

1 Tuesday, 8 September 2026 2 (10.06 am) 3 THE CHAIR: Thank you. Please be seated. 4 Well, may I begin by welcoming you all to the first 5 of the Eljamel Inquiry's evidential hearings. 6 Many of you are attending in person today at the 7 hearing suite here in Edinburgh. Others are joining 8 remotely and watching via the live feed. 9 But whatever your interest and from wherever you are 10 observing, you are all very welcome. 11 Many of you will also have attended one or other of 12 the public meetings which were organised in October 2024 13 as part of the consultation held in connection with the 14 setting of the Inquiry's Terms of Reference. 15 On those occasions, I addressed myself directly to 16 the former patients of Mr Eljamel, and I said that I was 17 very conscious of the length of time you had already 18 waited for answers to your questions, and I recognised 19 that you may have felt frustrated and worn down by the 20 time it had taken to get to that point. 21 Given the circumstances in which the present 22 hearings were postponed in the spring, I can only think 23 that that frustration will have grown. Indeed it will 24 likely be shared by others who have a different but 25 nonetheless significant interest in the Inquiry's work. Page 1	1 medical treatment they received and their experiences 2 subsequently. They deserve special mention on what will 3 doubtless be a day of very mixed emotions indeed. 4 It is also a moment of profound significance for all 5 those who have long campaigned for and promoted the 6 necessity for this public inquiry. Im personally 7 recommitting myself today to its very important work, I 8 will do all I can to meet the expectations that so many 9 have invested in it. 10 As has been said before and will likely be 11 reiterated this set of hearings involves to 12 a significant extent, although by no means exclusively, 13 an exercise in context-setting for the later and more 14 involved sections of the Inquiry's evidential plan. 15 The evidence you will hear over the next four or 16 so weeks may well lead to the exploration of further 17 lines of investigation or the revisiting of issues that 18 have arisen which may merit more detailed examination. 19 Witnesses may in due course be recalled to give evidence 20 in later sections if our investigations justify that 21 course of action. We go, as I have said before, where 22 the evidence takes us. 23 But even allowing for the introductory nature of the 24 hearings you should understand they are themselves the 25 product of a considerable body of preparatory work Page 3
1 Mr Dawson will shortly be providing me, and you, 2 with an update of where broadly our investigations stand 3 and report on our plans going forward. He may also 4 touch on the circumstances which led to the postponement 5 of the hearings originally scheduled for April of this 6 year. And let me be clear, what happened was deeply 7 disappointing, as was the extent to which having to 8 address the issue in advance of the decision to postpone 9 was time-consuming and extremely disruptive to the 10 Inquiry team's focus, a point that has been made 11 forcefully in the recent past. 12 I should nevertheless record my appreciation of the 13 recent efforts that were made to address this, by means of 14 a legal solution, the technical fire safety concerns 15 that had arisen to the point where I can now be 16 satisfied that these hearings can properly and safely 17 take place. The solution device may come with practical 18 and financial consequences for the Inquiry but these 19 will be for me to deal with. What matters is that the 20 hearing suite is now available for its intended use with 21 the result that we are in a position to commence with 22 the evidence in section 1 of the Inquiry's evidential 23 plan today. 24 It is indeed a watershed moment for all those who 25 have suffered or continue to suffer as a result of Page 2	1 involving the drafting and completion of detailed and 2 lengthy statements and expert reports and the recovery, 3 production and preparation for disclosure of many 4 documents. 5 It is therefore right that I should also record my 6 appreciation not only of the hard work of the Inquiry 7 team, which has been considerable, but also the efforts 8 already committed by core participants and their 9 representatives to the evidence-gathering process, the 10 consideration of disclosed materials, and more recently 11 the exercise of contributing with suggestions to the 12 evidence proposals for individual witnesses. 13 Contributing in this way is of the essence of the 14 privileges and responsibilities of being and acting for 15 core participants in a public inquiry. I have said 16 before but it merits repetition, the Inquiry team and 17 I rely on your positive engagement to help us to fulfil 18 the challenging mission set for us by the Terms of 19 Reference. We all have an interest in the successful 20 pursuit of an investigation underpinned, if I may say 21 so, by a spirit of dignity, courtesy and respect and 22 which meets the justifiable expectations of former 23 patients, members of the medical profession then and 24 now, and the wider public who rely on the provision of 25 safe, reliable, patient-centred and accessible Page 4

1 healthcare. 2 If these objectives are to be achieved, and I'm sure 3 they will be, I will necessarily continue to rely on 4 your help and support as well as your encouragement. 5 On a separate but related point I anticipate that 6 during his address Mr Dawson will remind you of 7 an important paragraph in the Inquiry's protocol on its 8 approach to evidence and written statements which 9 concerns the provision of evidence by individuals and 10 organisations to the Inquiry. In particular I expect he 11 will take the opportunity to issue a further call for 12 evidence as we move towards more detailed systemic 13 investigations which will follow the hearing of the 14 evidence in Section 1 and evidence of the patient group 15 in Section 2. 16 Can I simply ask anyone watching these proceedings 17 or reading about them to pay close heed to that call. 18 I strongly encourage anyone to get in touch with the 19 Inquiry team if they feel that they have information, 20 views or recollections to share with us. You may be 21 assured that any such approaches will be greatly 22 appreciated and valued. 23 In a statement I issued to coincide with the 24 commencement of these hearings I expressed the hope that 25 those with an interest in our work would find their Page 5	1 Mr Dawson. 2 Opening statement by MR DAWSON 3 MR DAWSON: Thank you, sir. I am Jamie Dawson KC, senior 4 counsel to the Inquiry. I appear at these evidential 5 hearings alongside my learned junior Mr Ross Crawford. 6 I'm also accompanied by other members of the Inquiry 7 legal team as well as members of the Inquiry secretariat 8 team who have played and continue to play a dedicated 9 role in the delivery of these Inquiry Section 1 10 hearings. 11 Sir, the Inquiry has reached a significant milestone 12 today in that this is the first day on which oral 13 evidence will be heard by this Inquiry. For many, 14 indeed many who join us today, this day has been a long 15 time coming. The subject matter of this Inquiry is 16 relatively historic, focused as it is on the systems 17 surrounding the practice of Mr Sam Eljamel, a consultant 18 neurosurgeon who worked in the Tayside area, in 19 particular at Dundee Royal Infirmary and at Ninewells 20 Hospital, a prominent teaching hospital in that city, as 21 a consultant neurosurgeon from 1995 until his suspension 22 on 10 September 2013, resignation from his post at 23 Ninewells on 31 May 2014 and the subsequent voluntary 24 erasure of his name from the General Medical Council's 25 medical register. Page 7
1 content interesting and informative in providing 2 evidential context for what will follow in later 3 sections of the Inquiry plan. In saying that, I also 4 recognise the risk that some aspects of the evidence may 5 be difficult, even traumatic for some to listen to. 6 I make no assumptions as to what that evidence might 7 be, but wish to stress that the risk is well appreciated 8 and that steps have been put in place in an effort to 9 address it as best we can, consistent with the 10 trauma-informed approach which we have sought to adopt 11 in our work. 12 I therefore wish to assure you that support and 13 assistance is available through the Inquiry secretariat 14 and through the professional services of the Spark 15 charity, representatives of whom will be available at 16 the hearing suite each day or remotely for those 17 watching online. They are all on hand to offer help and 18 support if you need it. 19 With those introductory remarks I now intend to 20 invite Mr Dawson, senior counsel to the Inquiry to 21 address the hearing with his update and overview of the 22 stage we have reached in our investigations with a view 23 to commencing the evidence of the first witness in the 24 Inquiry, Liz Smith CBE, immediately after we break for 25 lunch today. Page 6	1 Many who have been harmed as a result of treatment 2 received over that period or as a result of the way that 3 the state has responded to their treatment in the 4 subsequent years have fought for a long time to reach 5 today. It is right that we recognise their efforts and 6 their sacrifice as well as those of their loved ones in 7 reaching this point. 8 The evidential hearings of any public inquiry like 9 this one represent a significant milestone in their 10 progress. Sir, this is a public inquiry. Inquiries 11 like this are inevitably fought for by members of the 12 public. They concern matters of public interest, in our 13 case the most revered of our public services, our 14 National Health Service, the fundamental principle and 15 purpose of which is to promote and protect public health 16 and safety. They are commissioned by public servants 17 for the benefit of the public. Often, as here, they are 18 commissioned because of a reasonable apprehension that 19 previous efforts to address or deal with an issue of 20 public importance have been inadequately focused on the 21 interests of those members of the public whom some 22 service or agency was designed to protect and serve. 23 Far too often in my experience of them to do these 24 processes look like lawyers speaking to lawyers. We are 25 lawyers and I am afraid we cannot help that fact. We Page 8

1 are used to speaking to one another in language that we 2 understand and are used to or even at times in Latin but 3 that does not mean that an important public process like 4 this which is designed for the benefit of the public, 5 and which has been committed by you, sir, to being 6 patient-centred, that we cannot do better. 7 Thus, this address is unashamedly aimed at the 8 public whose interest we serve and the patients for whom 9 you have deliberately placed at the centre of what we 10 do. 11 I take a keen, deliberate and direct interest, sir, 12 in correspondence received by this Inquiry from members 13 of the public be they former patients of Mr Eljamel or 14 others with a direct involvement in or interest in our 15 work. This correspondence often expresses 16 disappointment and apprehension about the past which 17 manifests itself as an apprehension about the Inquiry 18 process and what it will be able to achieve. In 19 particular in light of external forces which place 20 impediments in our path. 21 However, this correspondence also shows hope. It 22 shows faith in you and in the Inquiry team, albeit at 23 times not in others which must never be assumed or taken 24 for granted that this Inquiry can work and fulfil its 25 not immodest aims. That correspondence often shows Page 9	1 at an early stage allowing the Inquiry to take account 2 of what was said at that time in its planning. But also 3 so that at this hearing the focus could be on oral 4 evidence from the outset. 5 As a result, we will hear from our first oral 6 witness this afternoon. In light of your desire, sir, 7 to get to the oral evidence at these hearings as soon as 8 possible, and in light of the opportunity afforded to 9 them to make extensive submissions and written and oral 10 statements at the Inquiry's three previous hearings, 11 core participants have not been called upon to produce 12 written submissions in advance of the hearings today, 13 nor have they received a written Counsel to the Inquiry 14 note as they did at previous hearings. They will, 15 however, have an important part to play over the next 16 four weeks and indeed have been part of our preparations 17 for these hearings before today to which I will return 18 in due course. 19 Though the focus today and the weeks to follow is 20 and must be on oral evidence, it is incumbent upon me to 21 provide some important context to the proceedings which 22 are about to commence for those who have an interest in 23 our work. It is important for those who have been with 24 us since the start that they be provided both with 25 an update on what has been happening since we last held Page 11
1 selflessness, a keen interest in the wider public good, 2 and expresses itself in particular and clearly well 3 thought through terms. It shows the courtesy and 4 respect for your process which you have offered and 5 expected from others. It embodies, sir, a commitment 6 from those who take the time to get in touch, that this 7 Inquiry can be a force for good and that it can be 8 an Inquiry which takes place properly in public with the 9 participation of the public and ultimately for the 10 benefit of the public. 11 I taken encouragement from that and from the 12 possibilities that such a collaborative attitude has the 13 potential to bring. 14 Sir, it would not be uncommon in statutory public 15 inquiries or this one for the opening days of 16 an evidential hearings like these to be focused on 17 hearing opening statements from, or on behalf of, the 18 Inquiry's core participants. Instead, as those who have 19 been following the progress of this Inquiry are well 20 aware, the procedure which we have adopted took 21 a different course. You, sir, heard opening statements 22 from the Inquiry's core participants at a hearing 23 specifically designed for that purpose in November 2025. 24 That course was taken both so that proposals and 25 aspirations of our core participants could be ventilated Page 10	1 a public hearing in May this year and also that they 2 receive a clear indication as to the structure and 3 intentions for these hearings as well as an explanation 4 as to where they sit and what will happen after these 5 four weeks are finished. 6 In addition, it is likely that there are others who 7 have had or who have acquired an interest in our work 8 who are taking a keener interest as we have now reached 9 the evidential stage, including representatives of the 10 media who are welcome and an important part of our 11 public function. They too deserve an explanation of 12 what is passed, what we plan for these hearings and 13 where we intend to go next. Therefore, sir, we have set 14 aside some time this morning to enable me to make this 15 opening submission in the hope that it will fulfil those 16 important purposes. I intend to address the following 17 matters this morning which are designed to help explain 18 the intentions for these Section 1 hearings as well as 19 to provide an update on progress in the Inquiry and our 20 planning more generally. 21 Therefore my submission will be split into the 22 following parts. 23 One, representation. Who is here today and their 24 role in the proceedings. Two, the delay in the holding 25 of these hearings and developments in connection with Page 12

1 our hearings venue here at Waverley Gate in Edinburgh. 2 Three, the scope of the Section 1 and the Inquiry's 3 evidential plan and the witnesses who are due to give 4 evidence at these hearings. Four, the procedural plan 5 for these hearings. Five, Section 2 progress and the 6 plans for the next set of evidential hearings 7 in December 2026. Six, planning beyond December 2026. 8 Seven, other important developments in the Inquiry's 9 progress. And eight, conclusions and next steps. 10 To turn then, sir, to representation. Who is here 11 today and their role in the proceedings. 12 It is very important to observe, sir, that these 13 proceedings are being transmitted to those who cannot or 14 do not wish to be here today via a feed available 15 YouTube. A video of the proceedings will be available 16 after the hearing for those who wish to watch it back. 17 A transcript of the proceedings for each day will be 18 uploaded to the Inquiry's website as soon as the end of 19 each day's proceedings finish and it can be reasonably 20 achieved in the light for the need for it to be 21 accurate. The availability of this feed and the regular 22 publication of transcripts of the proceedings are 23 derived from your statutory responsibility, sir, to take 24 such steps as you consider reasonable to allow public 25 access to our proceedings but are also important parts Page 13	1 supporters, who are all most welcome here today. 2 Their presence either in person or online is 3 of fundamental importance to the work of this Inquiry and 4 consistent with the public commitments you have made, 5 sir, to putting them at the centre of our work. 6 By way of reminder, those wishing to take a formal 7 role in the Inquiry were invited to become core 8 participants within the meaning of Rule 4 of the 9 Inquiries (Scotland) Rules 2007. Those applications for 10 core participant status were considered by you, sir, as 11 chair of the Inquiry in accordance with Rule 4 of the 12 2007 Rules. 13 All of our core participants are legally represented 14 at these hearings and they are the following. 15 139 former patients of Mr Eljamel and 16 21 representatives of former patients represented by 17 Levy & McRae solicitors a total 160 patient core 18 participants as individuals. 19 These patient core participants are represented by 20 my learned friends Ms Joanna Cherry KC and 21 Mr Euan Scott. 22 NHS Tayside are represented by a solicitor from the 23 NHS Central Legal Office and by my learned friends 24 Ms Una Doherty and Cat MacQueen. Healthcare Improvement 25 Scotland and Public Services Delivery Scotland are Page 15
1 of your additional commitment, sir, to making our work 2 including but not limited to what goes on at our public 3 hearings available to as wide an audience as possible in 4 the knowledge that there are individuals who take 5 an interest in our work and who cannot be here due to 6 physical disability, geographical distance or due to the 7 fact that attending would be too difficult for them for 8 some other reason. Such individuals include but are not 9 limited to members of the patient core participant body 10 upon whose active engagement in our work we do and will 11 continue to rely. 12 This hearing, as I said, sir, is taking place at 13 a hearing room in our hearing suite at Waverley Gate 14 premises in central Edinburgh. When not available to 15 us, the space is used for the hearings of the Scottish 16 Covid-19 Inquiry, another public inquiry set up by the 17 Scottish Ministers. Within the hearing room today my 18 colleagues within the secretariat have, as at previous 19 hearings, managed to configure the seating arrangements 20 as they are currently so that every patient who applied, 21 along with at least one supporter if they wanted one, as 22 well as all representatives of our core participants who 23 wished to be here, have been offered a seat. This has 24 been done to accommodate everyone who applied, in 25 particular the former patients of Mr Eljamel and their Page 14	1 represented at these hearings by another solicitor from 2 the Central Legal Office and my learned friend 3 Mr Shane Dundas. 4 The latter body is the successor of the 5 previously designated core participant NHS Education for 6 Scotland which has, this year, become part of a new body 7 Public Services Delivery Scotland, as a result of 8 an administrative rearrangement of the NHS which has 9 resulted in the dissolution of the previous body and the 10 redesignation of the new one as an organisational core 11 participant in this Inquiry. 12 It is also worth clarifying, sir, that these two 13 bodies are separately represented from NHS Tayside. 14 The Scottish Ministers are represented at these 15 hearings by solicitors from Messrs Harper Macleod and my 16 learned friends Laura Thomson KC and David Blair. As at 17 previous hearings of the Inquiry they represent the 18 Scottish Ministers in their capacity as core 19 participants in and material providers to the Inquiry 20 only as opposed to the sponsors of the Inquiry in which 21 capacity they were represented at the last hearings we 22 held in May but in which capacity they are not 23 represented today. 24 The University of Dundee is represented at these 25 hearings by solicitors from CMS and my learned friend Page 16

1 Emma Toner KC. The Royal College of Surgeons of 2 Edinburgh are legally represented at these hearings by 3 Brodies solicitors from which firm Mr Marshall appears 4 as their representative at these hearings. 5 For clarity, sir, some may recall that at previous 6 hearings of the Inquiry you invited Professor Stephen 7 Wigmore, chair of the Independent Clinical Review or 8 ICR, to be a represented and extended to him the same 9 rights of reply and participation in those procedural 10 hearings as others for the objective of seeking to allow 11 them to contribute to the efficient work of those 12 hearings and ultimately of the Inquiry. 13 As the Inquiry moves into its evidential phase, it 14 has not been considered appropriate for the ICR to 15 continue to be represented as they have no role in the 16 leading of the evidence which we will hear, unlike our 17 core participants. Though I do have something to say in 18 due course by way of update about the ICR and its work 19 as part of this submission. 20 Indeed as we move to our evidential phase the 21 participation of the ICR and its representatives may 22 become in the capacity of witnesses providing evidence 23 as opposed to contributors to our structural plans. 24 Sir, we will also be joined at these hearings on 25 occasion at least by legal representatives of witnesses Page 17	1 from this Inquiry as to further changes which should be 2 made, the Inquiry's conclusions will be of great 3 importance to NHS Tayside as the safety, well-being and 4 trust of patients is at the heart of its work. As 5 a learning organisation it wants to hear from patients 6 and families, those best placed to advise and share 7 their experiences as to how it can consistently improve 8 and build confidence in the services it delivers. 9 10 NHS Tayside went on to say it is fully committed to 11 assisting the Inquiry and will work collaboratively with 12 the Inquiry team. It welcomes the Inquiry's 13 trauma-informed approach, to which I will return, and is 14 keen to ensure that this is adhered to. NHS Tayside 15 recognises that its systems and processes are 16 a significant focus of the Inquiry's investigations and 17 it will closely review relevant materials and will 18 listen carefully to the evidence to understand the 19 perspectives of those directly affected, all with 20 an openness and willingness to get things right for 21 patients. 22 In their opening written statement to the Inquiry 23 the Scottish Ministers said that they welcome the 24 opportunity to participate in this Inquiry and to assist 25 the Inquiry in its work. They said that the Scottish Page 19
1 who are not from core participant groups or not 2 themselves core participants in this Inquiry. As 3 presently advised, Mr James of Circle Healthcare, the 4 witnesses who will give evidence from the GMC, 5 Dr Gillies of NHS Lothian and Professor Smith of the 6 Royal College of Surgeons of England are legally 7 represented or have some form of legal support being 8 provided to them in connection with their evidence. 9 Those representatives will usually sit at the front row 10 of the hearing suite while their witnesses are giving 11 evidence. 12 I will say more, sir, in due course about the 13 practical features of the important role which our core 14 participants and their legal representatives can play at 15 this hearing. I would say, sir, that the opportunities 16 for participation in the hearings, unlike in some other 17 public inquiries, are neither small nor illusory. They 18 are considerable and of considerable value to our work 19 both at these oral hearings and beyond. 20 All of our core participants have committed to 21 cooperation with the Inquiry in the fulfilment of its 22 stated aims. In their written opening statement to this 23 Inquiry, NHS Tayside said that it very much views this 24 Inquiry as an opportunity for an independent assessment 25 of what went wrong and why. It welcomes recommendations Page 18	1 Ministers recognise that legitimate questions and 2 concerns exist regarding their responsibilities to 3 secure the effective provision of national health 4 services in Scotland and in particular oversight of 5 NHS Tayside and the handling of complaints about 6 Mr Eljamel. 7 They welcome, they said, both the scrutiny and the 8 opportunity for learning that this Inquiry will bring. 9 They say that the Scottish Ministers wish to ensure that 10 the Inquiry of their commitment to learning lessons and 11 to taking positive steps to improve the experience of 12 all who receive treatment and care within the NHS. They 13 said that patient safety is their priority. 14 They also added that the Scottish Ministers are 15 grateful for the opportunity to contribute to the 16 Inquiry's work in particular by making the opening 17 statement which they were invited to make in November. 18 They reiterated their willingness to work 19 collaboratively with the Inquiry and to assist the 20 Inquiry in fulfilling its Terms of Reference. 21 In their written opening statement to the Inquiry, 22 Healthcare Improvement Scotland said that HIS looks 23 forward to working with and assisting the Inquiry in 24 fulfilling its Terms of Reference. They said that that 25 organisation will share any knowledge and experience Page 20

1 that it has in relation to the Inquiry's areas of 2 investigation and they renewed their commitment to 3 supporting the Inquiry with its work in any way that 4 they could. 5 In their written opening statement to the Inquiry, 6 NHS Education for Scotland, now as I've said part of 7 Public Services Delivery Scotland, said that NES looks 8 forward to working with and assisting the Inquiry in 9 fulfilling its Terms of Reference, that it will share 10 any relevant knowledge and experience that it has in 11 relation to the Inquiry's areas of investigation and NES 12 also renewed its commitment to supporting the Inquiry 13 with its work in any way that it can. 14 In their written opening statement to the Inquiry, the Royal 15 College of Surgeons of Edinburgh said that the Royal 16 College will seek to assist the Inquiry in any other way 17 the Inquiry considers appropriate. 18 And in their written opening statement to the 19 Inquiry, the University of Dundee stated that the 20 university would wish to make clear that it welcomes 21 this Inquiry and recognises immediately its importance 22 and undertakes to co-operate fully with the Inquiry in 23 its investigation of the issues noted and more 24 generally. They added that finally, if the Inquiry 25 should find in due course that there may be any lessons Page 21	1 Inquiry's work. When you selected our core participants 2 for this Inquiry, sir, you exercised your wide 3 discretion bearing in mind a number of features. You 4 considered the applications you received in light of 5 your obligation to run the Inquiry as thoroughly and as 6 effectively as possible, bearing in mind the Inquiry's 7 wide-ranging Terms of Reference and the need for Inquiry 8 processes to be rigorous and fair. As is set out in the 9 Inquiry's core participant protocol, you assessed 10 carefully whether applicants could assist the Inquiry in 11 its work and whether their designation would actively 12 contribute to the efficient and thorough operation of 13 the Inquiry. That is the touchstone by which you 14 determined their applications and the benchmark for our 15 expectation that they will participate actively in what 16 we do. 17 As we committed to doing, core participants in this 18 Inquiry have been accorded rights, roles and 19 responsibilities which exceed the rights they derive 20 automatically from the law to ensure that they have 21 every opportunity to participate actively in our work. 22 Bodies which have received such status have the 23 responsibility of and experience of important features 24 of our remit: patient care and safety; the organisation, 25 funding and operation of hospital-based surgical care; Page 23
1 to be learned on the part of the university in relation 2 to any of the Inquiry's Terms of Reference both the 3 Inquiry and the public should be in no doubt that 4 comprehensive steps will be taken by the university to 5 address those matters which have been identified. 6 And in their written opening statement to the 7 Inquiry the patient core participant group said that 8 this Inquiry has been a long time coming and hard-fought 9 for, a matter which I've already recognised. They said 10 that the group are fully intent on supporting the 11 Inquiry so that it may fulfil its remit. 12 The Inquiry, sir, very much welcomes these 13 commitments made by these various different bodies or 14 groups and values the contribution which the Inquiry can 15 expect as a result of them having been made and made so 16 publicly. 17 In that regard may I say a few words about our 18 organisational core participants. It is too often the 19 case in public inquiries in my view, sir, that 20 organisational core participants see themselves as 21 occupying a defensive role. With respect, may I suggest 22 that that is not an appropriate way in which to view the 23 designation of organisational core participants even if 24 their designation has been based, in part at least, on 25 the possibility that they may face criticism in the Page 22	1 the performance of surgery and the setting of the 2 surgical standards; medical and surgical education and 3 training; and the betterment of those important 4 services. 5 In line with the Inquiry's commitment to cooperation 6 and the commitments which have quite properly been made 7 by these organisations, I would remind them of the 8 background to their involvement, the importance of their 9 active participation, the commitments they have made and 10 the opportunity which this Inquiry affords for the 11 betterment of the care of those who receive surgical 12 treatment or care in Scotland. 13 I look forward to continuing to work with them in 14 the achievement our mutual aims and aspirations for this 15 process. 16 Sir, to move on then to a matter which you have 17 mentioned in your opening address, namely the delays in 18 the holding of these hearings and developments in 19 connection with the hearings venue in which we find 20 ourselves in Waverley Gate in Edinburgh. 21 Sir, before I turn to the objective of and plans for 22 these hearings as well as the plans beyond them which 23 I will in due course, I must, I feel, take some time to 24 seek to explain developments with regard to the safety 25 of this building, an issue which necessitated the Page 24

