think we'll take a short 9 break now, sir. 10 THE CHAIR: Yes. We'll just take a few minutes Ms Gillies. 11 There may be some more questions but certain discussions 12 may need to take place before that happens but we'll 13 resume again shortly. 14 (4.17 pm) 15 (A short break) 16 (4.29 pm) 17 MR DAWSON: Briefly, sir. 18 THE CHAIR: Yes, certainly. Thank you. We're ready to 19 resume, Ms Gillies. 20 MR DAWSON: Just very briefly I hope, Ms Gillies. We were 21 discussing at the end of your evidence your views and 22 the section of your report in relation to the question 23 of the voluntary erasure of Mr Eljamel's name from the 24 GMC medical register and in particular questions around 25 the extent to which NHS Tayside could/should have been Page 196

1 involved in indicating something to do with that. You 2 were clear I think that there were sources of evidence 3 available to you/not available to you which would have 4 been helpful to try to help you come to firmer 5 conclusions about that; isn't that right? 6 A. Yes. 7 Q. And that included, for example, an explanation or 8 further evidence from the medical director in 9 particular? 10 A. Yes. 11 Q. Insofar as you have helpfully given us a view as to 12 whether this is the sort of circumstance in which you 13 would expect a health board to intervene or say 14 something, you've expressed a view on that but just to 15 be clear, that view proceeds on the assumption I think 16 that the health board in 2015 knew that the voluntary 17 erasure process was going on? 18 A. So what I tried to indicate is that ordinarily there is 19 notification to the responsible officer that 20 an individual has applied for voluntary erasure. So you 21 have a ten day window after that notification to provide 22 the GMC with any information for them to consider -- 23 it's their decision -- about whether they support and 24 complete that voluntary erasure or not. 25 Q. Yes. Yes. Page 197	1 Q. Thank you very much, that's very helpful. Thank you 2 very much for your evidence. 3 THE CHAIR: Thank you. 4 Well, Ms Gillies as you'll have gathered, that is 5 the end of this afternoon's session and brings your 6 evidence to an end. Before you leave the witness stand 7 can I express on behalf of the Inquiry, and indeed on my 8 own behalf, my thanks for your attendance today for the 9 work I know goes into generating statements of the kind 10 that you have been -- you have produced, the associated 11 materials and indeed, if I have noted it correctly, the 12 offer to look again at the possibility that there may be 13 other material. If there's any dubiety about what that 14 might be, then that can no doubt be dealt with in 15 correspondence. But in the meantime, thank you very 16 much, you are free to go. 17 MR DAWSON: I think sir, if I could just on that procedural 18 point, I may be of some assistance. I think it's likely 19 in your case, given the testimony you've given, and in 20 particular the information about specific documents that 21 you hold, that we probably issue another Rule 8 request 22 in order to try to set out with more clarity what it is 23 we're looking for and hopefully that will be of 24 assistance. 25 THE CHAIR: That's helpful too, thank you, Mr Dawson. Page 199
1 A. So there is a mechanism in place so I receive 2 notification when any doctor connected to me for whom 3 I'm the responsible officer is seeking voluntary erasure 4 so that if there are issues currently being investigated 5 that I have not yet told the GMC about, or a reason why 6 I don't believe that that voluntary erasure should 7 proceed, I can notify -- I can provide that information 8 to the GMC. 9 Q. Thank you. 10 A. Is that clearer? 11 Q. That's extremely clear. And so that's the ordinary 12 course. 13 A. Yes. 14 Q. All I'm trying to understand is that you didn't have 15 available to you any evidence that that ordinary course 16 necessarily had followed, for example you didn't have 17 an explanation from Dr Russell as to what had happened, 18 nor did you see any documentation suggesting that the 19 board had been called or the responsible officer had 20 been called upon to express a view in that way. You 21 didn't have access to that, you're just applying, 22 I think, what you understand from your own experience 23 the ordinary course to be; is that right? 24 A. Yes, there was an absence of evidence about anything 25 that had happened in Tayside. Page 198	1 You're free to go. Thank you. 2 Right, I take it that brings our considerations to 3 a close for this week. I remind myself that we don't 4 expect to sit on Monday so we'll see everybody again on 5 Tuesday next week. Thank you. 6 MR DAWSON: Thank you, sir. 7 (4.34 pm) 8 (The hearing adjourned until 10.00 am on Tuesday, 9 15 September 2026) 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 200

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