1 postponement of our Section 1 evidential hearings which 2 were originally due to take place in April and May of 3 this year and which was the main focus of the procedural 4 hearing you held on 14 May. 5 I require to do so for the reasons you held the 6 hearing at that time in the interests of transparency 7 and openness with all those in attendance and who take 8 interest in our work. 9 It is an important feature of the Inquiry's approach 10 to its hearings and indeed its work more generally that 11 people should feel safe when they engage with our work. 12 That is why, sir, when safety issues beyond your control 13 came to light earlier this year they were not taken 14 lightly, they were interrogated and investigated, action 15 was taken as a result. 16 As many of those who are in attendance today will 17 recall you held a procedural hearing on 14 May this 18 year, part the purpose of which was to seek further 19 clarification from the Scottish Government as to what 20 steps were being taken by it, in its capacity as the 21 tenant of this building which has accorded the Inquiry 22 permission to use it, to address fire safety concerns 23 which had arisen. At that time I set out a detailed 24 history of what had happened to that point, when the 25 issue had arisen and what the Inquiry knew about it, as Page 25	1 had been conveyed by you in particular on behalf of 2 patient core participants by various means. 3 The Inquiry received a further letter from the 4 Scottish Government on 27 May of this year which set out 5 more detail of the shaft wall works which were proposed. 6 It was stated that a meeting had taken place the day 7 before the procedural hearing on 13 May between the 8 government and the property's landlord and that the 9 outcome was as follows. 10 At that meeting the landlord confirmed that in order 11 to ensure compliance with the required fire safety 12 standards, a shaft wall was required along the whole of 13 the corridor serving both Inquiry spaces which serves as 14 fire escape route. The City of Edinburgh Council has 15 indicated that a full corridor shaft wall remedy would 16 be acceptable and meet the standards required to secure 17 the necessary building warrant sign-off. The landlord 18 has indicated that they are willing to undertake the 19 required works on behalf of the Scottish Government 20 subject to agreement from the Scottish Ministers on the 21 funding arrangements. The landlord is currently engaged 22 with contractors to explore the practical delivery of 23 a solution. 24 It was also pointed out that at a subsequent meeting 25 which took place on 26 May to ensure the landlord and Page 27
1 well as what steps had been taken by that point by us 2 and to our knowledge to seek to resolve the issue. 3 That history as a matter of public record was fairly 4 not disputed by the Scottish Government at the hearing 5 and need not be rehearsed here. Needless to say, the 6 Inquiry's position at that time was characterised by 7 a dissatisfaction with the fact that the issue had 8 arisen in the first place as well as with the limited 9 and poorly explained efforts to resolve them on the part 10 of the Scottish Government and the amount of time and 11 effort which had to be spent by the Inquiry team in 12 seeking to see that it was resolved. Counsel who 13 appeared on behalf of the Scottish Government at the 14 hearing in May made clear that fire safety issues had 15 arisen which would necessitate certain works being 16 undertaken on what was called a shaft wall which forms 17 part of these premises. Relatively few details could be 18 provided at that time as to what those works would 19 entail but it was intimated that plans were being 20 progressed to have the works undertaken so as to 21 facilitate the Inquiry in progressing with its planned 22 public hearings which, by that stage, you had committed, 23 sir, would be hearings at which public attendance would 24 be possible, in light of the public nature of this 25 process and the importance of physical attendance which Page 26	1 contractors remained committed to the urgency of the 2 completion of the works and that, to quote, "Other 3 options are also being looked at by the landlord on 4 which we will update you as early as we can". 5 In that correspondence it was concluded that while 6 progress is being made, it is not yet possible to 7 confirm a resolution date due to the ongoing design and 8 options work outlined above. 9 On 11 June the Inquiry was provided with a copy of 10 a note intimated by the Scottish Government which 11 explained that another solution to the ongoing fire 12 safety issue may have arisen despite the previous 13 apparent requirement for and commitment to the building 14 works which the Scottish Government had intimated would 15 take place. The proposed solution involved a new lease 16 being entered into between the Scottish Government and 17 the landlord which would include the corridor within the 18 area leased to the Scottish Ministers and combine the 19 two current leases held by the Scottish Government over 20 this hearing suite and the neighbouring office used by 21 the Inquiry into one overall lease to the Scottish 22 Ministers. 23 This, the Inquiry was told, would align the 24 arrangements for the occupation of this floor of the 25 building with the leased areas on the upper floors of Page 28

1 the building. It was suggested without further 2 explanation that this conveyancing solution would allow 3 the construction which had taken place to configure this 4 floor as it is to comply with the technical safety 5 standards required without the need for further works to 6 be undertaken at all. 7 It was intimated that agreement in principle on this 8 proposed solution had been secured between the council 9 and the landlord supported by their technical advisors. 10 On 17 June the Inquiry responded to this proposal 11 with a number of further queries about the proposed new 12 arrangement. In any event, work proceeded with the 13 implementation of a new lease which was considered by 14 the Scottish Government to be necessary based on the 15 assurance provided to them by the landlord which 16 included the assurance that the council will be content 17 with this new arrangement. A project plan was issued to 18 the Inquiry with steps setting out when the new solution 19 could be delivered against various milestones. 20 By 16 July an update was received by the Inquiry 21 that the initial steps undertaken in terms of the 22 project plan involving intimation of a new draft lease 23 arrangement and a commitment from the sponsoring 24 Minister of the Inquiry to enter into such a lease meant 25 that a retrospective building warrant had been granted Page 29	1 full in-person hearings as-planned in September at the 2 hearing suite in Waverley Gate. 3 Sir, an important part of the Inquiry's commitments 4 to safety, as part of its trauma-informed strategy and 5 more widely, involves clarity about why it is that those 6 who are here today with us should feel that they are now 7 safe. That is particularly difficult to set out when 8 the Scottish Government has not taken any action, as 9 they explained in May that they were required to do, to 10 undertake or instruct any works on this property at all. 11 That may seem unusual, and reasonably so, in the face of 12 detailed explanations provided to you, sir, on behalf of 13 the Scottish Government in May about the nature of the 14 remedial works which would be necessary for the property 15 to be made safe at that time. 16 Those who are in attendance should feel safe and 17 should feel that the Inquiry has done everything it can 18 to make sure that they do. The secretary to the Inquiry 19 has spent a considerable amount of time over many, 20 many months trying to resolve the safety issue as, to 21 a lesser extent, have all members of the Inquiry senior 22 team. 23 The Inquiry is now as satisfied as it can be that 24 the fire safety issue has been resolved. The Inquiry 25 secretariat staff are on hand to address any concerns or Page 31
1 by the council in connection with the previous building 2 works which had been undertaken to configure the 3 property as it is. Further intimations were received by 4 the Inquiry when key aspects of the project plan were 5 met including the signature of the new lease. 6 On 5 August the Scottish Government confirmed that 7 use of the hearing suite could resume as a building 8 warrant had been received from Edinburgh City Council 9 and missives had been exchanged relating to the new 10 lease over the premises. On 17 August after further 11 reassurances about progress received by the 12 Inquiry from the government including in relation to the 13 issuing of a completion certificate by the council 14 relating to the building works and progress towards the 15 finalisation of a new lease. As a result the Inquiry 16 was able to publish the following on its website that 17 day. The Scottish Government as tenants of the premises 18 has informed the Inquiry that: 19 "It has now been confirmed that the lease 20 arrangement has been finalised and the required 21 retrospective building warrant is now in effect. The 22 hearing suite therefore fully complies with the 23 appropriate building regulations which set the necessary 24 safety standards." 25 Based on this update, the Inquiry intends to hold Page 30	1 queries which those who are here with us today have in 2 that regard or indeed any other. Many of those with 3 a keen interest in our work have told us that in the 4 past they have not felt safe and moreover that when they 5 had expressed that that is how they feel they have not 6 been listened to or their sensation of insecurity has 7 not been treated with dignity and respect. Our 8 commitment to safety is not just to assert that people 9 are safe but to do what we can to make them feel that 10 way. Their safety is not a matter to be taken lightly 11 or for granted, it is a matter to be secured by us for 12 them and for us to show them that we have secured it. 13 Throughout this process the need to keep people 14 informed of details which could be shared has been at 15 the forefront of the Inquiry's approach. Aspects of the 16 detailed negotiations to do with the property could not 17 be shared because of their commercial sensitivity. 18 However, the need for openness and transparency has been 19 appreciated and actioned by the Inquiry as best it could 20 at all times. Moreover, the needs of those who 21 participate in our process to remain adequately informed 22 about what is going on has been impressed upon the 23 Scottish Government by the Inquiry team at all stages of 24 the process and it continues to be. 25 These principles need not only to be adhered to by Page 32

1 our staff, which they are, but by those such as the 2 Scottish Government on whose support and services the 3 Inquiry continues to require to rely. It is our hope, 4 sir, that shortcomings in that regard on the Scottish 5 Government's part will not be repeated and that the need 6 not only for speed and efficiency in their support of 7 the Inquiry but also for the ability to share details of 8 what is going on with our core participants and the 9 wider public will be appropriately factored into our 10 dealings with them in future. That is what those core 11 participants reasonably expect and it is what you and 12 your team are committed to delivering. 13 Sir, can I now move to the scope of Section 1 of the 14 Inquiry's evidential plan and the witnesses who are due 15 to give evidence at these hearings. 16 Before turning to the ambit of the evidence which we 17 intend to cover at these hearings, sir, may I take some 18 time to remind those listening about our approach to the 19 gathering of evidence at this Inquiry as well as the 20 purpose of evidential hearings such as these. 21 It is the process which has been adopted by this 22 Inquiry and authorised by you, sir, that evidence does 23 not require to be spoken to at oral hearings to be 24 amongst the evidence which you can consider in the 25 determination of your findings in your ultimate report Page 33	1 The public hearings of the Inquiry serve a number of 2 important purposes including (a) in accordance with the 3 Inquiry's obligations under Section 18 of the 2005 Act 4 to permit attendance by core participants, members of 5 the public including reporters, at the Inquiry and to 6 see and hear a simultaneous transmission of the 7 Inquiry's proceedings subject to any restriction notice 8 or order made under Section 19. 9 At evidential hearings to enable evidence already 10 gathered by the Inquiry in the form of written 11 statements or other documentary evidence to be 12 ventilated in public, explored, examined and their 13 contents clarified or supplemented by the oral evidence 14 heard as hearings, to challenge witnesses on the 15 evidence already given by them to the Inquiry in the 16 form of written statements, or based on material 17 contained in documentary evidence recovered by the 18 Inquiry, ultimately to assist the Inquiry in making 19 findings in its report or reports, including where 20 appropriate the identification of things which occurred 21 falling within the ambit of the Inquiry's Terms of 22 Reference and/or which fell below a reasonable standard 23 which they did as well as who or what organisations were 24 responsible. And finally to enable core participants 25 via their legal representatives to submit questions for Page 35
1 or reports. That final report or those final reports 2 are the ultimate aim of your process, the written record 3 of what you have found, what you have found went wrong, 4 who was responsible and what you think can reasonably be 5 recommended for such adverse outcomes as you have found 6 to have taken place at a broad level to be avoided in 7 the future. 8 Evidence contained in documents, including for 9 example in ICR applicant statements and other witness 10 statements provided to the Inquiry, will be deemed by 11 the Inquiry to be evidence in the Inquiry which you as 12 the Chair can consider in making findings and 13 recommendations in the fulfilment of your Terms of 14 Reference. 15 Such evidence will be able to be relied upon without 16 the need for it to be spoken to in oral evidence in 17 hearings or otherwise adduced formally. You have 18 determined that such formality would be inconsistent 19 with the inquisitorial nature of this process and likely 20 to involve unnecessary cost. 21 Thus, evidential hearings are not an end in 22 themselves but a part, though an important part, of the 23 journey to the report or reports which are the ultimate 24 aim of everything we do. Paragraph 5 of the Inquiry's 25 Public Hearings Protocol provides as follows. Page 34	1 consideration by Counsel to the Inquiry and to make 2 applications, if necessary, under Rule 9 of the 3 Inquiries (Scotland) Rules 2007 as set out in 4 paragraphs 31 below. 5 Thus evidential hearings such as these ones have 6 been designed to serve the purpose of the public 7 ventilation of issues covered by the Inquiry's Terms of 8 Reference, challenge of evidence received by the 9 Inquiry, and the opportunity for our core participants 10 to submit questions for consideration by the Inquiry as 11 part of our investigative process. I will return to the 12 precise processes which have been and will be adopted in 13 particular to allow core participants to contribute 14 proposed questions for witnesses but it is important to 15 understand that the ability of core participants to 16 contribute to these hearings is a very important feature 17 of the hearings process. 18 In essence, sir, the Inquiry has the ability to ask 19 questions and even to compel them to be answered at any 20 time by issuing Rule 8 requests for witness statements 21 and/or documents to be produced or Section 21 notices 22 for those purposes where required. Though the questions 23 which have been asked by us are, in this Inquiry, 24 apparent to core participants and the wider public as we 25 have asked respondents to repeat them in their ultimate Page 36

1 written statements, core participants do not contribute 2 to the formation of Rule 8 requests or Section 21 3 notices other than in a general sense as a result of the 4 broad suggestions as to the lines to follow which have 5 been made by them, for example in their opening 6 statements to the Inquiry. 7 Thus, the opportunity for core participants to 8 propose questions which our systems are designed to 9 promote and also take seriously represents 10 a particularly important feature of these evidential 11 hearings and subsequent ones in which matters will be 12 examined with witnesses in more detail as we progress 13 beyond our introductory evidential phase. 14 In too many public inquiries in my view the role of 15 core participants is too passive. Not here, as far as 16 we are concerned. 17 Sir, as was announced as early as the preliminary 18 hearing last September and is set out in the Inquiry's 19 Public Hearings Protocol which was published as long ago 20 as 10 June 2025, Section 1 of our evidential plan and 21 hence these hearings which are associated with it is 22 unashamedly introductory in nature. It is inevitable 23 that amongst our audience there will be those with 24 a deep interest in the subject matter of this Inquiry, 25 to whom some or possibly even much of the information we Page 37	1 them are equally important, we must treat all within 2 them equally. To assume the knowledge of those who 3 already know the most on the part of others who may, for 4 whatever reason, know less would be to exclude those who 5 have an equal right to be here and to be provided with 6 a reasonable opportunity to learn from and participate 7 in our process. 8 It is important that for our investigations to be 9 focused and appropriately orientated we spend time at 10 the beginning understanding the context in which the 11 detailed investigations to come must be undertaken. 12 That is not to say, sir, that there may not be 13 matters into which these hearings will enable to us 14 delve more fully than others. It may be by the end of 15 these hearings, or even by the end of evidential 16 Section 1, that you, sir, will form the view that the 17 evidence that we have heard means that certain matters 18 which are important to your investigations could be 19 deemed to have been proven to your satisfaction. That 20 is not to say that you or we will close our minds to the 21 possibility that the evidence may reveal new information 22 which requires such matters to be looked at with fresh 23 eyes. However, it is a feature of going where the 24 evidence takes you that we anticipate that there will be 25 matters which become clear or at last clearer within Page 39
1 will examine in this section is already apparent. 2 However, this Inquiry is conducted in the public 3 interest and it must not be assumed that everyone with 4 a legitimate interest in our work has the same degree of 5 understanding or insight into what we are investigating. 6 Some who may have made certain assumptions about what 7 has occurred may even be enlightened by the evidence 8 which actually emerges. In any event, it is important 9 that we start at the beginning in particular for those 10 who may know less. Those who know less at this stage 11 have no less of a right to understand what we have 12 discovered and what we will discover. On one view they 13 rely on the Inquiry even more to provide them with 14 information about what has happened which is within our 15 remit. The public ventilation of the evidence we have 16 uncovered is an important part of our public function 17 after all. 18 Even amongst our core participants groups it is 19 already apparent, sir, that there is a varied level 20 of understanding of what the professional practice of 21 Mr Eljamel in the Tayside area entailed, what it caused 22 and what issues it created. There is certainly a varied 23 understanding of what was done or could have been done 24 about those issues possibly even to have prevented them. 25 As all of these groups and the individuals within Page 38	1 this evidential section whereas there will inevitably be 2 others where a much fuller investigation will be required. 3 That is particularly the case, sir, in this Inquiry 4 where there is considerable uncertainty as to what 5 questions can be answered by reference to 6 contemporaneous documents. Indeed, it is part of the 7 purpose of this section to try to understand what 8 documents exist, what they contain and hence what level 9 of controversy in relation to the issues you have 10 undertaken to resolve remains. It is only by gaining 11 an understanding of that context that it will be 12 possible to formulate a plan as to where we go next and 13 how deeply we need to look into certain areas for 14 answers. 15 The result of this approach we hope will be to 16 provide a proper and useful context in which our more 17 detailed investigations can be undertaken in due course. 18 The matters related to which we will hear evidence 19 have been published for some time in the Section 1 scope 20 which is available on our website. 21 It is an important aim of this section of our 22 evidential plan to try to ascertain an impression as to 23 what documents are held within organisations as I have 24 said which played or could have played a part in key 25 events falling within our remit. This is an important Page 40

1 part of scene-setting for a two reasons. One is that 2 Term of Reference 14 requires us to examine document 3 management systems within NHS Tayside including the 4 extent to which absence of documents undermine the 5 effectiveness of previous investigations into the 6 professional practice of Mr Eljamel and systems 7 surrounding it, such as those listed in Term of 8 Reference 12. 9 In addition an analysis of available documents is of 10 evidential significance. Where documents exist they may 11 tell us the answers we need. They may not have been 12 previously available and provide illumination for those 13 who have not had access to them before. They may 14 confirm suspicions or answer burning questions. 15 Equally, they may not tell the whole story. They may be 16 partially useful or even not exist at all in connection 17 with certain matters of significance to our mission. 18 Whatever the picture which emerges, this is a useful 19 part of our preliminary foray into the evidence. Where 20 questions are answered by existing recovered documents 21 we are on the way to fulfilling our mission which is to 22 resolve our list of issues. Where we remain in the dark 23 we will find ways to seek evidence from other sources 24 directly from other witnesses in our quest for the 25 truth. Either way, we hope that we will able to form Page 41	1 may I emphasise that systems have been put in place so 2 questions from core participants which are deemed to go 3 too far, too deeply into the details to be merited being 4 addressed within the context of our present introductory 5 ambitions will be retained for future use. It should 6 not be thought that these hearings will be the last 7 opportunity for witnesses to be examined, or issues 8 which merit more detailed investigations to be 9 undertaken. 10 An introductory section means just that. By the end 11 of our Section 1 investigations, which I should say will 12 stretch beyond these hearings, we will merely be at the 13 end of the beginning. We will use what we have 14 discovered here as a basis for what comes next. 15 Sir, I'd like to say something about patients. From 16 the time of your public consultation on the Terms of 17 Reference you committed, sir, to putting patients at the 18 centre of our process. That is why you have taken steps 19 to designate that 160 patients or patient 20 representatives are core participants, why they have 21 a full-time funding award for lawyers to assist their 22 participation to support and advise them in their work 23 and why you have sought their input on key aspects of 24 this Inquiry, from the Terms of Reference to the list of 25 issues, to letters of instruction for experts and our Page 43
1 a clear impression of what evidence there is and what we 2 need to find by the end of the section. I will return 3 to the contribution we anticipate core participants 4 making to that process in due course. 5 Sir, in this section we will also hear independent 6 expert evidence, instructed by the Inquiry itself, from 7 three expert groups. I will discuss the remits of these 8 groups and their proposed role in more detail in due 9 course but in broad terms they will provide important 10 independent expert context on surgical procedures, rules 11 and systems, considerations of best practice and 12 developments in their areas of expertise, all of which 13 relate to key areas covered by the Inquiry's Terms of 14 Reference. 15 It is inevitable I think, sir, that those with 16 a keen interest in the subject matter of this Inquiry 17 will be keen that we delve deeply into certain subjects 18 of interest to them. That is an entirely natural 19 instinct especially amongst those who have waited so 20 long for answers to their ever more pressing and urgent 21 questions. 22 Sir, I will return in a moment to the processes 23 which will be followed to achieve participation from 24 core participants in this section and the importance of 25 that in these hearings. However, for present purposes Page 42	1 procedural planning via the three procedural hearings 2 including in their valuable written and oral opening 3 statement. 4 It is a fact of these hearings that evidence will 5 not be heard in this section from patients directly. 6 This, in my submission, should not be taken into be any 7 departure from or even dilution of your firm commitment 8 this that is a patient-centred Inquiry. It most 9 certainly is not. In fact the entirety of the oral 10 hearings led in December which will now come from 11 patients or their representatives, a matter to which 12 I will return in due course. The importance that the 13 patient voice be heard will in part, we anticipate, be 14 satisfied by the oral evidence we will hear from 15 Liz Smith CBE, a former MSP and long time campaigner on 16 behalf of a considerable number of Eljamel patients. 17 Written statements have also been obtained and disclosed 18 to core participants from other political 19 representatives who are able to relay an element of the 20 communal patient experience as well as a result of their 21 involvement in the campaign for this Inquiry, namely 22 Willie Rennie MSP and Michael Marra MSP from different 23 parts of the political spectrum and with different 24 experiences of the patient voice and patients' 25 experiences. Page 44

1 It is anticipated that Ms Smith's evidence will 2 cover her long-standing acquaintance with the experience 3 of Eljamel patients including but not limited to her 4 experience of campaigning for this public inquiry as 5 well as her more recent involvement in the Scottish 6 parliament's public administration committee's 7 investigation into the cost-effectiveness of public 8 inquiries in Scotland which forms an interesting context 9 to our own investigations under Term of Reference 12 of 10 the Scottish Government's approach to the announcement 11 of this public inquiry. 12 The Inquiry's forward-looking function and the 13 importance of patient care in that aspect of our work 14 means that patients are also represented to an extent in 15 the evidence of the Patient Safety Commissioner, 16 Karen Titchener, who it is anticipated will cover the 17 remit and ambitions for that relatively new role, her 18 experiences so far of issues in the achievement of good 19 quality patient care in Scotland, some of which we 20 anticipate will chime with the experience of the 21 patients at the centre of this Inquiry, thus enabling it 22 to become a focused environment in which wider patient 23 safety and patient care considerations can be examined 24 and possibly addressed. 25 It is hoped that that evidence will provide a useful Page 45	1 Edinburgh, Mr Robbie Pearson of Healthcare Improvement 2 Scotland, Ms Emma Watson of Public Services Delivery 3 Scotland of which NHS Education for Scotland now forms 4 a part. The evidence of these individuals relate to 5 their role and remit and any connection they may have to 6 Mr Eljamel or involvement they may have had in aspects 7 of his professional practice to which this Inquiry 8 directly relates. 9 As far as other organisations are concerned, sir, 10 you will also hear evidence from representatives 11 of other organisations which had, or could have had, 12 roles to play in the matters with which this Inquiry is 13 primarily concerned. These representatives are expected 14 to be able to provide evidence to the Inquiry on the 15 general functions/operation remits of their organisation 16 but have also, as part of the Section 1 remit, been 17 asked to provide evidence of more specific aspects of 18 the Inquiry's remit in which their organisation did have 19 a role. Such witnesses including Professor Frank Smith 20 of the Royal College of Surgeons of England. As well as 21 outlining that organisation's general role evidence is 22 also anticipated on the RCS investigation into 23 Mr Eljamel practice which took place in 2013 as referred 24 to in Terms of Reference 12. Dr Tracy Gillies of NHS 25 Lothian who will outline that organisation's general Page 47
1 context in which the Inquiry's ambitions to making 2 patient-centred recommendations can be fulfilled 3 ultimately in Section 6 of our evidential plan which 4 will be devoted to evidence relating to recommendations 5 which may future in your final report. 6 Though patients will not give evidence at this 7 hearing session, their voice will be heard through these 8 witnesses and through the participation of the large patient 9 core participant group in the proceedings in the next 10 four weeks. These patient-focused witnesses will be 11 heard near the start of these sessions, this afternoon 12 and on Thursday morning, to ensure that the evidence 13 which you hear, sir, will rightly be heard in 14 a patient-orientated and centred context. I say 15 "rightly" because patient care is legally required to be 16 at the centre of the National Health Service in 17 Scotland. So patients should be at the centre of 18 an Inquiry whose remit concerns that institution. 19 Sir, could I say something about our approach to 20 core participant organisational witnesses. You will 21 hear evidence, sir, from witnesses who speak on behalf 22 of a number of organisations with remits which are 23 related to the subject matter of this Inquiry. In 24 particular, you will hear from the following. 25 Mr Mark Egan of the Royal College of Surgeons of Page 46	1 role, but evidence is also anticipated from her on the 2 investigation undertaken by her in 2018/19 also referred 3 to in Terms of Reference 12. Mr Charles Massey and 4 Mr Anthony Omo of the GMC. They have requested that 5 evidence be given by both of these individuals though 6 the GMC statement was provided by and is signed by 7 Mr Massey alone. Mr Omo, we understand, has experience 8 of the GMC's current fitness to practice rules and 9 systems. As well as outlining the organisation's 10 general role, evidence is anticipated on the broad 11 nature of any involvement of the GMC in matters relating 12 to the professional practice of Mr Eljamel which arises 13 under Term of Reference 7 and Term of Reference 13, as 14 well as information which they have about the voluntary 15 removal of Mr Eljamel's name from the GMC's medical 16 register, in particular focusing on the role of 17 NHS Tayside in that process which is covered by Term of 18 Reference 11. 19 Professor Rory McCrimmon and Professor John Connell 20 of the University of Dundee, two witnesses are being 21 called from that organisation. As was the right of any 22 organisational recipients of a Rule 8 request, the 23 university elected to complete two statements as, in its 24 view, this would be the best way of responding to the 25 Inquiry's relate request Rule 8 request. One was Page 48

1 completed by each of the witnesses who were giving 2 evidence during the course of these hearings. As well 3 as outlining that organisation's general role, evidence 4 is also anticipated to be heard on the roles which 5 Mr Eljamel held within the university, his 6 responsibilities in them, how he was appointed to them, 7 the extent to which his teaching and other commitments 8 with the university occupied his time and attention 9 possibly with an effect on his clinical commitments 10 covered by Term of Reference 2(d), any oversight 11 function carried out by the university of Mr Eljamel's 12 work possibly relevant to Term of Reference 6 as well as 13 his research and his commitment to research activities 14 covered by Term of Reference 2(e). 15 Mr Peter James of Circle Healthcare, the body 16 ultimately responsible for the operation of Fernbrae 17 Hospital in Dundee where Mr Eljamel undertook his 18 private work, will also give evidence. I have already 19 explained at previous hearings that the Inquiry 20 interprets its Terms of Reference as not permitting 21 a detailed systemic analysis of the systems which 22 related to the neurosurgical service provided at 23 Fernbrae which was in part delivered by Mr Eljamel. 24 This is an Inquiry with a focus on the NHS. However, as 25 well as outlining that organisation's general role, Page 49	1 Government's involvement in or knowledge of other 2 reviews conducted by other bodies including those listed 3 in Term of Reference 12. 4 It will also be intended to cover the broad picture 5 with regard to the Scottish Government's approach to 6 handling calls for a public inquiry into the Eljamel 7 affair which Ms Cherry told us in her opening 8 statement started in 2014, the Government's position 9 on and in response to that, including the thought 10 process of alternatives to a public inquiry being 11 offered and the thinking behind the announcement of 12 a public inquiry in September 2023. 13 It was submitted indeed in the patient group's 14 written opening statement that this Inquiry is also 15 about the way the patients and their loved ones have 16 been treated simply for seeking answers and redress. 17 The potential that the state response to traumatic medical 18 treatment may be as serious as the treatment itself and 19 its potential to compound the harm already suffered by 20 patients is not lost on this Inquiry. It will be 21 examined by the Inquiry in its examination of the 22 Scottish Government at these hearings and in Section 5 23 of its evidential plan. 24 Sir, as far as NHS Tayside is concerned, as will no 25 doubt have been expected by those who take an interest Page 51
1 evidence is also anticipated from Mr James on the nature 2 and extent of Mr Eljamel's private work, the time 3 commitments he had to it, as well as the practising 4 privileges which he enjoined at Fernbrae, all of which 5 are relevant to Term of Reference 2(a). In addition 6 there will be an investigation of the issues, if any, 7 which arose in the practice of Mr Eljamel at Fernbrae as 8 well as the systems which were in place for any issues 9 to be communicated to the NHS which is covered by Term 10 of Reference 3(c). 11 Miss Caroline Lamb will give evidence on behalf of 12 the Scottish Ministers. As well as outlining the 13 Scottish Government's general responsibilities for the 14 delivery of healthcare and in particular neurosurgical 15 services in Scotland, it is anticipated that matters 16 which will be covered by her will include the nature and 17 extent of the Scottish Government's knowledge of and 18 involvement in issues relating to the professional 19 practice of Mr Eljamel, including but not limited to the 20 investigations into him and the systems surrounding him 21 conducted by others under Term of Reference 12. There 22 will also be an opportunity to understand the remit, 23 operation and main conclusions of the Scottish 24 Government review of unresolved and outstanding concerns 25 concerning Mr Eljamel in 2022 as well as the Scottish Page 50	1 in our work, a significant number of witnesses who will 2 be called at these hearings will be employees or former 3 employees of NHS Tayside. This is the result of two 4 related matters. 5 First the bulk of the Inquiry's Terms of Reference 6 relate in some way to the systems and actions or 7 inaction of NHS Tayside. Their Rule 8 request was 8 therefore by far the most comprehensive. Even though these 9 hearings are introductory in nature, there are lots of 10 matters relating to NHS Tayside which require to be 11 introduced. Further, as a consequence of the wide range 12 of subjects covered in the statement, NHS Tayside, as 13 was their right, took the view that having a number of 14 different individuals respond to the Inquiry's questions 15 would be the best way for the organisation's evidence to 16 be presented. Therefore different topics have been 17 covered by a number of different individuals all of whom 18 have important aspects of the NHS Tayside position to 19 cover. 20 These witnesses will not be called in the order or 21 at the time when the Inquiry would have liked not, 22 I should say, as a result of any issues with the 23 witness' availability, they have in fact been most 24 accommodating in that regard, but due to the need to 25 accommodate availability or other issues and due to how Page 52

1 numerous the NHS Tayside witnesses are. We will do what 2 we can to make sure the evidence is presented in a way 3 which maximises comprehension despite these unavoidable 4 consequences of availability considerations. 5 Sir, as far as NHS Tayside is concerned the Inquiry 6 will hear evidence from the chief executive, 7 Nicky Connor. Her evidence will include an examination 8 of the destruction of theatre logbooks which would have 9 been relevant to the Inquiry's investigations, how that 10 was allowed to occur, and the steps which have been 11 taken in the aftermath of their destruction. It was 12 made clear, sir, in the opening statement and associated 13 submissions by Ms Cherry on behalf of the patient group 14 that this was a matter of some considerable and some 15 might say understandable concern on part of the patient 16 group. As such, this matter will be addressed with 17 Ms Connor in the first week of these hearings. 18 In addition, sir, it is an important part of 19 providing evidential context to our work to do what 20 lawyers might describe as narrowing the ambit of the 21 dispute. What that means, sir, is trying to understand 22 what it is from the outset that NHS Tayside, 23 an organisation with which this Inquiry is principally 24 concerned, accepts and does not accept. Again, it is 25 intended to try to address those matters with Page 53	1 responsibilities he had and the terms on which he held 2 them, including the rules relating to matters covered by 3 Term of Reference 2 such as private work, workload, 4 teaching and research commitments and the 5 responsibilities of consultants towards junior staff, 6 including the allocation of surgical responsibilities to 7 them. 8 Her contribution also covers the rules within 9 NHS Tayside relating to supervision, suspension, 10 dismissal and removal of a medical professional's name 11 from the GMC medical register as well as Mr Eljamel's 12 clinical supervision, Term of Reference 8, his 13 suspension, Term of Reference 9, his resignation from 14 NHS Tayside, Term of Reference 10, and the removal of 15 Mr Eljamel's name from the GMC medical register in 16 particular NHS Tayside's role in that process under Term 17 of Reference 11. 18 Also in week three the Inquiry will hear the 19 evidence of the board's secretary of NHS Tayside, 20 Ms Margaret Dunning. It's anticipated that her evidence 21 will focus on the broad roles and responsibilities of 22 NHS Tayside and other bodies which exercise control over 23 the operation of neurosurgical services in the past as 24 well as the roles and identities of key individuals 25 within the board and those other bodies. Her Page 55
1 Nicky Connor and other witnesses. 2 In the second week of the hearings the Inquiry will 3 hear from the Executive Nurse Director of NHS Tayside, 4 Mr Simon Dunn. It is anticipated that his evidence will 5 focus on the NHS Tayside complaints and feedback systems 6 as well as the nature and extent of the complaints and 7 feedback received from NHS Tayside relating to 8 Mr Eljamel, investigations broadly undertaken as 9 a result, the remaining documentation which was held 10 relating to those and the steps taken by NHS Tayside as 11 a result of these investigations, all of which are 12 covered by the Inquiry's Terms of Reference 4 and 5. He 13 also covers NHS Tayside's significant event management 14 policy and adverse event management policy as well as any 15 incidents relating to Mr Eljamel falling within those 16 systems. 17 In week three the Inquiry will hear evidence from 18 NHS Tayside's Director of People and Culture, 19 Ms Elaine Watson. It is anticipated that her evidence 20 will focus on the appointments of Mr Eljamel and 21 information relating to how he was successful in gaining 22 key positions he held including his appointment as 23 a consultant in 1995, all of which are covered by Term 24 of Reference 1. It will also cover the trajectory of 25 his career in NHS Tayside, the main roles and Page 54	1 contribution also covers the roles of certain committees 2 within NHS Tayside as well administrative records 3 management within the board and data protection. 4 In the final week of the hearings, the Inquiry will 5 hear from Dr James Cotton, NHS Tayside's Executive 6 Medical Director. Dr Cotton is the signatory of the 7 NHS Tayside written statement and has answered by far 8 the largest number of questions in it. It is 9 anticipated that his evidence will cover the 10 investigations undertaken under Term of Reference 12 11 insofar as they involve NHS Tayside including the 12 ambitions, remit, methodology and broad conclusions of 13 each, as well as steps taken or not taken in the 14 aftermath of them. His contribution also covers 15 a number of other important aspects of the NHS Tayside 16 evidence including the remits of various departments and 17 committees, relative responsibilities of the board and 18 other bodies with key roles in the provision of 19 healthcare in Scotland, mortality and morbidity 20 structures, professional governance structures, internal 21 and external information sharing systems, including with 22 patients, professional regulators, the Scottish 23 Government and the police, the NHS Tayside neurosurgical 24 service, the use of products and devices in 25 neurosurgery, aspects of Mr Eljamel's career with Page 56

1 NHS Tayside including his teaching and training 2 responsibilities and NHS Tayside's responsibility for 3 investigating complaints against surgeons. Which is 4 hopefully enough to cover in a day. 5 The Inquiry will hear from NHS Tayside's Chief 6 Officer for Acute Services, Ms Lynn Smith. It is 7 anticipated that her evidence will focus on the work of 8 the neurosurgical services offered by the NHS in Tayside 9 as well as its main operational methodologies including 10 working practices between the neurosurgical unit at 11 Ninewells and other clinical departments of the 12 hospital, as well as document management within the 13 neurosurgical unit and information about the spread of 14 work covered by Mr Eljamel himself. 15 Also in week three the Inquiry will hear the 16 evidence of NHS Tayside's Director of Communications and 17 Engagement, Ms Jane Duncan whose evidence will focus on 18 apologies which have been made by NHS Tayside in 19 connection with the professional practice of Mr Eljamel 20 including when and why they have been made. 21 Finally the Inquiry will hear the evidence of 22 NHS Tayside's former Deputy Chief Executive, 23 Ms Sandra MacLeod. Her evidence will include 24 information about NHS Tayside's document management 25 systems with a focus on the management of patient Page 57	1 principles of which are made clear to experts not least 2 in their letter of instruction which forms the basis of 3 their engagement with and provision of evidence to the 4 Inquiry, to the terms of which core participants were 5 invited to contribute suggestions as happened with the 6 standard form letter of instruction sent to the ICR's 7 neurosurgical experts. Along with expertise in the area 8 in which they are instructed independence forms 9 an important part of the experts' instruction. 10 Paragraph 10 of the Expert Evidence Protocol provides 11 that individuals who are appointed as experts are 12 commissioned by the Inquiry to give it their independent 13 professional opinions. The Inquiry looks to receive the 14 best available input each is able to give and to be 15 informed by the best available independent expert 16 opinion. No expert will be expected to act as 17 a spokesperson for or representative of any individual 18 or organisation interested in the Inquiry nor will they 19 be instructed for that purpose. 20 All three of these groups have provided detailed 21 written reports in response to their detailed letters of 22 instruction to which, as I have said, core participants 23 had the opportunity to contribute. It is important to 24 understand that consistent with the methodology and 25 ambition which underpins these evidential sections these Page 59
1 medical records and subject access requests. Such 2 evidence is important. As I have said, Term of 3 Reference 14 requires the Inquiry to look at the 4 effectiveness of such systems. It is also important, 5 sir, for us to understand what documents exist and why 6 they exist in order to inform our future investigations. 7 Sir, as I have set out at previous hearings and as 8 I have mentioned already today, the Inquiry will also 9 hear evidence from its three expert groups who have been 10 instructed by the Inquiry to assist you by providing 11 technical, factual and opinion evidence to inform and 12 help guide your understanding as well as your 13 investigation and assessment of the factual evidence. 14 In terms of understanding and orientation, it is hoped 15 that the evidence of these groups will be of value to 16 core participants, their recognised legal 17 representatives and others who take an interest in the 18 work of the Inquiry in maximising their participation 19 and engagement in our work. The areas of expertise 20 which have been covered are neurosurgery, medical ethics 21 and healthcare administration. Evidence from these 22 groups will also be heard at these hearings to assist 23 with these important purposes. 24 Sir, the Inquiry's approach to the instruction of 25 experts is set out in its Expert Evidence Protocol, the Page 58	1 experts have not been asked at this stage to consider or 2 address any evidence relating to Mr Eljamel's 3 professional practice. That is because the Inquiry will 4 continue to go about the process of gathering that 5 factual evidence in its subsequent sections. 6 However, it should be understood that the 7 instructions issued to these groups have not been 8 compiled completely in the abstract. They have been 9 specifically designed to seek expert opinion and 10 technical information relating to areas, activities or 11 matters which are a part of the Inquiry's remit already 12 such as the training involved in becoming 13 a neurosurgeon, the purpose and main complications of 14 common neurosurgical procedures, or the duties of 15 candour of neurosurgeons which feature under Term of 16 Reference 7 or which the Inquiry reasonably anticipates 17 will arise as its factual investigations progress, such 18 as the ethics of taking a patient's informed consent or 19 the pitfalls involved in operating a successful 20 complaint system. It remains the Inquiry's intention to 21 seek to re-involve these expert groups at later stages 22 of the Inquiry's work in particular when more evidence 23 of the factual matters involved in Mr Eljamel's practice 24 come to light. To the extent that you require it to be 25 of assistance in your assessment and analysis as well as Page 60

1 becoming involved when we turn, sir, to the 2 consideration of recommendations in Section 6. 3 It is important to reiterate, sir, that as in court 4 actions experts do not determine the matters which are 5 for you to decide. That applies equally to the expert 6 groups whom we have instructed as it does to the experts 7 who have been instructed in the neurosurgical field by 8 Professor Wigmore of the ICR. You are the ultimate 9 arbiter of what happened, what went wrong and who is 10 responsible as well as why. These experts therefore 11 have an important part to play in providing opinion and 12 technical support but their role should not be 13 misunderstood or overstated. Equally, the evidence 14 which they provide including their opinions are not 15 conclusive on any matter. The conclusions are for you 16 to draw. 17 Sir, the Inquiry has instructed a neurosurgical 18 group from which we will hear evidence in the second 19 week of our plan, which comprises 20 Professor Peter Whitfield, honorary professor and 21 consultant neurosurgeon who is the group lead, 22 Mr Robert Redfern, a retired consultant neurosurgeon, 23 and Mr Crispin Wigfield, a consultant neurological and 24 spinal surgeon. This group has extensive knowledge and 25 experience of clinical practice in neurosurgery. It is Page 61	1 been disclosed to core participants for their 2 consideration in advance of these hearings. The group 3 which has been put together deliberately comprises three 4 slightly different perspectives on the important ethical 5 issues which have been covered by them. One is a lawyer 6 by training and academic with a strong interest in 7 a number of matters of direct relevance to the Inquiry's 8 remit. One is an academic lawyer based in Scotland and 9 hence with a particular Scottish perspective on matters. 10 And the other is a consultant colorectal surgeon with 11 an academic interest in medical ethics, in particular 12 the importance of the application of ethical principles 13 in surgical practice. 14 The evidence which will be presented will in fact 15 come only from two members of the group as Dr McMillan 16 is, for very good reasons of which the Inquiry has been 17 aware for some time, unavailable to attend to provide 18 oral evidence as these hearings. We will take care in 19 presenting the evidence from other two members of the 20 group one of whom is the group's lead to make clear if 21 there are any matters of detail which will be more 22 appropriately addressed to Dr McMillan and 23 an opportunity can be afforded for those to be addressed 24 to her at a later date. Professors Huxtable and McNair 25 are both based in Bristol and in light of their Page 63
1 an independent group, none of the experts has worked 2 within neurosurgery in Tayside. The group was selected 3 based on the experience of its members and their 4 slightly different backgrounds, one being focused 5 currently on spinal surgery, one on intracranial surgery 6 and one with experience of being a consultant 7 neurosurgeon from a period around our relevant period in 8 which we are interested as a general neurosurgeon in 9 an environment not dissimilar to the service offered to 10 NHS patients in the Tayside region in which Mr Eljamel 11 played a part. 12 Sir, we have also instructed and received a detailed 13 report along with a number of documents from our medical 14 ethics group which comprises Professor Richard Huxtable 15 who has kindly taken the role as the group lead, 16 Dr Catriona McMillan and Professor Angus McNair. They 17 are respectively the professor of medical ethics and law 18 at the University of Bristol, a reader in medical ethics 19 and law at the University of Edinburgh and deputy 20 director of the Mason Institute for Medicine, Life 21 Sciences and the Law, and a professor of colorectal 22 surgery at the University of Bristol and honorary 23 consultant colorectal surgeon in the North Bristol NHS 24 Trust. 25 As with the neurosurgical group their report has Page 62	1 considerable clinical and academic commitments you, sir, 2 have agreed that they will give their evidence remotely 3 from there, a matter to which I will return. 4 The Inquiry team has also obtained an expert report 5 from its healthcare administration group which covers 6 matters which have been set out in previous 7 documentation including in our expert protocol. The 8 members of the group are Professor Anne-Maree Farrell, 9 the professor of medical jurisprudence and director of 10 the Mason Institute at the University of Edinburgh who 11 has kindly taken on the role as that group's lead. 12 Professor Kieran Walshe, professor of health policy and 13 management at the University of Manchester, and 14 Dr Fay Gilder a former NHS trust medical director and 15 consultant anaesthetist. As with other groups this 16 group was put together with particular regard to the 17 various experience and perspectives of its members. 18 Professor Farrell is an academic lawyer based in 19 Scotland who, as well as having published and researched 20 widely in the field of healthcare administration, also 21 has considerable experience in the field of medical 22 ethics. Professor Walshe is a very experienced academic 23 with a particular focus on a wide range of matters 24 relating to healthcare administration who also, as it 25 happens, has a particular interest in healthcare-related Page 64

1 public inquiries. Dr Gilder is a consultant 2 anaesthetist who not only has considerable surgical 3 experience as a result of holding that position but has 4 also held the position of medical director of an English 5 health trust and so has considerable practical 6 experience of clinical governance issues which arise in 7 connection with that role and which form 8 a very important part of our remit, sir. 9 May I say that the Inquiry is grateful to the 10 members of these expert groups for their contributions 11 to date and the contributions which I hope they will 12 make in future. The evidence of these groups will be 13 heard in weeks two, three and four of the Inquiry 14 respectively. It is right also to acknowledge the 15 Inquiry's appreciation to the experts who are giving up 16 their time to give evidence which they will provide. In 17 particular as all have multiple other professional 18 clinical or academic commitments which make their time 19 extremely precious and hence all the more valuable to 20 us. 21 Sir, may I make one observation about the Inquiry's 22 evidential expectations of the witnesses. I will 23 explain in due course what steps have been taken to 24 ensure witnesses are well placed to provide useful and 25 accurate evidence to the Inquiry at these hearings. Page 65	1 about what has been produced for the illumination of the 2 Inquiry and its wider audience within the clearly 3 expressed aims of this section of the Inquiry's work. 4 Equally, from the other perspective, those who seek 5 to have questions asked amongst our core participants 6 should remember that the time divide between where we 7 are now and the events we are seeking to examine as well 8 as the approach of the Inquiry to seeking largely 9 organisational evidence in section 1 will inevitably 10 place some limitations on what witnesses can speak to at 11 this stage. In particular, those who advise their core 12 participant clients will be expected, as a feature of 13 their professional advisory obligations, to advise when 14 questions their clients seek to pose go beyond what 15 could reasonably be asked of witnesses in this forum at 16 this time. That does not mean that we are not here to 17 probe. We are. To be effective, however, such probing 18 must be undertaken in light of our evidential aims in 19 this section and the reasonable expectations which can 20 be placed on the witnesses in light of them. 21 Sir, I have a little more to say about some of the 22 materials which have been collected as part of the 23 section 1 workflow before moving on to other sections 24 but as I tend to speak very quickly, I suspect the 25 stenographer may require a break. So perhaps I Page 67
1 These have been thorough and systemic and deliberately 2 so as per the Inquiry's Public Hearings Protocol. The 3 Inquiry has received witness statements from 4 organisations in Section 1 who were selected to speak 5 for these organisations. In the case of NHS Tayside, as 6 I have said, multiple contributors to the statement were 7 selected and so there will be multiple witnesses from 8 that organisation to speak to the various aspects of 9 NHS Tayside's evidence. 10 Few, if any, of the witnesses were involved in 11 the events of the time though some who have been 12 selected by the organisations have deliberately been 13 selected because of the fact that they were, at least to 14 some extent. Witnesses who are called to evidence under 15 oath will be expected to be able to speak to the 16 passages that they have contributed to statements and to 17 documents which they have produced in a reasonably 18 discursive and explanatory way. There will be little 19 point in simply expecting to attend to read out the 20 statement or to point to a document for the answer. All 21 organisations involved have committed, or are at least 22 certainly expected to contribute, to the important 23 public work of this Inquiry constructively. At this 24 stage this means witnesses from those organisations 25 attending with the aim of answering reasonable questions Page 66	1 could suggest that we have a break at this stage maybe 2 for around 20 minutes. 3 THE CHAIR: 20 minutes. If that is a convenient moment, 4 yes, of course we'll do that. Ladies and gentlemen, 5 you've heard Mr Dawson signal an appropriate moment 6 where it might be expedient for all concerned to have 7 a break. We'll do that and we'll resume again in 8 20 minutes' time. Thank you. 9 (11.30 am) 10 (A short break) 11 (11.52 am) 12 THE CHAIR: Yes, Mr Dawson. 13 MR DAWSON: Sir, I was in the process of explaining the 14 preparations which have been undertaken for this hearing 15 and our intentions for it and I had just got to the part 16 where I was going to set out some information about 17 materials which have been sought and to some extent 18 obtained by the Inquiry as part of its Section 1 19 workflow which are perhaps unlikely to feature during 20 the course of these hearings. 21 There is a good deal, sir, of evidential material 22 which has been gathered under the Section 1 workflow of 23 general contextual importance to the remit of the 24 Inquiry and to our investigations to come which is 25 unlikely to be ventilated at these hearings. Page 68

1 I will turn in a moment to suggesting what can be 2 done with that material by core participants which would 3 be of use to the Inquiry. However, for present purposes 4 I would not like to seek to suggest that it is not of 5 importance to our work when that material certainly is. 6 It is just that other material was thought to be more 7 worthy of public ventilation at this stage and in 8 connection with the witnesses whose identities I have 9 outlined. As previously announced written statements 10 and associated documents for which the Inquiry is 11 grateful with have been obtained from campaigning members of 12 the Scottish Parliament, Mr Marra and Mr Rennie and from 13 a number of other organisations, including Police 14 Scotland, the BBC, the Health and Safety Executive and 15 the British Medical Association. 16 In addition further evidence requests have been 17 issued by the Inquiry as its investigations in this 18 section have progressed. It became apparent that 19 documents of relevance to the Inquiry's Terms of 20 Reference which were held by organisations which no 21 longer exist and possibly other documents passed to them 22 from other bodies may be held by the National Records of 23 Scotland. Therefore a written witness statement and 24 document request has been sent to that body seeking 25 further documents which may be of use and which may be Page 69	1 investigations that Mr Eljamel appears to have carried 2 out a relatively large amount of functional 3 neurosurgery. Functional neurosurgery is an area of 4 that field which adopts procedures to target the nervous 5 system for the alleviation of the symptoms of other 6 conditions. Examples would include deep brain 7 stimulation for conditions such as Parkinson's Disease, 8 dystonia, tremor or pain. This is an area in which, as 9 you will discover, the experts on our neurosurgical 10 group have relatively less experience than in other 11 areas of neurosurgery though they have been able to 12 provide some helpful general assistance in understanding 13 its goals and ambit. 14 We have therefore issued a Rule 8 request to the 15 British Society for Stereotactic and Functional 16 Neurosurgery to find out more about their role, 17 functional neurosurgery in general and what we 18 understand to have been Mr Eljamel's connection to that 19 organisation in light of the organisation's apparent 20 involvement in that potentially significant area of 21 practice. 22 Assertions were recently made by the patient group 23 to the Inquiry about matters concerning the role of 24 nurses involved in their care. Connected to that was 25 a suggestion that a Rule 8 request similar to that sent Page 71
1 of value to you, sir, and the core participants in the 2 Inquiry as we go forward. 3 The Society of British Neurological Surgeons is 4 a national body which supports the study advancements of 5 the neurology. Equally, it became apparent that it was 6 a body that either did or could have had involvement in 7 matters relating to the professional practice of 8 Mr Eljamel and so a Rule 8 request has been sent to that 9 body to find out more about that. 10 Further, it also became apparent during the course 11 of our investigations that there was a body called the 12 Managed Network for Neurosurgery which played 13 a significant part in the way in which neurosurgical 14 services have been delivered in Scotland. In particular 15 by supporting the delivery and audit of neurosurgical 16 units in Scotland including in Dundee and reporting to 17 the Chief Medical Officer for Scotland as well as 18 issuing evidence-based national standards for 19 neurosurgery in Scotland, the first of which appears to 20 have been issued in September 2010. A Rule 8 request 21 has thus been sent to that organisation to understand 22 the role it plays, played, or could have played in 23 connection with matters relating to Mr Eljamel's 24 professional practice. 25 Further, it emerged during the course of our Page 70	1 to the General Medical Council could be sent to the 2 Nursing and Midwifery Council. It has not unfortunately 3 been specified what the particular issues are which have 4 been experienced nor what evidence should be sought from 5 the NMC or what Terms of Reference such investigations 6 would be connected to or why. However, in light of this 7 helpful suggestion a Rule 8 request has been drafted and 8 issued to the NMC. For clarity it is not currently 9 accepted by the Inquiry team that it would be 10 appropriate for such a Rule 8 request to be of a similar 11 nature to the one issued to the GMC given the fact this 12 is an Inquiry which focuses on the systems involving the 13 practice of a neurosurgeon as opposed to nurses and the 14 clear, direct involvement of the GMC in parts of the 15 Inquiry's Terms of Reference. Nevertheless, it was 16 considered in light of this representation to be of 17 relevance for aspects of the role and responsibilities 18 of the NMC and of the nursing profession to be examined 19 to a certain extent and it is expected that a draft of 20 the Rule 8 response from that organisation will be 21 received in early course which will be analysed and 22 processed in the normal way. 23 These written statements and any exhibits as well as 24 any other documents produced by these organisations in 25 response to calls made of them by the Inquiry have been Page 72

1 or will be disclosed to core participants in due course. 2 It should of course be borne in mind that the Inquiry 3 will, in Section 4 of its evidential plan, assess the 4 responsibilities of bodies that did play or could have 5 played a role in the professional practice of Mr Eljamel 6 to the extent that has not already been made reasonably 7 clear by that point. I will return to the thinking 8 behind their disclosure when I address the plans for 9 what will happen after these hearings in due course. 10 Sir, I turn now to the procedural plans for these 11 hearings. 12 Against that background, I would like to say more, 13 sir, about how these hearings will work. It is 14 important to understand that these hearings are part of 15 a process of investigation. They are an important part, 16 as I have said for reasons I will return to in a moment, 17 but they are not the only part of what we do in this 18 section. They are part of a process of investigation, 19 analysis and planning which has been ongoing and which 20 will continue when all of the oral evidence in these 21 four weeks has been heard even within the 22 introductory confines of Section 1. Beyond that they 23 are part of a process which is designed ultimately to 24 lead you to expressing conclusions about matters within 25 your remit in a report or reports at a stage in the Page 73	1 Amendments were made by the providers to draft 2 statements accordingly and further sets of documents 3 provided, as the material provider or witness saw fit in 4 accordance with the comments and suggestions provided by 5 the Inquiry team before the statements and documents 6 became evidence in the Inquiry, at which time they were 7 catalogued using the Inquiry's referencing system by 8 which unique reference and page numbers are attached to 9 all evidential documents. 10 The information and documents received as a result 11 of the Rule 8 requests for written statements and 12 documents produced went through a lengthy process of 13 legally required assessment for relevance and then 14 redacted in line with the Inquiry's general restriction 15 order so as to remove sensitive material such as 16 personal data amongst other generally applied 17 restrictions and the two restriction-related protocols 18 which have been prepared and published. 19 The Inquiry has taken a view that, given the general 20 introductory nature of the evidence being looked at in 21 this section, it is unlikely that individual patient 22 cases or experiences will be examined in any detail and 23 so it is unnecessary for the names of patients referred 24 to in documents to be disclosed or published. Thus the 25 names of all patients have been redacted from the Page 75
1 proceedings when you feel you have heard enough to be 2 able to reach those important conclusions. They are not 3 the end of anything, not even a Section 1 of our 4 evidential plan. 5 The importance of hearings in general terms 6 including these hearings is set out, as it has been for 7 some time and as I've already said, in the Inquiry's 8 Public Hearings Protocol. What is contained there from 9 a procedural perspective merits clarification and 10 explanation at this time. 11 In order to achieve its investigatory aims the 12 Inquiry has followed certain processes and will continue 13 to follow others at these hearings. I will set out now 14 what has happened in advance of these hearings and what 15 will happen at them so that everyone with an interest 16 knows how things will work and why. 17 As with all material received by the Inquiry, draft 18 statements and documents either exhibits to statements 19 or otherwise required by the Inquiry in terms of our 20 requests were analysed by the Inquiry team. Comments 21 were provided on the draft statements by the Inquiry and 22 proposed sets of documents produced with a view to 23 seeking to improve the overall quality and 24 comprehensiveness of the evidence being provided by 25 an individual or organisational material provider. Page 74	1 materials other than two prominent campaigners whose 2 names do appear in the documents and may need to be 3 referred to and who have agreed to that course, as well 4 as having been given the opportunity to make 5 representations about any sensitive passages within 6 documents relating to them in connection with which they 7 have been offered the opportunity to make 8 representations about possible restriction. In due 9 course, when patients' cases become a greater part of our 10 investigations as they become more focused on patient 11 and their important experiences, patients will be 12 offered the opportunity to apply for anonymity. Thus, 13 for now the Inquiry has applied temporary redactions to 14 patients' identifying information for the sake of 15 efficiency and respectful to the undoubted wish of some 16 of them to remain anonymous. 17 For those who do it will be the default that 18 anonymity orders will be granted to patients who wish 19 them. In such cases the redactions protecting the 20 identity of these individuals will remain in the 21 documents which have been which have had temporary 22 redactions applied for present purposes. 23 There are other redactions which have been applied 24 to documents for reasons of the proper administration of 25 the work of the Inquiry in accordance with the Chair's Page 76

1 statutory power to do so. Some of these may be able to 2 be removed when certain further steps are taken, in 3 which case documents will be redisclosed and if necessary 4 republished. Given these decisions about the 5 application of potentially temporary redactions, the 6 Inquiry's General Restriction Order and relevant 7 protocols have been slightly altered to cover this 8 course for the sake of clarity. Updated versions are 9 available on the Inquiry's website. 10 For the sake of completeness, those who follow these 11 matters keenly will have observed the Scottish Ministers 12 made an application to have the names of junior 13 officials mentioned in their documents redacted. That 14 application was refused by you, sir. Your reasoning is 15 available on the Inquiry's website. With the result 16 that these names of these junior officials remain to be 17 seen in these documents, as will the names of other 18 public officials unless there is a reason why, sir, you 19 have thought it fit to redact them whether permanently 20 or temporarily for a good reason in accordance with the 21 balancing exercise you're obliged to carry out of openness 22 and transparency on one hand and other competing rights 23 on the other. 24 Documents including written statements have been 25 gradually disclosed to core participants in the lead up Page 77	1 deal with reasonable witness requests based on 2 availability. Further, some witnesses have been allowed 3 to give evidence remotely, to which I will return. 4 In accordance with our published processes, 5 documents called Evidence Proposals have been drafted 6 and circulated for every witness. These are contributed 7 to by core participants and the witnesses themselves and 8 serve two broad purposes. Namely (a) to inform the 9 witness and core participants of the broad topics which 10 may be covered with the witness in the oral evidence 11 session and (b) to list the documents which might be put 12 to the witness in their evidence. That is in the 13 interest of fairness but also to allow the witness to 14 prepare properly for their evidence session. 15 Further, on the basis of the materials they have 16 received in the disclosure, core participants have been 17 provided with the opportunity to contribute proposed 18 questions for witnesses. The input of core participants 19 to the Evidence Proposals and their proposed questions 20 have been and continue to be considered by myself and my 21 learned junior Mr Crawford. We are 22 grateful for them and the contributions made and to be 23 made by core participants to the list of witnesses, the 24 Evidence Proposals and the questions in due course. 25 The way that witnesses will be called to give Page 79
1 to these hearings in tranches as the processes I have 2 described have been completed and the redactions have 3 been applied to the documents. It is neither necessary 4 nor proportionate for the Inquiry to disclose every 5 document it receives. That is not required and would 6 hinder the Inquiry in the performance of its functions. 7 It would also be a derogation from the Inquiry's 8 functions were it to pass to the core participants all 9 the material that it receives. 10 However, in this section at least a liberal approach 11 to disclosure has been taken to maximise the information 12 available to core participants and to provide them with 13 a broad context in which to participate in these 14 hearings but also to assist the Inquiry with the steps 15 we intend to take next to which I will return. 16 A draft list of witnesses was sent to core 17 participants to contribute to in the week of 6 July 2026 18 as had been planned after initial contact had been made 19 prior to that with proposed witnesses themselves to seek 20 to understand where they had any availability issues 21 which the Inquiry sought to respect as far as possible. 22 Alterations and additions to the witness list were made 23 according to the reasonable requests and suggestions of 24 the core participants, a final witness list was then 25 published after accommodation had been incorporated to Page 78	1 evidence will be that they will enter the room, for 2 remote witnesses they will appear on screens. They will sit in 3 the witness seat which is opposite me there. They will 4 either swear or affirm that they will tell the truth, 5 the whole truth and nothing but the truth before their 6 evidence commences. The oath or affirmation as the 7 witness prefers will be administered by you, sir. The 8 witness will then be asked questions by me. 9 Previous consultations with our core participants 10 have made it clear that for very good reasons those with 11 an interest in our work who are either here in person or 12 watching via the YouTube link prefer to have regular 13 breaks and be aware in advance what our plans are in 14 this regard. Anyone who has experience of inquiries, 15 courts or other similar tribunals will know there are 16 numerous factors which can scupper the best laid plans 17 for hearings like this but in light of these reasonable 18 requests and the need for careful management of the 19 precious time at the hearings we have put some time into 20 developing a detailed plan, at least as our starting 21 point. We will generally work on the basis that the 22 hearings will commence 10 am and will aim to finish the 23 day by 4.30 pm. As was clearly conveyed in previous 24 consultation there is a need for breaks to be 25 incorporated into our planning as I have said and we Page 80

1 have listened to that reasonable request. 2 Though there are many factors that can influence 3 running times, such as unexpected turns in the evidence, 4 technological hitches which we will do our best to avoid 5 and reasonable requests by core participants for 6 important questions to be put to a witness, the 7 following is the basic timing structure which we intend 8 to adopt. The day will be split into a morning and 9 afternoon session. On most days a witness will be 10 called in the morning and in the afternoon but on 11 some days there will be a full-day witness or a group 12 giving evidence. The morning and afternoon sessions 13 will generally be split into two equal sessions of 14 2 hours 45 minutes with a break for lunch from 12.45 15 until 1.45 which will occur every day. 16 There will generally be breaks in the morning 17 session and in the afternoon session totalling 18 30 minutes meaning that evidence will be heard for up to 19 2 hours 15 minutes in each half-day session. It is 20 important to understand that core participants' main 21 opportunity to contribute proposed written questions was 22 7 days before the hearings when these were communicated 23 between counsel. As I have said these have been and 24 will continue to be considered by myself and my learned 25 junior and incorporated into our planning as we see fit. Page 81	1 areas. Core participants' recognised legal 2 representatives have been informed they will need to 3 develop systems for gathering possible questions from 4 their clients, formulating them and deciding upon 5 proposed questions as we go along. There will not be 6 long breaks, the timetable will simply not permit it. 7 In our view they would be unnecessary. 8 Equally, those recognised legal representatives have 9 been reminded that these are introductory hearings and 10 that matters of detail beyond our stated remit in this 11 evidential section will need to wait until later. 12 Though questions from client core participants are 13 welcomed, recognised legal representatives will be 14 expected to use their professional judgments in making 15 their proposals for further questions in light of our 16 plans and not simply act as a postbox for their clients. 17 They are all experienced and skilled professionals whose 18 role involves judicially picking what questions need to 19 be asked and advising their clients why. In particular, 20 they will be expected to propose questions which are 21 designed to fulfil the basis upon which their clients 22 were recorded CP status in the first place, their 23 ability to assist the Chair of the Inquiry in the 24 investigation and the determination of key matters 25 within our remit. Page 83
1 In light of our plans and areas we think are likely to 2 be useful in illuminating you, sir, and the public more 3 widely, some have been retained for later use as I have 4 said as they are too detailed for now. However, there 5 will be a further opportunity on the day of a witness's 6 evidence for questions to be proposed. Guidance on the 7 timings and opportunities which this window affords have 8 been explained between counsel. 9 Therefore for a half-day witness whose evidence will 10 be heard over a total 2 hours and 45 minutes, there will 11 be 2 hours notionally allocated to examination by the 12 Inquiry with a 15-minute break in the middle. That will 13 leave around 15 minutes for a further break during which 14 time proposed further questions from core participants 15 will be considered and 15 minutes will be reserved for 16 those additional questions to be asked. 17 Some witnesses will be shorter than that, given the 18 limited scope of their evidence, but that is the basic 19 structure. For a full-day witness we will follow the 20 same plan as that in the afternoon session with 21 a half-hour break in the morning. Lunch will usually be 22 taken, as I say, for an hour between 12.45 and 1.45. 23 For the expert groups we will endeavour to leave a bit 24 more time for the core participant input given that 25 their evidence is wide-ranging within their specialist Page 82	1 It is against that context that proposed questions 2 will be judged. We have every confidence that those 3 core participants have a huge amount to contribute and 4 that their recognised legal representatives will 5 represent their clients with skill and judgment. Being 6 a core participant does not equate to the role of 7 a spectator, sitting on the sidelines passing judgments 8 or a criticism. Your role is to be part of the play on 9 the pitch suggesting and supporting the Inquiry team 10 and the Chair in progressing towards our common goals. 11 Witnesses whose evidence go over a break will be 12 told that they are not permitted to discuss their 13 evidence with anyone during the break. They will be 14 held to that and are therefore not entitled to discuss 15 their evidence with anyone including their recognised 16 legal representatives over that period. When witnesses 17 return they will remain subject to the oath or 18 affirmation they are given. The Chair may see fit to 19 remind them of that but whether he does or not, that 20 will be the position. I will generally ask witnesses at 21 the end of their evidence if they have anything to add. 22 That can be a pre-prepared statement if they wish, that 23 is a matter for them, but witnesses are asked to bear in 24 mind the purposes and remit of the Inquiry and that 25 ultimately the purpose of their evidence is to assist Page 84

1 the Chair. Therefore we do not expect or require 2 witnesses to come along with pre-prepared scripts in the 3 expectation that they will be delivered at the start of 4 their testimony. Our experience is that such statements 5 are often unhelpful to the extent that they tend to be 6 subsumed within the testimony given anyway in response 7 to questions and by the end of his or her testimony the 8 witness can, in light of our plan, reassess what they 9 feel needs to be assessed in light of the general final 10 question which I intend to ask. 11 The Chair will normally give me or another 12 questioning counsel the opportunity to ask follow-up 13 questions arising from that response to that overarching 14 question. Core participants will of course be entitled 15 to propose follow-ups to this or any other part of the 16 witness's evidence as I have set out. 17 Witnesses should remember that their evidence is 18 their responsibility even if they are giving evidence on 19 behalf of an organisation or a group. As with written 20 evidence to which they have attested in written 21 statements that they have said is true, they are giving 22 evidence under oaths or affirmations administered by the 23 Chair under his legal authority to do so under the Act. 24 Some witnesses will give evidence remotely. What 25 that means is they are not physically here and will give Page 85	1 other members of the Inquiry team. They will stop the 2 transmission. We will most likely have a short break to 3 work out how to proceed. My apologies to all in advance 4 for any interruption which we need to make to the 5 evidence of any of the witnesses for this purpose. This 6 is why it will be necessary to do so. 7 I would urge witnesses to avoid revealing any 8 matters which are likely to be potentially confidential 9 including patients' names other than of the two 10 prominent campaigners, Ms Jules Rose and Mr Pat Kelly, 11 who have waived the right to be anonymous and whose name 12 does appear in materials which have been disclosed by 13 the Inquiry in this section. Any such information which 14 is inadvertently referred to must not be referred to or 15 otherwise shared outside this room and is subject to the 16 Inquiry's First Order covering those in attendance 17 including members of the media. 18 For the avoidance of doubt you have pronounced 19 a further Order of the Inquiry, sir, shortly in advance 20 of these hearings relating specifically to the 21 information which may be transmitted to those within the 22 hearing room but ultimately not published via the 23 YouTube feed or becoming part of the published video of 24 proceedings or in published documents. If there is any 25 doubt about what can be transmitted or broadcast outside Page 87
1 evidence via a videolink. The default position the 2 Inquiry expects witnesses to appear before the Inquiry 3 in person. If they have been granted dispensation by 4 the Chair to give evidence remotely it's because the 5 Chair considers it within the public evidence that their 6 evidence be taken in this way in the exercise of his 7 statutory power and responsibility to regulate the 8 procedure of the Inquiry as he sees fit within the 9 strictures of Section 17 of the 2005 Act. 10 Witnesses will be treated as best we can and in all 11 legal respects in precisely the same way if they appear 12 remotely as if they have been here in person. They will 13 be subject to the same oath or affirmation as other 14 witnesses and be subject to the same rules about not 15 discussing their evidence with anyone during breaks or 16 otherwise. 17 As I've said at previous hearings, the video feed by 18 which we are watching the evidence via YouTube will be 19 transmitted with a delay of 3 minutes. This mechanism is 20 part of the systems we have to try to prevent any 21 confidential information being transmitted to the wider 22 public which should not be. In the event that something 23 is said by me or by any another contributor which seems 24 to contain information which ought not to have been 25 referred to, I will cut the feed or told to do so by the Page 86	1 the room the Inquiry legal team can be contacted or 2 spoken to for clarity. 3 Sir, these proceedings are not adversarial and 4 parties do not have the same rights to object as they do 5 in adversarial litigation. The question of policing 6 restricted information is largely a matter for you and 7 the Inquiry team in accordance with the approach which 8 has been adopted or ordered by you in connection with 9 the disclosure and publication of documents which have 10 been produced in connection with these hearings. If 11 a recognised legal representative wishes to assert the 12 materials should be restricted they should ordinarily 13 communicate that to the Inquiry's solicitors by email on 14 their legal email address that they think material ought 15 to be restricted or that they wish to apply for 16 restriction bearing in mind that time to do that is 17 limited in light of the feed delay being only 3 minutes. 18 Sir, the statutory rules relating to the rights of 19 core participants to make opening and closing statements 20 are to be found in Rule 10 of the 2007 Rules. As there 21 will be no opening statements in addition to those 22 delivered in November, for the reasons I have already 23 touched on, the same logic underlies the position that 24 there will also be no closing statements or submissions 25 by core participants at this time. The focus of these Page 88

1 hearings is evidential and core participants have had 2 the opportunity to contribute via question proposals as 3 I have set out. We had a separate opening statement 4 hearing so we could listen to what core participants had 5 to say and incorporate their helpful contributions into 6 our plans and investigations as well as allow the focus 7 to be on the evidence at these hearings. There will be 8 an opportunity afforded to core participants to make 9 closing statements and written submissions at the end of 10 our hearings. 11 This may not be the experience of some participants 12 from other public inquiries where core participants have 13 the opportunity to make opening or closing statements in 14 each evidential section. Those that do adopt such 15 an approach tend to be more modular in scope where their 16 subject matter lends itself to sections or modules on 17 different subjects with separate submissions being 18 appropriate on each. Examples might be the UK Covid-19 19 Inquiry or the Scottish Child Abuse Inquiry. Our 20 approach to our remit is different. As our Terms of 21 Reference all relate to the systems surrounding the NHS 22 career of one man and our sectional approach looks to the 23 totality of the evidence relevant to each section and 24 focuses on different categories of witnesses. It has 25 thus been thought to be of more use to the Chair if the Page 89	1 discussing or disseminating the information or documents 2 more widely. 3 Generally certain materials will be published at the 4 end of the day of the evidence or the next day. This 5 may be in addition to the information contained in this 6 speech and the oral testimony of any witness which by 7 that stage will have been published publicly via the 8 YouTube feed. The material which will generally be 9 published will include the statements of witnesses who 10 have given evidence or the statement of an organisation on 11 the last day on which evidence is given about it or 12 extracts from those statements as the Inquiry deems 13 appropriate. In addition the Inquiry will publish 14 documents referred to in the evidence that day or 15 extracts from them as appropriate. 16 Care should be taken by those who are in possession 17 of information or documents which have been disclosed to 18 them to make sure that they are aware of what has been 19 published on the Inquiry's website so that they do not 20 release information or material which has not been more 21 widely disseminated than is permitted. 22 I would like to take the opportunity to reiterate 23 the principles of the First Order and the further Order 24 of a similar nature relating to these hearings which 25 I have mentioned. I should say that I do so for the Page 91
1 core participants' contributions at this stage focus on 2 the evidence and that statements and submissions on the 3 totality of the available evidence will be invited later 4 in order to assist you, sir, in the compilation of your 5 final report or reports. 6 That is not to say that core participants may not be 7 invited to make submissions as we go along in the course 8 of the Inquiry on a particular matter which you, sir, 9 deem to be of any particular assistance at any time. 10 Indeed, I will return to a proposal for such 11 a submission to be made later in this opening address. 12 Finally, sir, in relation to the plans for these 13 hearings I would like to say something about publication 14 of material. The Inquiry's protocols differentiate 15 between disclosure on the one hand and publication on 16 the other. Disclosure relates to the dissemination of 17 material or information to core participants or others 18 such as witnesses or recognised legal representatives 19 who are bound by the Inquiry's First Order and 20 confidentiality undertakings provided to the Chair of 21 the Inquiry by individuals from publishing beyond the 22 groups in which they reside. Publication, on the other 23 hand, involves information or documents being available 24 to the public at large which generally removes the 25 restrictions on core participants and their lawyers from Page 90	1 sake of completeness and not out of any particular 2 concern or by way of censure. In fact our experience 3 has been that our core participants, in particular 4 patients and their recognised legal representatives, 5 have been careful and respectful of the need to observe 6 the Inquiry's confidentiality rules and have taken care 7 to seek advice where necessary and otherwise to respect 8 and observe their terms. Again, if those in attendance 9 who have otherwise received materials or information 10 from the Inquiry have any questions about their 11 publication or the rules in that regard the Inquiry 12 legal team is on hand to deal with any such queries. 13 Sir, moving now beyond the intentions for these 14 hearings I'd like to say something about Section 2 15 progress and the plans for the next set of evidential 16 hearings in December of this year. 17 As those with an interest in this Inquiry will know, 18 Section 2 of the Inquiry's workflow is the part in which 19 we gather and examine the evidence of former patients of 20 Mr Eljamel and in certain cases their personal 21 representatives. There are two components to this work, 22 both of which are well underway, namely the oversight 23 function which the Inquiry holds over the work of the 24 ICR and the direct gathering of evidence by the Inquiry 25 from patients and patient representatives. The ICR, as Page 92

1 those who take an interest in our work will certainly be 2 aware, is a review process in which applicants, former 3 patients of Mr Eljamel or their representatives, can 4 seek to have their cases subjected to clinical analysis 5 by one of a term of independent expert neurosurgeons 6 appointed by Professor Stephen Wigmore, the chair of 7 that process. 8 The ICR evidence itself has two main parts, namely 9 the completion of statements of applicants to the ICR 10 and exhibits to those statements and separately the 11 neurosurgical reports themselves as well as any exhibits 12 associated with those. The Inquiry has the ability to 13 nominate patients' cases which it wishes the ICR to 14 prioritise either by way of identifying cases where 15 individuals have applied to the ICR to be amongst this 16 priority group or by referring cases for neurosurgical 17 review. I will return to progress in the ICR and its 18 impact on our procedural plans in a moment. 19 A provisional outline of the scope of Section 2 of 20 the Inquiry's evidential plan has now been published on 21 the Inquiry's website which provide some further detail 22 of the matters which we intend to cover in that section. 23 The broad areas set out there are the areas in which the 24 Inquiry feels patients are most likely to have 25 an important and valued perspective and on which Page 93	1 and harm occurring and whether those systems were in any 2 way defective. 3 By way of reminder, patient evidence contained in 4 the Inquiry Rule 8 statements will be taken into account 5 by you, sir, in addition to the ICR applicant statements 6 and any exhibits. For individuals not called upon to 7 provide Inquiry statements their ICR applicant 8 statements and exhibits stand as their evidence in the 9 Inquiry. 10 Sir, I will return in a moment to the progress of 11 the ICR but those with an interest in our work will 12 recall that concerns were expressed by me at the time of 13 the procedural hearing in May as to progress in the 14 ICR's work in light, in particular, of the need to be 15 ready for the important evidence of patients to be heard 16 at the hearings which have been scheduled for December 17 of this year. At that time I reiterated the need for 18 efforts to be redoubled within Levy & McRae, in 19 particular in light of the fact that they would soon 20 become responsible, as they have been over the last 21 six weeks, for assisting with two important streams of 22 work at the same time, namely the ICR applicant 23 statements with which they had been supporting their 24 clients during the course of this year and the Inquiry 25 Rule 8 statements which were issued around six weeks Page 95
1 neurosurgical experts in the ICR may have relevant 2 opinions to offer. Around 6 weeks ago, the Inquiry 3 issued Rule 8 requests to 23 former patients of 4 Mr Eljamel and two spouses of former patients of 5 Mr Eljamel, 25 Rule 8 evidential requests in total. 6 These Rule 8s had been issued in accordance with the 7 Inquiry's known duplication principle which seeks to 8 minimise the number of times a patient requires to 9 repeat their story about what happened to them. Amongst 10 the means by which the patient voice will be heard in 11 this Inquiry on matters of systemic significance or the 12 matters foreshadowed is in paragraph 22 of the Inquiry's 13 protocol on its approach to evidence and written 14 statements which form part of what patients have been 15 asked about in this Inquiry Rule 8 requests. In most 16 cases in addition to their perspective on clinical 17 matters which they have already provided to the Inquiry 18 via their ICR applicant statements and associated 19 exhibits. 20 Sir, in terms of the Inquiry's Term of Reference 16 21 the Inquiry will be obliged to take account of the ICR's 22 finding in its work. The intention is that the ICR will 23 set out what went wrong clinically. The Inquiry's role 24 will then be to investigate what systems should have 25 existed to detect and prevent those things going wrong Page 94	1 ago. 2 In order to assist with this development, sir, you 3 have funded an additional solicitor to be involved 4 in the work of the Inquiry within the firm of 5 Levy & McRae in order to enable the clear targets for 6 the drafting of the Rule 8 statements to be met. As 7 will be in hearings when draft Rule 8 are due, which is 8 this week as it happens, progress will be able to be 9 monitored and discussions can take place alongside them 10 as representatives of the Inquiry and the patients will 11 be on hand to address any issues which may arise. Given 12 the reasonable demands on the part of Levy & McRae and 13 indeed other parties at previous hearings for clarity 14 and advance notice of what would be expected of them, we 15 have made efforts to be clear about what will be 16 required, when and perhaps most importantly why, as well 17 as you, sir, going the extra mile to ensure that 18 adequate funding for the process was in place. 19 We helpfully received a breakdown from Levy & McRae 20 a couple of weeks ago about the progress which had been 21 made towards the completion of the Rule 8 statements for 22 the recipients of the Rule 8 requests whom they 23 represent. I was also pleased to learn from my learned 24 friend Ms Cherry recently that she has been taking 25 a keen interest in trying to ensure that reasonable Page 96

1 progress is being made, for which the Inquiry is 2 grateful. We hope that the process of drafting these 3 written statements by those who have been called upon to 4 do so by the Inquiry has been a profitable experience 5 for them and very much look forward to reading and 6 commenting on the written drafts of them in early 7 course. A team is waiting and ready to do so as soon as 8 they are received. We are appreciative of the work 9 which has gone into the production which we are sure 10 will not have been easy for some. It is integral to the 11 success of this Inquiry that the voices of patients are 12 heard, in particular at our hearings in December and 13 those ongoing efforts play, and will continue to play, 14 a pivotal part in that aspect of our plans and of our 15 evidence. 16 By way of an update on the work of the ICR I can 17 report, sir, that as its work has moved into the sphere 18 of the instruction and production of neurosurgical 19 reports in order to provide additional assistance to the 20 ICR in this expert stage of its work in addition to the 21 oversight which the Inquiry provides by way of 22 commentary on draft neurological reports the Inquiry 23 team has also created a draft template for the surgeons, 24 much like the template for the applicant statements to 25 ensure consistency, both from the point of view of Page 97	1 in November I had occasion to point out that delays in 2 getting the ICR initially up and running had become, by 3 that point, intolerable. 4 A plan was put in place based on a timetable which 5 had been put in place by Professor Wigmore involving 6 a three-month projection for the completion of 7 an applicant's case which involved the top 50 cases 8 being completed by March 2026. No objection to that 9 plan at that time was raised though an opportunity was 10 afforded to everyone represented at the hearing to do 11 so. As a result of the forced postponement of the 12 Section 1 hearings to this hearing slot now 13 in September, and the subsequent knock-on delay of the 14 planned Section 2 hearings to December, a further 15 opportunity was taken to get a second batch of priority 16 cases underway so as to increase the pool of cases to 17 which the Inquiry might have regard in Section 2 in 18 addition to plans for our own investigations amongst the 19 patient group via the Rule 8 requests which I've already 20 referred to. 21 Thus the priority group was increased to 111 cases, 22 an increase designed to mitigate the effects of the 23 forced procedural delay. That group of 111 cases is 24 comprised of three separate batches of cases. The first 25 is the top 50 priority cases which were selected by the Page 99
1 evidence being provided to the Inquiry in both form and 2 substance, but also clarity and consistency amongst the 3 applicants who are the primary recipients of the ICR 4 evidence. 5 It is important to understand that the evidence of 6 the ICR plays a number of important roles in the 7 investigation of the Eljamel affair. It allows for the 8 ambition of the appointing Cabinet Secretary to be met 9 that patients who wish to have one will have 10 an individualised review of their care. It allows 11 a wide variety of patient voices to be heard in the 12 Inquiry on a variety of clinical matters in addition to 13 evidence they provide on systemic matters to the Inquiry 14 directly. It constitutes a body of clinical evidence of 15 what went wrong across the period of Mr Eljamel's 16 working life in Tayside both in the NHS and in private 17 care upon which basis the Inquiry's systemic 18 investigations of the NHS can proceed. 19 A Rule 8 request has been issued to 20 Professor Wigmore as the Chair of the ICR some weeks 21 ago. I'll return to the intention with regard to oral 22 evidence of Professor Wigmore and potentially from the 23 ICR beyond that in due course in connection with our 24 plans. You will however recall, sir, as part of my 25 opening address at the opening statement hearing back Page 98	1 Inquiry for the ICR to handle first based on materials 2 to which the Inquiry had access. A further group of the 3 next priority cases, 51 as it happens, was identified by 4 the Inquiry thereafter using the same materials and 5 criteria. Further, a third group of ten cases was set 6 in motion by the ICR itself thus completing the set of 7 111 priority cases now making their way through the ICR 8 process. 9 At the procedural hearing in May the process was up 10 and running but had continued to be affected by delay 11 predominantly arising from the need to address issues 12 relating to the quality and comprehensiveness of draft 13 applicant statements prior to their consideration by 14 an expert, this resulted in deadlines set down by the 15 ICR process being missed often by considerable margins. 16 As I say so far 111 cases are making their way through 17 the ICR process. Of these 18 are cases which were 18 referred to the ICR by the Inquiry for review. 93 are 19 applicant cases, meaning cases in which an application 20 has been made by a patient or patient representative and 21 an applicant statement has been provided. Of those 22 93 applicant cases I understand that 46 applicant 23 statements have now been completed and are available for 24 evidence to the Inquiry along with their attached 25 exhibits. Those statements will be used by the Page 100

1 neurosurgical expert instructed in those cases as part 2 of the evidence to which they will have regard in 3 compiling their final reviews. All applicant statements 4 and neurosurgical reviews which emanate from the ICR 5 will, as I said, ultimately be evidence in the Inquiry 6 in accordance with our processes. 7 I will return to the subject of progress of these 8 neurosurgical reviews in due course, but as a general 9 observation progress in the ICR remains too slow with 10 various consequences which I will outline momentarily. 11 It is worthy of note, sir, that in order to address the 12 issues which were debated at the May hearing the Inquiry 13 redoubled its efforts to perform its support and 14 oversight role in the work of the ICR. This has 15 involved a full-time team of two junior counsel and one 16 assistant solicitor as well as a team of three 17 paralegals doing nothing but the work of the ICR for 18 most of the time since May. In addition the Inquiry 19 will shortly benefit from the services of a new 20 assistant solicitor whose role will, in part, involve 21 that function also. The plan for the longer term had 22 been, and remains, that the two junior counsel and one 23 assistant solicitor will move on to later sections as 24 befits the systemic focus of the Inquiry's work. 25 However, systems we put in place to ensure that cases of Page 101	1 take for the Inquiry to go through it's own risk disclosure 2 processes relating to the materials associated with the 3 examination of the ICR's neurosurgical evidence. The 4 result of this is a necessary change of plan 5 for December and beyond, the main goals of which are to 6 try to make what progress we can and to seek to maintain 7 the important concept of stability for patients. 8 Accordingly, the intention is that the December 9 hearings will involve patient and possibly patient 10 representative evidence only. 11 In order for this to be able to be achieved once 12 again I must stress to those patients who have received 13 Rule 8 requests and their legal advisers the importance 14 of meeting the Inquiry's deadlines both in terms of time 15 but also in terms of comprehensiveness, of clarity and 16 of formatting as are clearly set out in the Rule 8 17 request in its terms. The position and experiences of 18 the witnesses will, as with all such statements, be 19 expected to be set out as clearly as the witness is 20 able. Exhibits will be expected to be clearly 21 referenced and their significance to the witness clearly 22 laid out in the statement. Those responding to Rule 8s 23 and their recognised legal representatives are reminded 24 of the provisions of the Inquiry's protocol and its 25 approach to evidence in this regard. Paragraph 59 says Page 103
1 novelty or apparent significance continue to be analysed 2 by the Inquiry throughout, all will be evidence in the 3 Inquiry and available to you, sir, in the determination 4 of your ultimate findings. 5 Sir, as far as the December hearings are concerned 6 it had been the intention, as I announced previously, 7 that the Inquiry would hear evidence at that time both 8 from patients, patient representatives and the evidence 9 of Professor Wigmore who was due to provide a Rule 8 10 statement in the form of an interim report on what the 11 neurosurgical experts in the ICR had discovered in their 12 reviews. In order to enable necessary preparations for 13 that evidence to be made, it had been intimated to the 14 ICR that the 50 preliminary priority reviews required to 15 be completed by the end of July and the remaining 61 by 16 the end of August. 17 At this moment I understand that only one 18 neurosurgical review has been finalised and signed. 19 There are a few more which, as I understand it, are in 20 their final stages towards signature. While that 21 situation is likely to change hopefully in early course 22 it is unrealistic in our view to think that reviews will 23 be advanced in sufficient numbers and to a level which 24 would permit consideration at hearings as soon 25 as December, in particular in light of the time it will Page 102	1 that not every document in the medical records will be 2 relevant. For instance, many may contain details of 3 other medical issues of no relevance to the Terms of 4 Reference. Only key documents for medical records, if 5 they are available, should be exhibited to any written 6 statements together with any other documents that may be 7 relevant to matters outlined in the Rule 8 request. 8 The Inquiry's clear and consistent formatting 9 requirements will need to be respected in order to avoid 10 delay after a first draft is produced. A failure in 11 this regard will jeopardise the Rule 8 statements being 12 completed and the witness not being eligible to be 13 considered as a witness for the hearings in December. 14 Sir, it is anticipated that their now considerable 15 experience of solicitors at Levy & McRae in providing 16 assistance and advice in connection with the ICR 17 applicant statements since the start of this year will 18 prove to be of considerable assistance in this regard, 19 given that the processes involved there were 20 deliberately designed to be similar to the Inquiry's own 21 process for completing written statements as well as the 22 additional funding to which I referred which you have 23 provided. 24 Your further guidance in that regard features as 25 parts of correspondence you have also sent to the firm Page 104

1 in July and should, I anticipate, have proven useful in 2 responding to the Inquiry's evidential request for 3 written statements as well. 4 In addition the Inquiry will continue to have regard 5 in its oral witness selection process to completed ICR 6 applicant statements which of course focus on the 7 clinical experience of the applicants. Of the 8 93 applicant cases going through the ICR presently, as 9 I have said, I understand that 46 applicant statements 10 have been completed. These are being further analysed 11 by the Inquiry team as we speak. However, those which 12 are near completion may also be considered for the oral 13 hearings and so should be attended to as quickly as 14 possible by the applicants for that important purpose. 15 For the sake of clarity the Inquiry team intends to 16 meet and discuss the finalisation of a witness list of 17 patient or patient representatives whom it would like to 18 call to give oral evidence in December. That 19 process is planned to take place in the week after these 20 hearings, the week commencing 5 October, at which time 21 the Inquiry team will take decisions about whom to 22 invite to call in December soon thereafter. Those on 23 the list will be contacted about specific dates 24 thereafter and a final timetable will be issued to core 25 participants and published as soon as possible. Page 105	1 before these materials are disclosed or published. 2 As I have said, the default position for patients is 3 that such an order will be granted with the result that 4 identifying information redacted from any materials 5 disclosed or published. Anonymous witnesses will 6 generally give evidence in the room where they can be 7 seen by those in attendance and will be restricted 8 from revealing any information publicly about the individual 9 in question. They will normally be able to be heard on 10 the YouTube feed, but their faces will not be shown. 11 Any other adjustments which any witness wishes to apply 12 for will be listened to and sensitively handled by the 13 Inquiry. The patient's voice must be heard but not in 14 a way which causes undue distress or risks 15 retraumatising patients at all. 16 The same process will apply to the Inquiry Rule 8 17 statements and exhibits as I said where witnesses do not 18 wish to apply for anonymity. Where witnesses do not 19 wish to apply for anonymity sensitive passages of the 20 materials relating to them will be put to them for their 21 views of possible redaction of them as well as their 22 right as material providers or interested parties in the 23 contents of the material. 24 Sir, as far as the preparations going forward are 25 concerned as part of the preparations for the Section 1 Page 107
1 Disclosure of documents received in response to 2 Rule 8s will continue to be done in an order which is 3 appropriate to the way in which the Inquiry's sections 4 are structured. Given that the Inquiry will, in 5 Section 2, focus on the evidence of patients and in due 6 course evidence emerging from the ICR it is considered 7 likely that disclosure for the updated December hearings 8 will focus on written statements from patients and 9 exhibits, applicant statements and exhibits, as well as 10 relevant complaint files and extracts from medical 11 records which the Inquiry or the patients may wish to 12 ventilate in their evidence. 13 These materials are the most closely related to the 14 patient experience of and perspective on the subject 15 matter of the Inquiry. 16 Sir, entirely understandable concerns have 17 repeatedly been expressed to the Inquiry about its 18 intentions with regard to the publication of material 19 emanating from the ICR including applicant statements 20 and associated exhibits as well as Inquiry materials 21 which may reveal the identity of individuals who wish to 22 be anonymous. Before publishing an applicant statement 23 and any attached medical records or other exhibits and 24 any Inquiry statement, the patient in question will be 25 given the right to apply to the Inquiry for anonymity Page 106	1 hearings organisations or some selected individuals 2 which were thought to hold relevant documents were 3 issued with requests for them. Some were issued by way 4 of Section 21 notice given the sensitivity of the 5 material which it was anticipated they would contain. 6 Where it was thought that the documents held by any 7 recipient would be of a relatively small scale those 8 organisations were in fact asked for all the documents 9 they hold relating to the Inquiry's Terms of Reference. 10 Examples of organisations falling into that category 11 were NHS Education for Scotland and Healthcare 12 Improvement Scotland. 13 Where it was thought that these documents would be 14 more numerous or where the types of documents held were 15 not yet well-known by the Inquiry, the Inquiry issued 16 more specific requests for documents of a more specific 17 nature relating to the matters to be covered in 18 Section 1 only. Examples of organisations falling into 19 that category NHS Tayside, Police Scotland and the BBC. 20 After these hearings the Inquiry will issue wider 21 documentary Rule 8s seeking documents more generally 22 relating to the full ambit of the Inquiry as appropriate 23 to an organisation or individual's involvement in the 24 subject matter with which we are concerned. These will 25 be processed and assessed as above, a process which the Page 108

1 Inquiry anticipates will take a longer period of time to 2 do due to its likely volume and potentially the 3 sensitivity issues which may be associated with some of 4 the documents. 5 Sir, to move then to our planning beyond 6 December 2026. 7 It remains the position that the section in 8 connection with which we are to hear evidence this month 9 will be an introductory one designed to try and help us 10 and those with an interest in our work to understand the 11 roles, structures and key milestones in the story 12 underpinning our remit. There's always been and remains 13 a section in which we seek to uncover the extent of the 14 disputes which lie within our Terms of Reference and try 15 to understand where the answers might lie beyond these 16 hearings to be looked at in more detail in later 17 sections of our evidential plan be it in documents or, 18 where documents do not exist, in the written and oral 19 testimony of those who live through the events on which 20 or focus is centred. A precise plan for where we go 21 next will depend on where we get to and that cannot be 22 known until the evidence laid over the next four weeks 23 has been heard and an opportunity has been taken to 24 reflect upon it. 25 It will for example be necessary for the Inquiry Page 109	1 work on which we feel that contributions would be of 2 benefit, we have sketched out the following working 3 plan. 4 Details of what precisely will be required will be 5 provided in due course but as clarity, transparency and 6 advance notice are always aspired to and I know are 7 appreciated, in particular by my professional colleagues 8 but also by others, it is hoped that the following broad 9 plan will be of value. 10 It is intended that considerable efforts will be 11 required all round to prepare for the Section 2 12 patient-focused hearings which will now take place 13 in December. Though that will involve all participants 14 to an extent it will be a particularly busy time for those 15 who represent witnesses whom we plan to call to give 16 evidence at those hearings, 17 particularly in the firm of Levy & McRae and their 18 instructed counsel and those witnesses themselves. It 19 would not be reasonable to expect that group to be doing 20 more than focusing on that important work for the rest 21 of 2026. 22 The focus then becomes on 2027 and what is planned 23 for then. The broad plan is as follows. The Inquiry 24 plans to hold a procedural hearing in mid-March 2027. 25 Core participants will be called upon to make a written Page 111
1 team to reflect on what documents it has received, what 2 documents it has been told exist beyond the sets which 3 have been recovered to date and to formulate a plan as 4 to whether existing Rule 8 requests can be relied upon 5 with more extensive searches being required under their 6 terms or whether further, more wide-ranging or more 7 specific Rule 8 requests will need to be issued for 8 further documentation to be recovered. It will only be 9 in light of the recovery of those materials that we will 10 be able to plot a clear and detailed way forward. These 11 hearings should help us know where to look and what we 12 expect to find. 13 The progress made as a result of the section 1 14 investigations to date and the changed circumstances 15 resulting from the impediments to progress in Section 2 16 which I have already outlined have, however, led to us 17 slightly altering our Section 2 plans. Further given the 18 change in the planning for the Section 2 hearings which 19 I have already set out there is a need in my submission 20 for core participants to be given an opportunity to 21 contribute to the details of those hearings which will 22 involve evidence of the ICR neurosurgical output being 23 examined by the Inquiry. We have currently planned 24 an evidence session for May 2027 to hear that evidence. 25 Therefore, as a result of these two components of our Page 110	1 submission to the Inquiry in advance of the hearing. 2 The details of the precise dates and the content of 3 those submissions will be clarified in due course. For 4 planning purposes the dates of Thursday and Friday, 11 5 and 12 March 2027 have been provisionally booked. 6 The purpose of the hearing and the written and oral 7 submissions will be twofold. In the first place core 8 participants will be asked to address the Inquiry in 9 writing and orally about the evidence which has been 10 gathered, led and shared with them in Section 1 for the 11 purpose of identifying what investigations they say 12 should be undertaken by the Inquiry in the more detailed 13 sections which are to follow. Which witnesses should be 14 contacted for Rule 8s. Which further documents should 15 be sought. Which other organisations should be 16 contacted for statements or evidence in light of the 17 framework which Section 1 of the evidential plan will 18 hopefully by then have created. 19 Core participants will not be being asked to provide 20 a final submission containing their analysis of the 21 evidence which will have been gathered to date but 22 proposals based on that evidence as to what should 23 happen next within the broad evidential framework which 24 the Inquiry has already announced. As I say, a more 25 detailed list of matters to be addressed such as the one Page 112

1 which was circulated to core participants in the advance 2 of the opening statement hearing last November will be 3 provided at the appropriate moment but this is the 4 general direction of travel. 5 It may be that the opportunity will be taken by core 6 participants in that submission to address written 7 material which has or will be disclosed to them by that 8 time which is not the focus of these evidential 9 hearings. As I have said, some evidence has been 10 gathered from certain bodies which provides context to 11 our work whether in the form of organisational 12 information, such as from the HSE or BMA, or other 13 bodies which have been or are conducting investigations 14 relating to the professional practices of Mr Eljamel, 15 which are not themselves the subject of the Inquiry's 16 investigations which may provide a useful base for 17 forward planning within the Inquiry. As I have said, 18 examples of such bodies are the BBC and Police Scotland. 19 I mention these as I know that some core participant 20 groups questioned why and what we wanted them to do with 21 that material. The answer is to analyse the material to 22 the extent you wish for question in these hearings but 23 also for the purpose of these later submissions. 24 The second purpose of the contemplated March 25 procedural hearing will be to address what core Page 113	1 anticipated further evidence on issues relating to the 2 ICR will be heard from patients at that time not least 3 because they would already have made positions clear in 4 written applicant statements or in some case would be 5 continuing to do so as the ICR progresses or would have 6 been called at the evidence sessions which will be 7 dedicated to patient evidence in December of this year. 8 Given the uncertainties, the Inquiry has reserved 9 the hearing suite for the whole of May and more details 10 will be released after the March hearing about what 11 dates will be used for the ICR evidence sessions in 12 Section 2. 13 By way of reminder, in section 3 the Inquiry will 14 hear evidence from medical professionals. In section 4 15 the focus will be on evidence from other organisations 16 not covered in section 5. Section 5 will focus on 17 NHS Tayside and the Scottish Government and section 6 we 18 will focus on recommendations. 19 Again, beyond the plans I have already announced the 20 timings of the hearings in Section 3 shall be focused on 21 the evidence of medical professionals. It's hard to 22 predict with any precision. It will of course depend on 23 the submissions made by the core participants at the 24 planned procedural hearing in March. The experience of 25 Section 1 has shown even though clear deadlines are set Page 115
1 participants propose should be the format of the 2 hearings in May, which as I have said will form the 3 second part of the Section 2 hearings of which the 4 Inquiry will consider, to the extent the Chair 5 ultimately considers appropriate, neurosurgical evidence 6 which will by then have emanated from the ICR. In order 7 to inform the decision-making around the preparation for 8 that hearing, the Inquiry intends to disclose to core 9 participants gradually over January and February 10 materials which will enable submissions to be formulated 11 about which witnesses should be considered to be called 12 to give evidence in that context and why. Those 13 submissions will then be able to be taken into account 14 in deciding the final format of the May hearings. 15 It follows logically from that intended hearing 16 in March that the precise format of the hearings in May 17 must remain up in the air until those submissions are 18 heard. It may be possible that at those hearings 19 evidence is only taken from Professor Wigmore about the 20 interim findings of the ICR process for which a Rule 8 21 request has already been issued or it may be that 22 evidence will need to be taken in the public interest 23 from others in connection with the work of the ICR most 24 notably the neurosurgeons or some of them who have 25 provided opinions to it. It is not currently Page 114	1 by the Inquiry they can sometimes not be adhered to 2 often due to draft statements or materials not produced 3 with sufficient quality by the deadlines necessitating 4 a more prolonged second drafting period than should have 5 been required and elongating the process. Rule 8s need 6 to be prepared which are fair but probing, precise but 7 not long-winded, if they are to serve their purpose. 8 When documents become evidence to the Inquiry it 9 requires to undergo lengthy but necessary processes of 10 review for disclosure and ultimate publication. These 11 are inherently time-consuming. 12 It is anticipated that evidence will be sought from 13 a wide range of medical professionals in Section 3 such 14 that a significant amount of time will be taken for these 15 processes. These inevitable labours are all part of 16 undertaking an investigation of this scale and dare 17 I say importance. Within the Inquiry structures and 18 processes have been devised to seek to minimise delay 19 but ensure substantive process such as having teams 20 which work ahead for future sections of the plan while 21 an earlier section is going on. The Inquiry constantly 22 reviews and refines its processes and operations to 23 maximise efficiency. Operational plans are regularly 24 updated to adapt to difficult or unforeseen 25 eventualities. The Inquiry remains, however, reliant on Page 116

1 those who have evidence to provide adhering to its 2 deadlines and providing what has been requested or 3 demanded to the desired quality. This does not happen 4 at times with significant results as far as planning is 5 concerned. The support provided by the Scottish 6 Government in connection with recruitment and other 7 logistics remains slow, a feature of our requirement to 8 rely on the systems of a large organisation when we 9 strive to be a small and nimble operation. 10 Slower than anticipated progress in the ICR to which 11 I have alluded has resulted in significant need for the 12 Section 2 operation for whom there are other operational 13 plans to remain committed to that section for around 14 six months longer than had been planned. That too has 15 had and will have a significant effect on our planning. 16 Despite these vicissitudes we remain committed not 17 only to striking the best possible balance between speed 18 and reasonable thoroughness, to which you have committed 19 us, sir, but also to our principles, including clarity, 20 honesty and cooperation. Our planning remains 21 orientated towards having Section 3 hearings in late 22 2027; November is currently earmarked for that purpose. 23 We will keep our core participants and the public aware 24 of our progress as ever and the achievability of that 25 aim. Page 117	1 wished to participate in it who had direct involvement and 2 interest in the subject matter of this Inquiry were 3 consulted, as opposed to relying solely on information 4 arising from other related, though possibly different, 5 contexts. 6 Thus our response is and will be based on the four 7 core lessons which have emerged from the consultation, 8 namely complexity and unfamiliar process can overwhelm 9 participants who have had traumatic experiences. Roles 10 and responsibilities require clear explanation. 11 Trauma-informed principles are interconnected. Safety 12 relies on trust, trust relies on collaboration and 13 choice and all depend on independence and clarity. And 14 finally, participants strongly value being heard. 15 Former patients want the Inquiry to understand their 16 experiences without requiring repeated retelling of 17 traumatic events. 18 Our policy, sir, is built on the definition of 19 "trauma" that it is in response to extreme or intense 20 experience which is frightening or distressing to the 21 person involved particularly if it is overwhelming, 22 difficult to cope with or feels out of their control. 23 It is derived from the evidence base to which we have 24 paid attention that such traumatic experience has the 25 potential significantly to affect the way in which the Page 119
1 Sir, to turn now to some other important 2 developments in our work. 3 As explained at previous procedural hearings the 4 Inquiry has undertaken a consultation exercise as 5 a means of creating an evidence base for its 6 trauma-informed policy which sets out the Inquiry's 7 practical approach to the way in which it intends to 8 honour its commitment to be trauma-informed, one of our 9 fundamental principles. As a result of that 10 consultation exercise the Inquiry has now published on 11 its website a statement of its approach being 12 trauma-informed for the consideration of those who have 13 an interest in contents. Given the importance of that 14 development I have a few things to say about the 15 Inquiry's intended and now published approach. 16 Sir, there is no existing model for making a public 17 inquiry trauma-informed. In fact we have been told and 18 have discovered in our consultation process and have 19 accepted that for a trauma-informed policy to be 20 effective it must be responsive to the particular trauma 21 experienced by the people engaging with a particular 22 process. That is why we have aimed and continue to 23 intend to deliver a bespoke approach for our 24 trauma-informed public inquiry. That is why we 25 undertook the public consultation exercise and those who Page 118	1 traumatised individual interacts with the rest of the 2 world. In our sphere such interaction includes 3 interaction with the Inquiry as a core participant, as 4 a witness, as a provider of information or material, or 5 otherwise. 6 Thus the focus of the starting point of our policy 7 is on those who have suffered trauma of this nature. It 8 is people who have had such experiences whom our policy 9 is designed to help, with a view to listening to them 10 and taking steps to maximise the value to them and to us 11 of their interaction with, connection to, experience of 12 and role in the Inquiry. Our policy also makes clear 13 that though others may have suffered trauma of this 14 nature it will be assumed that patients who assert that 15 they have, have indeed been affected by such past 16 trauma. We will not seek to interrogate those 17 individuals or have them vouch for their trauma. They 18 will be believed and they will be treated as set out in 19 the policy. 20 This approach to being trauma-informed does not mean 21 that the Inquiry does not acknowledge that being 22 involved in an Inquiry in any capacity be in itself 23 an unsettling and difficult experience, for many it may 24 be. Those people deserve to be treated with courtesy 25 and respect and have their experience of the Inquiry be Page 120

1 no more disturbing or unsettling than need be. They 2 will be. 3 It is not, however, with such individuals that the 4 trauma-informed policy and the putting of it into 5 practice is concerned. To have a trauma-informed policy 6 which did not recognise that trauma is something more, 7 something more impactful and more long lasting would be 8 to have a policy which was not sufficiently tailored to 9 those who need to have such a policy the most. 10 As I have set out before, the principles upon which 11 the policy is based will be safety, trustworthiness, 12 choice, collaboration and empowerment. However, the 13 statement of approach goes further than principles, 14 important though they are to the way we intend to work, 15 it also proposes practical steps which we intend to take 16 to help counteract aspects of the effects of trauma 17 which have been identified to us in our consultation 18 process. Those steps also seek to avoid retraumatising 19 individuals who have suffered trauma and to avoid 20 undermining any efforts they are already taking, to seek 21 to alleviate or address the impacts of trauma on them. 22 These will include information being shared about 23 the work of the Inquiry in a regular written 24 communication to which recipients are free to sign up as 25 they wish, sent directly to those who wish to receive Page 121	1 to deal with the immediate emotional reactions to 2 involvement in the Inquiry's hearings. Participant 3 support is available for a wider range of situations 4 including witness support but also other support for 5 participants. It will involve a number of support 6 sessions being made available at times when they may be 7 needed. It can be accessed via details on the website 8 or via our Inquiry phone line. The Inquiry's witness 9 liaison manager, Tracy Millar, an experienced 10 professional from the charitable sector who is and will be 11 in charge of directing people to the most appropriate 12 support mechanism for them. 13 Our approach to being trauma-informed will be one 14 which listens, adapts and evolves. The next step 15 towards that aim will be a further consultation which 16 will be launched after these hearings into the nature 17 and form of direct contact which those who have suffered 18 trauma would like the Inquiry to have with them beyond 19 efforts which were already made in this regard as are 20 already set out in the statement of approach. 21 It is contemplated that meetings between members of 22 the Inquiry team and those who wish to participate in 23 them to keep individuals informed, answer their 24 questions and interact with them in an appropriate and 25 helpful way will be part of the plan going forward. Page 123
1 it. This information will update people on the progress 2 of the Inquiry or lack of it for any reason but will 3 also seek to justify what we have done, are doing, 4 or will do, and seeks to respect and promote our 5 trauma-informed principles. Other initiatives the 6 Inquiry already has in place are set out in the 7 statement of approach. 8 These initiatives include ensuring that support 9 mechanisms which the Inquiry has put in place and which 10 I outlined at our procedural hearing in May and details 11 which are available on our website continue to be 12 available and to be effective. Support is available 13 from representatives of Spark, the Scottish-based 14 charity which provides counselling and mental health 15 support for individuals, couples, families, children and 16 young people, which has provided such services for 60 years. 17 Information about the support services which can be 18 obtained can be found on the Inquiry's support hub, 19 a new dedicated section on the Inquiry website. Such 20 support is provided in two forms: emotional support and 21 participant support. 22 Emotional support is available to all those who need 23 it during hearings such as these, including virtual 24 hearings, though in person at in-person hearings. 25 Trained counsellors can be accessed online or in person Page 122	1 However, precisely what this interaction should involve 2 is a matter on which we wish those who have suffered 3 trauma to express a view. We wish to listen as we have 4 done to this point and to tailor such meetings to what 5 precisely is needed and what realistically can be 6 delivered. 7 We are fortunate this work continues to be led by 8 the Inquiry's Deputy Secretary, Dan Farthing, who has 9 many years of experience of working with, promoting the 10 interest of and advocating for a wide range of 11 traumatised individuals in the charitable sector. His 12 efforts are supported directly by the Chair and other 13 members of the Inquiry's senior team, not least myself. 14 Sir, under Dan's expert direction in this area we remain 15 committed to making this Inquiry work for traumatised 16 people. That commitment is real. Informed by 17 consultation with our traumatised participants, built on 18 believing them, respecting them and accepting the 19 profound effects of their trauma and their ability to 20 engage with this Inquiry as a result. That commitment 21 will not diminish. 22 Sir, I have set out in previous hearings ongoing 23 issues that we have had with our engagement with 24 Scottish Government other than those relating to the 25 fire safety of this building. Needless to say a number Page 124

1 of those issues relating in particular to the 2 recruitment of appropriate staff for the Inquiry, your 3 reasonable requirement, sir, for those interacting with 4 the Inquiry to sign confidentiality undertakings and the 5 still unsigned management agreement between this Inquiry 6 and the Scottish Ministers are still outstanding. It is 7 hoped that those are matters which will be addressed by 8 the Scottish Ministers responsible for sponsoring this 9 Inquiry in early course. 10 Sir, as you have alluded to in your opening speech 11 I already set out the direction of travel as regards our 12 evidence gathering at previous hearings and in addition 13 a call to provide evidence or information about how that 14 could be done is to be found at paragraph 24 of the 15 Inquiry's approach to evidence and written statements. 16 That request and that information has been heeded by 17 some individuals who have got in touch with the Inquiry 18 with information about their involvement. However, as 19 we start to move towards the more detailed investigation 20 which will be involved in Section 3 and beyond I wish to 21 use this opportunity to issue a further, clear and 22 unequivocal public call for evidence as we plan or move 23 beyond the first two sections. 24 As we move beyond the evidence of the patient group 25 on which we will focus on in December and in our Page 125	1 this stage to those medical professionals who had 2 an involvement in the work of Mr Eljamel and who feel 3 that they may have something to contribute. They may be 4 other neurosurgeons or doctors or surgeons involved in 5 associated medical disciplines linked to Mr Eljamel's 6 work, such as but not limited to radiology, neurology or 7 anaesthesia. They may have been contemporaries or 8 subordinates. They may be nurses or other staff who 9 worked with him or had knowledge of his work either at 10 a hospital or somewhere else, like in the University of 11 Dundee. They may include medical professionals who were 12 involved in investigations into him or who made 13 complaints, raised concerns or provided feedback about 14 him. Any such individual who may wish to contact the 15 Inquiry can be assured that their approach will be 16 treated confidentially and professionally. 17 You are committed, sir, to accept evidence from such 18 individuals anonymously if appropriate to protect the 19 individuals concerned. As I have stated the Inquiry's 20 entirely prepared to deal sensitively and respectfully 21 with individuals who suffered trauma as a result of their 22 experiences or be otherwise apprehensive about 23 interacting with us. We are flexible about the way that 24 evidence can be provided to us or gathered by us, we can 25 help with finding ways of evidence being provided in the Page 127
1 continued oversight, input to, and analysis of patient 2 evidence emerging from the ICR which will continue as 3 I have said, I wish to invite any medical professionals, 4 current or former employees of organisations with 5 an interest in our work including NHS Tayside or the 6 Scottish Government, to make contact with the Inquiry 7 directly to explain what evidence they feel they can 8 offer relating to any matter falling within our Terms of 9 Reference or a more detailed List of Issues. 10 Though we will continue to do what we can to 11 identify and approach those whom we think may have 12 evidence to give, we are open to being approached by 13 such individuals. Some such individuals, as I say, have 14 already contacted the Inquiry directly. We wish to make 15 clear to others who may have stories to tell that, as 16 with all those with whom the Inquiry comes into contact, 17 they will be treated with courtesy and respect. Those 18 who may have something to add may have documents to 19 provide or simply recollections or views about matters 20 with which we are concerned. All are welcome and all 21 are encouraged to get in touch via any of the channels 22 available, which are carefully set out on the Inquiry's 23 website, www.eljamelinquiry.scot. 24 Though that is an open-ended invitation, I would 25 like to extend that call for evidence in particular at Page 126	1 way that suits the individual, for example by providing 2 oral evidence remotely and/or anonymously. Our 3 emotional support services are available to these 4 individuals as well. We are committed to our staff 5 upholding all of the principles to which I have referred 6 and upon which the Inquiry is based. 7 Equally the Inquiry is keen to hear from those with 8 an interest in surgery, in particular those who have 9 perspectives on how things may be improved for the 10 betterment of patient care in that field of practice 11 which gives rise to certain issues, considerations, 12 requirements and responsibilities which apply in 13 particular to it. We remain committed to inclusivity, 14 open-mindedness and going where the evidence takes us. 15 You do not need to wait to be contacted by us, 16 proactively contact us through our witness liaison 17 manager or the legal inbox. Witness engagement 18 initiatives are already being put together as part of 19 our investigations but we also welcome contact in this 20 way. 21 It should be stressed that it's not necessary for 22 an individual or organisation to be a core participant 23 in order to provide information or evidence to the 24 Inquiry. Many individuals and organisations beyond the 25 core participants will have relevant information to Page 128

1 provide in relation to the matters we are looking at. 2 There are many things that we do not know. We cannot 3 know unless those who were there and have recollections 4 about what happened and views of them shared with 5 us. We have power to investigate and to compel but do 6 not assume that we know everything. We have not 7 prejudged, it would be quite wrong for us to have done 8 so absent evidence. We will go where the evidence takes 9 us but we need evidence to move forward. 10 Like us, many who have evidence to provide will, 11 I am sure, have a commitment to the betterment of health 12 services in this country, in particular in the field of 13 surgery. It is only through wide engagement and careful 14 and meticulous evidence gathering that we will achieve 15 this important aim. If you have evidence to provide 16 please get in touch. 17 Sir, I have a few closing observations to make at 18 this stage. 19 Even though this section of the Inquiry is 20 introductory, there is a significant risk that the 21 evidence which will be heard will be difficult and 22 traumatic for some. For those who may require it in any 23 way, they will find support and assistance from your 24 dedicated team led by Natalie Smith, the Secretary to 25 the Inquiry and Dan Farthing the Deputy Secretary. They Page 129	1 oral submissions made at, or in connection with, the 2 Inquiry's three previous procedural hearings that they 3 would support the Inquiry's work and respect this 4 approach. They will be expected to do so and witnesses 5 who will come and give evidence, some from those 6 organisations, also deserve to be treated with the same 7 courtesy and respect. I have every confidence that all 8 those who participate in our work will adhere to these 9 important considerations. 10 Sir, you do not expect this Inquiry to be a forum 11 for grandstanding or protest, you expect it to be 12 a forum in which the aims of this process to which all 13 participants have pledged their commitment will be 14 achieved. As such you expect this to be a forum in 15 which all voices are heard and all willing participants 16 are given an opportunity to contribute. It is in that 17 spirit and in that expectation that it is a joint 18 endeavour in which we are all engaged that these 19 hearings will proceed. 20 At the first of the Inquiry's public hearings 21 in September 2025 I explained that this Inquiry had 22 a number of key themes. These themes remain at the 23 centre of what we are seeking to achieve and run through 24 all that we do. They bear repeating at this stage as we 25 turn to examining witnesses in public about them. Page 131
1 and their team will be on hand to offer support and 2 assistance at any time. Equally, as I have explained, 3 emotional support from the Spark team will also be 4 available. 5 In addition, a room has been made available in the 6 hearing suite for the use of the patient core 7 participant group and their recognised legal 8 representatives as they are the biggest group and also 9 a separate room for NHS Tayside and their legal 10 representatives as they have the most witnesses to 11 represent, as I have set out already. 12 Rooms will be available for witnesses each day where 13 they can meet with their legal representatives and with 14 the Inquiry team. Other rooms can be made available to 15 other teams. If they require them they can be booked 16 with the Inquiry secretariat team. The Inquiry legal 17 team, under the stewardship of Lynn Carey will also be 18 on hand to handle questions or queries more 19 appropriately directed to them. 20 Sir, against that background I repeat the Inquiry's 21 expectations that its work, including the proceedings of 22 these hearings, will be conducted in a spirit of 23 dignity, courtesy and respect. As I've set out in some 24 detail, sir, our organisational participants all pledged 25 in their opening statements and in other written and Page 130	1 This Inquiry is concerned with patient care. Where 2 that goal has been lost sight of, forgotten or 3 undermined, where it has been neglected or diminished 4 either in medical care or by corporate action or 5 inaction, this Inquiry will seek to find out why. 6 These hearings are the starting point of that 7 journey. Though it will be at the hearings in December 8 that we will turn to hear oral evidence from patients, 9 as I have outlined at these hearings, patient safety 10 will be a focus not least in the evidence to be heard 11 from Liz Smith and the Patient Safety Commissioner but 12 also in expert evidence which will focus on how patient 13 safety can be kept paramount in healthcare systems. 14 This Inquiry is built on an understanding of the 15 importance of trust, trust in any emanation of the state 16 but those parts which are responsible for healthcare in 17 particular. It is about when and how trust has been 18 undermined and lost, how that loss of trust has 19 manifested itself, whether and how it has been addressed 20 and how harm may have been compounded when it has not 21 been. These hearings, sir, have been built around the 22 Inquiry seeking to foster trust amongst those who will 23 participate in them. They will also be an opportunity 24 to examine the importance of trust and will examine 25 instances where, even in recent times, it appears to Page 132

1 have been lost. 2 This Inquiry's main area of investigation is in the 3 field of surgery, a theme which was emphasised on behalf 4 of the patient group by Ms Cherry KC in her opening 5 statement. In the field of surgery it might be said the 6 requirements of patient care and trust are at a premium. 7 Situations where surgical intervention is contemplated 8 or undertaken are, by their nature, situations of 9 extreme complexity, severity and vulnerability. 10 Considerations of respect, dignity and humanity are thus 11 paramount both from those involved in the surgery and 12 those involved when things go wrong. These themes will 13 be part of the evidence led from our neurosurgery and 14 medical ethics expert groups from whom we will hear at 15 these hearings. 16 This Inquiry is concerned, sir, with the importance 17 of communication. Communication is at the heart of good 18 patient care and in particular in the surgical field 19 before, during and after the surgery and where things 20 appear to have gone wrong. Communication is about truth 21 and the effective communication of it, both of which 22 patients deserve. The Inquiry requires to look at the 23 adequacy and candour of communication often with 24 vulnerable, distressed and harmed patients both in the 25 operative sphere and from and with the corporate Page 133	1 a senior representative of the Scottish Government and 2 senior representatives of numerous major organisations 3 who played or could have played a part in matters 4 falling within our Terms of Reference. 5 Sir, this Inquiry aims to be a part of achieving 6 improvement. The Inquiry has a forward-thinking 7 function to seek to make meaningful recommendations for 8 change so that aspects of medical, and in particular 9 surgical care, which have not worked well will work 10 better in future in the ultimate service of patient 11 care. At these hearings, though we are at the start of 12 our hearings process, we will have an eye to the future 13 and what might be done to make systems upon which 14 patients rely better and safer. 15 It is on the foundation of these themes, sir, and 16 the advice received from those with whom we consulted 17 that the Inquiry's bespoke principles of being 18 trauma-informed, open-minded, independent, to listening, 19 cooperation, clarity and thoroughness have been 20 constructed. Though, as is perhaps inevitable, hurdles 21 and impediments have been encountered along the way, 22 I said at the procedural hearing in May that we remain 23 committed to these principles and to the endorsement of 24 them provided by and on behalf of the patient body in 25 particular. I am proud to report, sir, that despite the Page 135
1 structures around it. It is about the maintenance of 2 ability to communicate the truth, by the maintenance of 3 records to be able to do so. It is also, sir, about the 4 way in which these structures and organisations whose 5 ultimate aim it is to promote good patient care 6 communicate internally and with each other. Again, at 7 these hearings communication will be a prevalent theme 8 not least in the evidence of the medical ethics group. 9 Sir, this Inquiry is about the need for people and 10 organisations to take responsibility. Our National 11 Health Service owes a legal and moral duty to patients 12 in its care beyond the more immediate duties or by 13 treating medical professionals. When patients go to 14 hospital they reasonably expect they will be protected 15 by a system beyond the individuals normally in charge of 16 their care. That responsibility will extend to 17 other professionals, the health board and other bodies 18 with responsibilities in that regard accorded to them by 19 law. 20 The Inquiry will look at the whole system whereby 21 health and well-being are meant to be promoted and 22 maintained and analyse whether that system was and is 23 fit for purpose. This hearing session has 24 responsibility at its core. Witnesses will include all 25 contributors to the NHS Tayside's Section 1 statement, Page 134	1 difficulties we have encountered this Inquiry has 2 maintained its focus on the fulfilment of its Terms of 3 Reference and its adherence to the principles which you 4 set out at the start of this process. 5 In addition, the investigation of its remit has been 6 carried out without fear of favour, facts being 7 investigated as fully as the current stage of our 8 progress will permit as well as fairly, as we were told 9 by the patient core participant group that it expected 10 us to do in its opening statement. It is on the basis 11 of these considerations and those principles that these 12 hearings will be conducted. 13 Thank you for your attention, sir, and for the 14 attention of those who are joining us here in person and 15 those who are joining us online. I would suggest that 16 we now break, sir, with a view to the Inquiry calling 17 its first witness in the afternoon session, beginning 18 around 2 pm. As is not uncommon with public inquiries, 19 there will no doubt be many issues which can be 20 canvassed and addressed so that all those in attendance 21 are comfortable and their needs catered for. The 22 Inquiry team stands ready to assist with any such 23 queries and we look forward to hearing the evidence of 24 Ms Liz Smith CBE this afternoon. 25 THE CHAIR: I'm grateful to you, Mr Dawson. Thank you very Page 136

1 much indeed. It's gone 1.10. We'll break now for 2 lunch. As you've just heard evidence will commence this 3 afternoon with the first witness in this hearing at 4 2 o'clock and I look forward to seeing you all then. 5 Thank you. 6 (1.14 pm) 7 (The short adjournment) 8 (2.07 pm) 9 THE CHAIR: Good afternoon. Please be seated. Mr Dawson. 10 MR DAWSON: Sir. Yes, the first witness is Liz Smith CBE. 11 THE CHAIR: Thank you, and you'll let me know when we reach 12 a suitable point for a break. 13 MR DAWSON: Of course. 14 MS LIZ SMITH CBE (sworn) 15 Questions by Counsel to the Inquiry: MR DAWSON 16 MR DAWSON: Good afternoon. 17 A. Good afternoon, sir. 18 Q. You are Liz Smith. If you could speak into the 19 microphone in front of you and try to keep your voice up 20 so that people can hear you around the room, that would 21 be extremely appreciated. You have received a Rule 8 22 request for evidence from the Inquiry? 23 A. That's correct. 24 Q. And the Rule 8 request asked you to provide a written 25 statement to the Inquiry and documents, is that right? Page 137	1 A. That is also correct. 2 Q. And you have a professional background in teaching? 3 A. Yes, correct. 4 Q. And you tell us in your statement that after graduating 5 you taught economics and modern studies at a school in 6 Edinburgh between 1983 and 2001? 7 A. That is also correct. 8 Q. And within that employment you were assistant head of 9 department between 1989 and 2001? 10 A. Those are the correct dates, yes. 11 Q. I understand that you worked for a period as a policy 12 adviser to Sir Malcolm Rifkind, is that right? 13 A. That's also correct, yes. 14 Q. What period did that cover? 15 A. Largely the period between me finishing my teaching 16 career and at the time when the Scottish Conservatives 17 had, let's say, not done terribly well in the election 18 and so Malcolm had lost his seat, I was an advisor 19 through my work in conservative central office. 20 Q. And so what role did Sir Malcolm occupy at that time? 21 A. Really having to look at the reasons in politics why the 22 Scottish Conservative Party had not done particularly 23 well in the election and he was asked by the then 24 chairman of the party to look at all aspects of policy 25 delivery and why perhaps that was not resonating with Page 139
1 A. That is correct, sir. 2 Q. And you provided a witness statement to the Inquiry 3 which I think was dated 10 March 2026, is that right? 4 A. That is also correct. 5 Q. For the record the reference for that document is 6 G0001-00032. Could we have that statement up, please. 7 Is that your statement? 8 A. Yes, sir, it is. 9 Q. Could we go to page 14, please. That's the last page, 10 I think. Is that correct? 11 A. That's correct. 12 Q. And although it's blanked out for our purposes, you have 13 signed that, haven't you? 14 A. I have. 15 Q. And are the contents of that statement true as far as 16 you are aware? 17 A. Yes, they are. 18 Q. You helpfully tell us in your statement that by way of 19 educational background you have I think a joint honours 20 degree in economics and politics from the University of 21 Edinburgh from which you graduated in 1982? 22 A. That is correct. 23 Q. And you also hold a diploma in education from Moray 24 House College of Education, Edinburgh, which you 25 received from the following year? Page 138	1 the general public and I was asked to be the secretariat 2 to that policy review. 3 Q. Understood, thank you. And we understand from your 4 statement that in May 2007 you yourself were elected as 5 a Member of the Scottish Parliament? 6 A. That's 2007, yes. 7 Q. In 2007. And you served in that position for 19 years? 8 A. I did. I was stood down from the parliament at the most 9 recent election. 10 Q. Indeed. And you are a Conservative MSP? 11 A. Yes. 12 Q. And I think that you were a regional member for 13 Mid-Scotland and Fife; is that correct? 14 A. That is also correct, yes. 15 Q. Could you tell us how you came to be a representative of 16 that geographical area in particular? 17 A. I had a long-time interest, particularly in the 18 Perthshire angle of that, both from sort of sporting and 19 general interest in that part of the world and I'd been 20 born and brought up in Edinburgh, been at school in 21 Edinburgh, been at the University of Edinburgh as well 22 and I wanted to broaden my horizons because I felt there 23 were a lot of political issues in Mid-Scotland and Fife 24 that resonated a lot with my own interests and I was 25 lucky enough to be selected in a seat there. Page 140

1 Q. Okay. And could you help us a little bit, one of the 2 things that sort of interest us is the geographical area 3 that's covered in terms of catchment of NHS Tayside and 4 the evidence that we have from other sources 5 suggests that NHS Tayside serves the population of the 6 Tayside region which encompasses the local authority 7 areas of Angus, Dundee City in Perth and Kinross, but 8 also that acute healthcare services are also delivered 9 by NHS Tayside or have been by other bodies in the past 10 relating to north east Fife. If you can, because 11 I'm sure these things are sometimes quite difficult to 12 do, tell us, to the extent to which the area that you 13 represented coincides with NHS Tayside's sphere of 14 operation, if you could? 15 A. Largely it coincided but not entirely. As you've just 16 mentioned, it covered different local authorities and 17 part of the Angus constituency was not part of 18 Mid-Scotland and Fife, that was part of the north east 19 regional alliance in Holyrood. So largely speaking, the 20 constituents from Mid-Scotland and Fife who were coming 21 to me broadly speaking were ones who had an interest in 22 NHS Tayside and the services provided by it. 23 Q. Right. And was that particularly the case in relation 24 to that aspect that I described which is to do with the 25 acute services, that it also provided it to the part of Page 141	1 period of time following the death of the late 2 Margo MacDonald and during that period of time I had 3 a lot of involvement in trying to widen access in the 4 sporting world and particularly for people with 5 disabilities and those who perhaps were not able to 6 access sporting facilities so I did a lot of work -- 7 kind of the cross-party group at Holyrood was 8 a representative body for lots of different sporting 9 interests and what I tried to do was to involve some of 10 the more minority sports and I think I was quite 11 successful in doing that, and it was a great privilege 12 and a great pleasure to be the convenor of that group 13 and I was taken aback but nonetheless very delighted to 14 receive a CBE two years ago. 15 Q. Thank you. Obviously we're keen on asking you questions 16 today about your long-standing representation of 17 patients who were former patients of Mr Eljamel, and in 18 doing so could I just point out a couple of aspects of 19 our approach to you. 20 As I highlighted in my opening address this morning 21 for various reasons we have taken the approach to these 22 hearings that where individual patient's names may 23 become involved we've decided to redact from the evidence, 24 not at all because we're not interested but because 25 we'll revert to a more specific analysis of their case at Page 143
1 Fife? 2 A. Yes. 3 Q. Yes and I think as we'll come on to find out, that was 4 an area -- a geographical area in which you had 5 a particular interest in relation to the Eljamel matter? 6 A. That's correct. 7 Q. Just reverting again to your CV. You told us you stood 8 down as an MSP at the election. I understand that 9 you're now working as a freelance education advisor, is 10 that correct? 11 A. Yes, I am. 12 Q. And that you've been appointed to the Court of the 13 University of St Andrews? 14 A. Correct. 15 Q. And that you're a patron of the Cricket Development 16 Trust (Scotland)? 17 A. Correct. 18 Q. I understand you played cricket for Scotland; is that 19 correct? 20 A. I did. Don't ask me the scores. 21 Q. And that you were awarded a CBE in 2024? 22 A. Yes. 23 Q. And was that in connection with your services to sport? 24 A. It was, sir. It was largely I'd convened the 25 cross-party group on sport at Holyrood for a very long Page 142	1 a later date. There are, however, two individuals with 2 whom I think you have had some contact who I think it 3 will be almost impossible to conduct a hearing of this 4 nature without mentioning. They are Ms Jules Rose and 5 Mr Pat Kelly. 6 If I can ask your indulgence to try to avoid, in our 7 discussions, mentioning any other patients but feel free 8 to mention them as we have already had conversations 9 with them about them being happy that that should be the 10 case. The other thing I wanted to say to you is we're 11 very interested in trying to understand from you your 12 experiences as they have been relayed to you by patients 13 over the years to try to provide an important context 14 for our hearings, but you shouldn't take any of the 15 questions that I am asking you as in any way seeking to 16 replace or be deemed more important than the evidence of 17 patients themselves. It's useful to speak to someone 18 who has spoken to so many patients to try to give us 19 a flavour of their experiences, but to reiterate, we 20 will return to ask them directly in due course. So 21 again, don't be worried too much about the details which 22 we will get from the patients directly but your 23 testimony in that context is very useful to us. 24 Could we have a look, please, at paragraph 2.1 of 25 the statement, if we could have that up on the screen. Page 144

1 Thank you very much. You tell us there that: 2 "In my role as a Member of the Scottish Parliament 3 for Mid Scotland and Fife, my primary responsibility in 4 terms of Eljamel case work has been to represent 5 Mrs Jules Rose (resident in Kinross) but I have also 6 provided a great deal of advice to other former patients 7 and their families and, in several of these cases, 8 particularly those relating to Mr Pat Kelly, I have 9 worked with other MSPs, principally Mr Michael Marra MSP 10 and Mr Willie Rennie MSP." 11 THE CHAIR: Sorry, Mr Dawson, just before you pose 12 a question can I just check that everyone in the public 13 gallery and elsewhere can make out the text of what 14 we're reading? I think we may need to enhance 15 paragraph 2.1 please. 16 MR DAWSON: Yes. So the text that I've just read out is the 17 text that I'm going to ask you some questions about but 18 that's very helpful, sir. You mention there doing case 19 work for Ms Rose. What does "case work" mean generally 20 and in connection with what you did for Ms Rose? 21 A. It's a parliamentary term that is used when 22 a constituent comes to you with a specific issue that 23 they would like you to investigate, and you have 24 an obligation, a responsibility as a member of 25 Parliament to ensure that you listen to all the points Page 145	1 on behalf of Mr Kelly at a time where he was doing 2 similar case work and he wanted some information. So 3 I was aware of the Eljamel situation but nothing like 4 the depth of information that I received from Mrs Rose 5 as a constituent. And the information that I then 6 received having gone into lots of different directions 7 thanks to Mrs Rose pointing me in the right direction, 8 I then picked up an awful lot of information about the case. 9 Q. And you provide us with a list which is heavily redacted 10 in your statement of individuals I think on whose behalf 11 you campaigned you did this case work but also 12 a secondary list if you like of people who have been in 13 contact with you to thank you for your work or to 14 acknowledge it. Does that list represent an accurate 15 reflection of cases that you would say you know about or 16 is there a wider pool? And could you put a number on 17 the sort of number of patients whose experience to some 18 extent you have visibility of? 19 A. In terms of the detail, both from a medical perspective 20 and also the interactions that they had with NHS Tayside and 21 with the Scottish Government and in some circumstances with 22 Police Scotland and other agencies, I would suggest to 23 you, sir, that there are probably five individuals from 24 whom I received a very considerable amount of detail 25 that allowed me to pursue quite a lot of aspects of this Page 147
1 and information that that constituent is putting in 2 front of you and if there is a concern or a complaint, 3 or in several cases concerns and complaints in plural, 4 then it is your job to go and find out exactly what 5 happened and that was my role in representing 6 Mrs Jules Rose but also representing some other 7 patients. 8 Q. So you had a role then in trying to engage with them to 9 understand their experiences, their -- 10 A. I did. 11 Q. -- views on things and what they wanted you to try and 12 achieve for them? 13 A. Yes. 14 Q. I understand Ms Rose is herself a former patient of 15 Mr Eljamel? 16 A. Yes. 17 Q. And she's also been a prominent campaigner on behalf of 18 a large number, I think, of other patients; is that 19 correct? 20 A. That's absolutely correct and a very good campaigner. 21 Q. Did your involvement generally or through Ms Rose lead 22 to you becoming involved with other patients? 23 A. Yes, it did. I first heard about the Eljamel situation 24 way back in 2015 when my former colleague, the late 25 Alex Johnstone, had issued some comments in Parliament Page 146	1 case in very considerable detail. But I was picking up, 2 right throughout my time as a member for Mid-Scotland 3 and Fife from 2015 onwards, an awful lot of information 4 partly through what the media was presenting but also 5 from what I was hearing from other angles and people 6 would phone me up about and it I would get a sort of 7 reference to some of that as well. 8 Q. There's an interesting aspect of what you just said that 9 interests us in the Inquiry because it's not just 10 about learning with the individual's clinical experience 11 and engagement with individual doctors or nurses but 12 their engagement with the wider systems of healthcare. 13 I think you mentioned NHS Tayside there. Was it a facet 14 of the patient experience with which you became familiar 15 that there were concerns being raised about their 16 clinical experiences, their experiences with healthcare 17 services more widely, or both? 18 A. It's a bit of both, sir. I was reading some 19 extraordinary pieces of information that upset me 20 greatly about what was being alleged from a medical 21 angle. They upset me greatly and I found it difficult 22 to accept that that kind of situation could happen but 23 I was absolutely determined as a Member of the Scottish 24 Parliament that it was my job to help these patients who 25 had gone through incredible trauma both physically and Page 148

1 psychologically, and their families had too, that 2 I became exceptionally interested in this case because 3 it alarmed me, it appalled me. I was very upset to read 4 some of the documentation and I saw it as my moral 5 responsibility to ensure that I was going to represent 6 these patients because they were not getting the answers 7 that I felt and I'm sure they felt should have been 8 forthcoming from NHS Tayside and from the Scottish 9 Government and so I made it my business to put this case 10 work really at the top of my agenda. 11 Q. Just so I understand the means by which you sought to 12 advance those issues and get those answers. You were 13 a Member of the Scottish Government and therefore able 14 to address questions to the Scottish Government? 15 A. Yes. 16 Q. And in your role as an MSP you had a responsibility to 17 scrutinise them, is that right? 18 A. That's correct. 19 Q. And the Scottish Government is ultimately responsible 20 for the delivery of NHS healthcare in Scotland? 21 A. Yes. 22 Q. Including NHS Tayside? 23 A. Including NHS Tayside, yes. 24 Q. So you felt, and no doubt those who contacted you felt, 25 that this would be a legitimate means by which to try to Page 149	1 played a role in trying to prevent that happening? 2 A. Yes, that's correct, sir. There are two aspects to my 3 mind and this has been the case right throughout. There 4 is the case of the alleged medical malpractice of 5 Eljamel and obviously the clinical reviews are 6 overseeing a lot of the aspects of that. But there are 7 the systems management, or lack of management in many 8 cases, of why Eljamel had been allowed to continue 9 practising when quite clearly there had been very 10 deep-seated concerns raised at earlier stages and why 11 this had been allowed to happen and I was interested not 12 only in that but in the accountability. Somebody 13 somewhere must have known why this was allowed to happen 14 and I was interested in trying to help the patients to 15 find out the answers to that. 16 Q. I think in your statement -- I'll get into this in 17 a moment -- you talk about learning about a particular 18 case in 2016 but you've mentioned in your evidence today 19 that what sparked your interest was in 2015. You've 20 explained what that is. Was it always a feature of the 21 patient's position in trying to get the answers that you 22 say that they sought that they were interested both in 23 getting answers to questions about their own clinical 24 experiences but also about that wider context of 25 oversight that you've talked about? Page 151
1 get to their answers which I think you said they had 2 struggled to get through other means? 3 A. Yes, that's correct. I'm not a medic and I was very 4 conscious that I was reading a lot of, firstly, 5 confidential private material that constituents had 6 chosen to allow me to see but I was also very conscious 7 that I was coming up against terminology and 8 descriptions of medical procedures that I had no 9 knowledge of and I had to go and find out a lot of 10 material to help in my understanding of exactly what had 11 gone on, but I thought, more importantly than that, was 12 to look at the procedures that had manifest themselves 13 within patients asking questions about why a lot of 14 malpractice had happened and why some aspects of the 15 surgery, in most cases, had been so appallingly 16 delivered and why the oversight of that and the 17 management procedures had, in my impression, completely 18 failed. 19 Q. So just to unpack that a little bit. Your experience of 20 patients was that in the first instance they were 21 interested in finding out why their surgeries appeared 22 to have gone wrong? 23 A. Mm-hmm. 24 Q. But beyond that they were interested in trying to find 25 out whether there were other bodies who could have Page 150	1 A. Yes, I think I could safely say that in the case of all 2 the patients and constituents that I saw that there was 3 the medical malpractice. There was a horrendous pain 4 and suffering that they had had to endure and they want 5 answers it that, quite rightly. But the bigger picture 6 in this is not least because there are so many -- we now 7 know there are so many patients who are seeking these 8 answers -- there is the much wider question and I think 9 very substantial question about why on earth was this 10 allowed to happen? 11 Q. Okay. Could I just ask about your preparation for 12 giving evidence today. Have you discussed your evidence 13 with some of the patients or their representatives whom 14 you act on behalf of? 15 A. Well, I think throughout my whole time of looking 16 after this case, I had a very large amount of case work 17 and in the documentation that I submitted to the Inquiry 18 back on December 4th, a lot of the discussion had 19 already happened. In preparing for this session, I have 20 re-read many, many pages of that case work and gone back 21 over it. Have I spoken to a lot of the patients again? 22 I have spoken to some just to check things rather than 23 just to go back over and try to revise things because 24 the patients have been outstanding in giving me the 25 facts about the situations that they have had to face. Page 152

1 So I think -- I hope that I was quite well informed 2 about their situations right throughout, and my job as 3 a representative in Parliament was to ask the questions 4 of the agencies or NHS Tayside or the Scottish 5 Government to answer the questions that I thought were 6 standing out almost in all the evidence that I saw. 7 Q. To be clear, Ms Smith, in case there's any doubt those 8 conversations either before your involvement in this 9 Inquiry or in connection with it were all done in your 10 capacity as their representative? 11 A. Correct. 12 Q. Understood, and I think you said that any conversations 13 that have taken place more recently have been on points 14 of detail? 15 A. Yes. 16 Q. Which I assume is to try and assist the Inquiry as best 17 you can? 18 A. Absolutely and obviously the Inquiry has sought 19 confirmation of certain bits of paperwork since 20 early August and so I took time -- especially when the 21 documentation came through again, I took time to re-read 22 all the bits of case work that I've had and that was 23 very helpful actually in preparing for today. 24 Q. Thank you. Could I ask a little bit -- you mentioned in 25 the passage that we looked at there that you formed Page 153	1 there were three of us from different political parties 2 and I hope that had some credibility from the First 3 Minister and some of his ministers because of that but 4 you know that was our job. As I say party politics 5 didn't come into it at all. 6 Q. Is that a common phenomenon in the Scottish Parliament? 7 A. In some things but in others not at all. 8 Q. I'm interested in that aspect of things, Ms Smith, 9 because if it is the case that is a rare-ish phenomenon 10 that that might be said to be an initiative from which 11 the Chair may be able to draw some conclusions. Now, 12 first of all as I think you've identified, my 13 understanding is that the other two represent sort of 14 different constituency, if I can use that word broadly. 15 Was it the case though that the questions that emanated 16 from their groups and the issues, was there a commonality in 17 that between what they had been told and what you had 18 been told? 19 A. Yes, it was almost identical I have to say and we met 20 very regularly, particularly in the last three years. 21 Particularly when the public inquiry was first announced 22 we met very regularly and it was very evident I think to 23 all three of us that people we were representing were 24 asking exactly the same questions. 25 THE CHAIR: Just to be clear, both the surgical aspect of it Page 155
1 an association in your capacity as an MSP with, in 2 particular I think, two others, Michael Marra and 3 Willie Rennie. Now they are individuals who have 4 an association with the broad geographical area in 5 different capacities as I understand it but they are 6 also individuals who come from a different political 7 persuasion to you. Could you tell me how it was that 8 you joined forces, if I could put it that way, to try to 9 represent the constituents on whose behalf you were 10 speaking? 11 A. Well, they were both representing constituents, as you 12 say, within the wider geographical context but party 13 politics didn't come into this at all. I have the 14 greatest respect for both Michael Marra and 15 Willie Rennie and I saw them as colleagues in the 16 Scottish Parliament who I knew were wanting to get to 17 exactly the same answers as I was and the more the 18 parliamentary debate went on the more I could see them 19 in action, asking many of the same questions that I was 20 and I felt that partly -- maybe because we were from 21 different political parties, I felt it was very powerful 22 several MSPs were coming forward with the same questions 23 of the Scottish Government and as time went on when 24 I felt -- I think we all felt we weren't getting the 25 necessary answers, it was actually very helpful that Page 154	1 and how it was led to happen aspect? 2 A. That's correct, sir, yes. 3 MR DAWSON: I mentioned a moment ago, Ms Smith, you tell us 4 in your statement that -- you told us that you became 5 aware of Eljamel related issues in 2015 but there was 6 a particular case that was brought to your attention in 7 2016, I think August of 2016. What was the context in 8 which that individual's case came to your attention? 9 A. That member wrote to me from the Perthshire area and it 10 was a heart-rending letter that I received about 11 a family member's maltreatment and it was a very long 12 letter. And I had a couple of phone calls thereafter and 13 one of my assistants in parliament likewise dealt with 14 some of the aspects of that case, finding out more 15 information and it was really quite appalling what I was 16 led to believe had happened in the family member's 17 treatment and I dealt with that as best I could. It set 18 me off on trying to find out other things about the 19 Eljamel situation and it wasn't terribly long after that 20 where I realised that this was not an event on its own, 21 that there were other patients who were involved in 22 this -- what became a dreadful scandal. 23 Q. And you've helpfully provided us with -- well, you've 24 provided us with a lot of documentation but in relation 25 to that particular case you managed to find the Page 156

1 documentation. Do you recall broadly what the clinical 2 circumstance of that case had been or we can go to the 3 document if you like, but it's as you say quite -- 4 A. Yes, I recall it vividly and it was obviously a case of 5 misdiagnosis alleged by the constituent who got in touch 6 with me about her father and the details about what 7 she was telling me were horrific and it was very 8 traumatic actually. I had a very difficult 9 conversation. Naturally she was very upset and I think 10 what came across to me was not just the appalling 11 treatment by Eljamel, but the fact that her whole family 12 had been turned upside down because of the failings and 13 the malpractice of Eljamel and it had a big effect on 14 that family and as I say it was a very traumatic 15 experience. 16 Q. I think as you say, this was a case in which it was put 17 to you that Mr Eljamel had failed to diagnose a serious 18 condition in the individual concerned, is that right? 19 A. Yes, that is correct. 20 Q. And that certainly the letter that was written to you 21 suggested that on what might be described as relatively 22 cursory examination of the symptoms and the 23 presentation, the family member effectively was able to 24 recognise them almost immediately and so had been very 25 shocked that the diagnosis had been missed? Page 157	1 a narrative. There's a narrative that comes before that 2 about the individual case and this passage starts to go 3 into some other areas and it says there in the second 4 paragraph that: 5 "We now have a copy of Dad's notes from NHS 6 Ninewells. Surprisingly it took 3 months for them to 7 'find' the notes as they '...had been misplaced'. 8 Alarming, there are 3 years missing AND there are no 9 notes of his detailing excruciating headaches (and I was 10 with him on occasion when he detailed this), nor upper 11 neck pain. Something is not right here and we are 12 seeking legal advice." 13 So I wanted to focus on that passage in particular, 14 Ms Smith, because there seems to be a suggestion 15 that in this very sad case that not only had there been 16 an alleged -- in fact the letter calls it 17 "non/misdiagnosis" because it's hard to describe exactly 18 what it is, but that there had been issues accessing the 19 medical records? 20 A. Yes, and I think that paragraph that you've just read 21 out tells a dreadful story that it took three months for 22 them to find the notes or they might have been misplaced 23 and alarmingly, there are three years missing and there 24 are no notes of dealing with excruciating headaches. 25 I'm sorry this -- Page 159
1 A. That's absolutely true. I think she had looked into 2 various internet aspects of the symptoms that her father 3 was suffering and she came up with the accurate 4 diagnosis and it was quite clear that Eljamel had pushed 5 the whole thing aside and misdiagnosed and I think the 6 letter I received spells out all the dreadful material 7 thereafter. 8 Q. I think just to get the sort of timescale though that 9 correspondence came to you in August 2016 that it was in 10 2012 that the alleged misdiagnosis or the missed 11 diagnosis had occurred, I think that's right? 12 A. Yes. Yes. 13 Q. And this letter goes on to tell us in some detail about 14 the fact that the patient, if you like, had been left 15 with permanent brain damage, is that right? 16 A. Yes. 17 Q. And that the assertion that was made by the relative who 18 spoke to you was that if this had been picked up, that 19 permanent brain damage could have been prevented? 20 A. That's absolutely correct, yes. 21 Q. I'm interested in looking at some particular aspects of 22 this letter which go beyond the clinical case into the 23 kind of area that you were telling us about. Could we 24 go to G0001-00002, please. I'm looking at page 5 of the 25 document, second paragraph of that. So we have there Page 158	1 Q. This was in 2016 at the latest? 2 A. Yes. 3 Q. And the treatment that we were talking about had only 4 been in 2012, so it's not as if you might have -- either 5 particularly historic or anything like that? 6 A. No, there's just alarm bells ringing for me about the 7 overall lack of oversight of what was going on and 8 I'm sorry to say that this is an example of some of the 9 other -- 10 Q. This is precisely what I wanted to ask you next, 11 Ms Smith. This passage tells us, as well as the 12 circumstances of the individual case, about problems 13 with the accuracy of notes and the time taken to locate 14 notes, in particular in this case a significant period 15 of time of being apparently missing. I was very 16 interested to know whether this was a pattern or 17 a complaint both relating to the accuracy of medical 18 records and the time taken for people to be able to 19 access medical records that came up in other patient's 20 experiences that you learned about later? 21 A. Yes, it did and it's particularly true I have to say for 22 the case of Mrs Rose and Mr Kelly for whom there is 23 a huge amount of documentation about things not being 24 properly documented and the delay in trying to access 25 some of the relevant notes. I'm sure we'll hear more Page 160

1 a little bit later on about just how difficult that was. 2 So, yes, I'm afraid this is a pattern and it was 3 a pattern with some of the other constituents with whom 4 I was dealing. 5 Q. I'm interested in just expanding on that a little bit 6 further because one of the themes that seems to come 7 through from your statement is the extent to which the 8 harm suffered by patients in the clinical experience can 9 be compounded or worsened by the response of the state, 10 if I can put it as broadly as that, because that could 11 be Tayside or the government thereafter. Is that 12 a phenomenon you recognise in the Eljamel patients whose 13 cases you have experience of? 14 A. Absolutely and I think it is probably one of the aspects 15 that frustrated and annoyed me the most, that I was 16 finding it incredibly difficult to get answers about 17 what I thought should be relatively simple questions and 18 patients were finding it very difficult to get to the 19 relevant notes and the accurate notes that I would have 20 thought should be there as a matter of course that in 21 particular when it's very difficult operations that are 22 being undertaken in difficult -- whether it's brain 23 surgery or spinal surgery, these notes should have been 24 immediately available and you know the documentation 25 that Mrs Rose gave to me -- and I had oversight of Page 161	1 Q. It's almost as if you know where I want to go Ms Smith 2 but this is exactly what I want to ask you next because 3 if one read on in this interesting letter from 2016, in 4 paragraph 3, what your correspondence says is that: 5 "My worry is that, it transpires, Eljamel had 6 accusations made against him from 2008. Why, on earth, 7 was this gentleman allowed to continue until 2013? 8 Ninewells have stated that my father did not receive the 9 care he should have done. My formal complaint was 10 admitted 6 weeks before the stories started to hit the 11 papers. We thought Dad was the only one to have been 12 permanently damaged. It is so upsetting to hear he 13 wasn't and there could be upwards of 140 people -and 14 those are the people who have a voice. How many people 15 died at his hands? 16 Eljamel has now handed his Licence to Practice back 17 to the GMC and can no longer carry out spinal surgery 18 nor neurosurgery. However, it has now come to light 19 that he has been attributing his education and 20 experience to institutes which are now refuting that he 21 completed training with them and are publicly distancing 22 themselves from him." 23 And it goes on to call for a public inquiry. Now, 24 I'm particularly interested, Ms Smith, in what 25 information you, either at this time, had or had Page 163
1 Mr Kelly -- it's obviously appalling about some of the 2 things that were happening and the lack of the accurate 3 medical notes that they had a right to be able to see. 4 So I'm afraid, yes, it is a pattern. 5 Q. So just to be clear, that passage was talking about 6 patient records and you mentioned that. You've also 7 emphasised the interest of patients to try to look 8 beyond that into the systems of oversight. Had patients 9 attempted, as far as you understood, to access documents 10 relating to that aspect of things, as well as their own 11 medical records? 12 A. Well, yes, they had. In Mr Kelly's case he was seeking 13 information about what had happened in theatre and who 14 was present in theatre. Mrs Rose was largely doing 15 exactly the same thing, quite rightly so. She was 16 wanting information about what had happened, 17 particularly as she was obviously going to have a second 18 operation, and I think there was a pattern as well that 19 those patients were wanting that information because by 20 that time they knew that serious questions had been 21 raised about Eljamel continuing with his surgery and 22 medical practice and alarmingly, very alarmingly, those 23 who should have been having proper oversight of what was 24 going on during operations and the aftercare, it's quite 25 clear that that was not happening. Page 162	1 acquired in your extensive representation of these 2 patients later about what, as it's put here, accusations 3 had been made against Mr Eljamel from 2008 or indeed any 4 other time period? 5 A. Yes, I think one of the most important things was the 6 review that was undertaken by the Royal College of 7 Surgeons where it was very clear indeed that some of the 8 independent analysis had grave reservations about some 9 of the medical actions of Eljamel. But there were also 10 other concerns that we were being pointed to by patients 11 whereby when they were quite clear about some specific 12 bits of information in medical notes that had been 13 given, they were quite sure that these were not correct 14 and their questions to NHS Tayside were not providing 15 them with the answers that would help them to understand 16 what had happened. So this was an ongoing process for 17 a very long period of time, I'm sad to say, whereby we 18 were not getting to the real information about what had 19 happened and why it had been allowed to happen when the 20 concerns had been raised that there was something wrong 21 within Eljamel and the department that he ran. That's 22 the big concern and yet he was allowed to continue in 23 his medical practice. 24 Q. Understood. So part of the purpose of this section of 25 our Inquiry is to try to orientate ourselves and the Page 164

1 different timescales and that may provide an opportunity 2 for me to do so. The Royal College of Surgeons report 3 to which you're referring is one -- we'll come on to 4 examine that in more detail, I'm not going to ask you 5 about that today -- but it is one that was commissioned 6 and reported in 2013 and looked at aspects of 7 Mr Eljamel's practice. What I'm interested in is trying 8 to understand what evidence base there was of there 9 being more historic problems because this correspondence, 10 in the very difficult circumstances of her father's 11 case, has had not only that to deal with but has also 12 had exposure to information which appears to suggest 13 that this had been going on for a number of years. The 14 treatment here is in 2012 and the suggestion is that 15 this had been going on since 2008. What was it that you 16 learned or campaigners told you was the basis for their 17 understanding that something had been going on which was 18 harmful to patients or potentially harmful to patients 19 before the case that we are talking about here? 20 A. I think it was a combination of some of the medical 21 notes that I saw and the fact that some of the 22 information did not tie up with what we had been told 23 had been documented officially. Plus I think the 24 questions I was asking of NHS Tayside at the time and 25 also of the Scottish Government but on a slightly Page 165	1 So it says there, you tell us there in your statement: 2 "Several of the former patients also expressed very 3 considerable concern and anger about the alleged 4 cover-ups within NHS Tayside. These sometimes related 5 to the perceived silencing of whistleblowers when they 6 wanted to raise issues about the medical malpractice 7 they believed they had witnessed, often in the operating 8 theatre, the alleged bullying by Mr Eljamel of medical 9 staff who worked with him, and the alleged refusal of 10 senior managers to address the situation even after Mr 11 Eljamel had left the employment of NHS Tayside. 12 Some patients alleged that the Scottish Government 13 had not taken the relevant action required given its 14 statutory responsibility towards NHS boards. A number of 15 patients allege that, at times, the Scottish Government 16 and NHS Tayside have been guilty of collusion in order 17 to cover up the true facts. These concerns remain 18 current for some patients." 19 So packed into those two paragraphs a lot of 20 interesting lines of investigation. But first of all, 21 again trying to understand the reasons why patients told 22 you about these things and asked for your help, what 23 were the reasons or what was the evidence that led you 24 to understand that patients considered that there had 25 been a cover-up within NHS Tayside? Page 167
1 different line, when I asked for specific information 2 that this information should be released to the 3 patient -- because it was my understanding that the law 4 should allow that, and it wasn't forthcoming -- and 5 I think there are various aspects within my evidence 6 that I have provided where I think we can safely say 7 that on at least four or five occasions we had to ask 8 several times over for answers to the questions. 9 I think there's one piece of evidence, if my memory is 10 correct, whereby I think -- Jules Rose I think we had to 11 ask five times for evidence to be provided back to the 12 patient and if I may be allowed to say so, sir, 13 I thought it was very interesting two weeks ago when the 14 Information Commissioner David Hamilton produced his 15 criticism of NHS Tayside that they were not responding 16 to FOI material, I think that was part and parcel of 17 a lot of the difficulties that my patients -- sorry, my 18 constituents, they were at the same receiving end of 19 this as well. 20 Q. But had been for a considerable period into the past? 21 A. Exactly. 22 Q. I understand. We'll get to that in a moment, Ms Smith, 23 but I wanted to ask you about -- if we can go back to 24 the statement now. Please take that one down and go 25 back to the statement, we're at paragraph 5.3 and 5.4. Page 166	1 A. Well, I think it started with the fact that many of the 2 patients found it very difficult to get access to their 3 information that would have helped them understand the 4 medical procedures that they'd had to undergo and more 5 importantly about the management procedures and the 6 oversight of Eljamel and those who were in his 7 department and we had Mr Kelly with his notes suggesting 8 that perhaps Eljamel was not actually in the operating 9 theatre at the time. 10 We had other allegations that perhaps some of the 11 people who had been allegedly assisting Eljamel were not 12 actually there throughout as they should have been. We 13 had some allegations that patients felt that NHS Tayside 14 had not responded to some complaints within the -- and 15 this comes out in the Royal College report -- had not 16 responded to some of the concerns that Mr Eljamel had 17 not been particularly caring about his staff or caring 18 about the patients and had taken himself off, some 19 allegations that he was preferring to go off and do some 20 private work and he was referring patients to do the 21 same, to get themselves on to a private register so he 22 didn't have to deal with them in NHS Tayside. 23 We had all that kind of allegation going on. But 24 these were allegations and I had to go and find out if 25 there was truth behind that. But I think those Page 168

1 whistleblowers who were quite clear in their mind that 2 there was something wrong in the Eljamel department. As 3 it transpired there were and I think the Royal College 4 of Surgeons report is pretty damning in its evidence in 5 that. 6 Q. Okay. And the passages here that I have just read out 7 go further than that because they then start to talk 8 about -- so you've detailed all the various 9 NHS Tayside -- or a number of the NHS Tayside-related 10 issues but you've then gone to say there were 11 allegations made against the Scottish Government and 12 allegations made of collusion between NHS Tayside and 13 the government. What was the basis of the concern or 14 where did that come from? 15 A. That we couldn't get to the answers. There were 16 allegations, and I stress that again, but we felt that 17 when it came to basic information that should have been 18 available in NHS Tayside, sometimes -- this happened to 19 me several times, as my documentation evidences. I was 20 pushed along to the Scottish Government. Scottish 21 Government will be able to answer that. Scottish 22 Government comes back: no, it's a matter for 23 NHS Tayside. And it was just this back and forth and we 24 could not get to the relevant answers and sometimes 25 patients had to use FOI information to try to address Page 169	1 information and neither were the patients, quite rightly 2 so. 3 We absolutely had to get to the right information 4 and there were sometimes I was beginning to ask myself: 5 am I asking the right question here? Because it's 6 possible that I wasn't, but I think I was and I was 7 encouraged by not just the patients but other 8 parliamentary colleagues who agreed with me the 9 information we were seeking was not forthcoming and 10 we had a duty to ask: why was that. 11 Q. Perhaps summarise where we've got to so far. Very 12 interesting evidence. What you have here is a situation 13 where across the various patients whose cases you knew 14 about as well as those represented by others, Mr Marra, 15 Mr Rennie and others whom you've mentioned, there was 16 a multiplicity of patients all of whom had been former 17 patients of Mr Eljamel or their representatives of 18 course, like the lady whose letter we looked at and they 19 were all relaying broadly similar sorts of problems, is 20 that right? 21 A. Yes, that is correct. 22 Q. And then a number of those patients started to try to 23 find out the answers to the questions and the issues 24 that they had and that there was a broad picture of them 25 being met with what you've called obfuscation on the Page 171
1 that. 2 But there was this obfuscation the whole time and 3 sometimes this was taking months and you know it was 4 frustrating for me as a parliamentarian but it was even 5 more frustrating for the patients who were obviously 6 suffering very considerable trauma. Some of this was 7 going on for such a long period of time and it was 8 infuriating to keep asking the same questions and we 9 could not get to answers which I was very sure should 10 have been available. And I think David Hamilton's 11 comments a couple of weeks ago suggest that this was 12 quite a problem. 13 Q. Okay, and you say you kept on asking the same questions 14 so I'll unpack that a little bit. Do you mean you were 15 asking the same questions on behalf of multiple patients 16 and/or were you asking the same questions on behalf of 17 a single patient because you weren't getting the 18 answers? 19 A. In both cases, yes. And you know the documents I think 20 show that sometimes we had to go back and forth to ask 21 the same person: why have you not responded to this, why 22 have I been referred somewhere else? Somebody must have 23 the answer to this and it was just this back and forth 24 and it was actually very time-consuming but I wasn't 25 going to give up on my search for the relevant Page 170	1 part of NHS Tayside, is that right? 2 A. Yes, that is correct. 3 Q. Is it then the case that as they considered their 4 requests to be entirely legitimate and reasonable, that 5 the fact that there had been this obfuscation gave rise 6 on their part to concerns as to whether there might be 7 something going on that they didn't know about or that 8 NHS Tayside didn't want them to know about? 9 A. I think it gave rise to suspicion as to why we weren't 10 being given the answers that we were seeking and that 11 suspicion -- especially as some of the delays that were 12 over quite a long period of time, that suspicion grew, 13 particularly amongst the patients who were having to 14 wait an awful long time for letters coming back, emails 15 coming back or parliamentary questions to be answered or 16 whatever it was. And that was a very frustrating time 17 because I don't think -- the investigative process which 18 should, in my opinion, have been much quicker, was just 19 causing more and more concern and I think it was feeding 20 the suspicion that nobody was wanting to be held 21 accountable for what actually happened. 22 Q. So the suspicion was fed by the questions not being 23 answered, the amount of time that it took to get 24 a response and the accuracy of the information that was 25 provided at the end of the day if there was anything? Page 172

1 A. That's correct, sir. 2 Q. Thank you. And this, as I understand it -- please 3 correct me if I'm wrong -- is a process involving a lot 4 of people with similar issues and similar frustrations 5 at their attempt to sort out those issues that led to 6 what you've described in your statement as a -- you 7 described today as a suspicion? 8 A. Yes. 9 Q. But you've said in your statement a suspicion of 10 a cover-up by NHS Tayside, is that right? 11 A. Yes, this suspicion was very strong and there was 12 a suspicion that things were being covered up because -- 13 and I include myself in this -- I think there was 14 a growing belief that NHS Tayside must have known more 15 about what had happened in the oversight of Eljamel than 16 they were ever letting on and that was fuelled I think 17 by the fact that we have this quite long time period and 18 it was actually very distressing, very distressing for 19 the patients, but I think there was a feeling that 20 nobody really wanted to delve too deeply into this 21 because they knew that there was a substantial concern 22 and by this time there were far more patients who were 23 coming forward in the media to explain what they had 24 gone through and, you know, we now know the numbers that 25 are involved and I think that that suspicion that there Page 173	1 eventually the First Minister, to ask some of the very 2 basic questions which in my opinion should have been 3 answered long ago. 4 Q. You mentioned in relation to Mr Kelly's case 5 specifically that he had been looking for information 6 I think particularly focused on whether Mr Eljamel had 7 been in the surgery that he had and also who else had 8 been there or not been there at the time, is that right? 9 A. Yes, that is correct. 10 Q. Do you know what a theatre logbook is? 11 A. I do know what a -- I didn't before this case but I very 12 much know about logbooks now. 13 Q. Is that the kind of document that you might expect to 14 contain the kind of information Mr Kelly was looking 15 for? 16 A. It should contain it, yes. 17 Q. Could I just ask you -- I'm very keen that we understand 18 at this stage of the Inquiry -- you've been very helpful 19 in giving us a flavour to the progress of the patients' 20 views and experiences, but one of the things I think 21 I don't want to lose sight of or I'm sure the Chair 22 doesn't want to lose sight of is the outcomes for some 23 patients. Can you give us -- you've already given us 24 some evidence about the potential for a compounding bad 25 clinical outcomes through the sorts of processes and Page 175
1 was some kind of cover-up going on was certainly growing 2 amongst the patients. 3 Q. And then in the subsequent paragraph you extrapolate 4 this out to involve the Scottish Government and suggest 5 that some of the patients thought there was collusion 6 between NHS Tayside and them. Is that because when 7 patients and the likes of representatives like you tried 8 to get answers from NHS Tayside and didn't, as you 9 described earlier in your parliamentary role than of 10 others, efforts were made to turn to another agency 11 Scottish Government for responsibility in this area and 12 that similar problems were encountered? 13 A. That's absolutely correct. The frustration was very 14 real because there were certain periods of occasions, which 15 again I have documented in my evidence, where we had 16 asked for very specific meetings with the health 17 minister of the time -- and there were various health 18 ministers involved throughout this case -- to meet with 19 the patients and could we get a date for this meeting? 20 It was put off and put off and put off and they would 21 have to go and inquire with NHS Tayside for some more 22 information. NHS Tayside sometimes gave some of the 23 information but not all of the information and it just 24 seemed to go on with this awful period of waiting and it 25 was tough getting time to see the minister, or Page 174	1 frustrations that you've experienced but as far as the 2 sort of clinical outcomes are concerned could you give 3 me a flavour of the sort of range of physical and mental 4 consequences that you have experienced in patients and 5 these are patients of course who are trying to find 6 answers to things? 7 A. Yes, I mean there's a whole range of disability, 8 physical disability for a start. There are allegations 9 that some body parts -- the wrong body parts were 10 removed and the physical disabilities that have -- well, 11 they're with the patients for the rest of their lives, 12 as we know. And some of these disabilities are quite 13 horrific. People have lost their mobility, people have 14 lost all their means of being able to look after 15 themselves, some of them can't look after themselves 16 without carers. Some of them have been through the most 17 traumatic of physical disability, but there's also the 18 psychological problems and the effects on families, the 19 effect on their well-being, the effect on the fact that 20 they can't do the things that they used to be able to 21 do, that they can't go out, they can't drive in some 22 cases, they can't walk in some cases. The list is 23 endless I would suggest and that's what makes it all so 24 terrible. 25 Q. And so it's important I think -- would you suggest that Page 176

1 the Chair of the Inquiry should bear in mind that the 2 frustrations, concerns, issues, questions, responses 3 that you have outlined as being at the core of the 4 experience of representing the patients in trying to get 5 answers, from their perspective also includes all of 6 those physical and psychological problems to start with? 7 A. Yes, and also the fact that it's gone on for such a long 8 period of time when these answers were not forthcoming 9 and so the trauma that they have endured, particularly 10 from a psychological aspect, it's just never ending. 11 Q. Okay, thank you. Can I ask you about another document 12 that you helpfully provided to us. This document is 13 G0001-00024. It will come up on the screen. I should 14 say for the sake of clarity, core participants will 15 already know this but you've provided to us, as we asked 16 you to, a very large body of material and a huge amount 17 of correspondence with lots of details of the sorts of 18 experiences patients had and sorts of things you did on 19 their behalf. If we were to try to go through anything 20 like that we'd be here for several weeks with just you, 21 Ms Smith. So I think that, as the Chair has already 22 indicated, is all evidence in the Inquiry but this is 23 a document which was of particular interest to us. 24 This document purports to be a CV of Mr Eljamel. 25 Can you tell us how you got this? Page 177	1 Mr Eljamel's career started going in a different 2 direction to the one that you've described as being 3 represented in this very impressive CV. Based on your 4 experience is that a fair assessment? I know that 5 others may take different views about that, but -- 6 A. Yes, I think it is a fair assessment it certainly begs 7 various questions and we know that some aspects of the 8 CV that he said that he had various -- undertaken 9 various studies and medical practice in America, in 10 Connecticut et cetera and it turned out they denied all 11 that. So it begs a lot of questions about what is real 12 on this CV and what was alleged fabrication. 13 Q. I mean, without needing to look at the -- I know you've 14 looked at the document before and the document will be 15 published and people can look at it but the document 16 contains a broad variety of high-level appointments on 17 Mr Eljamel's behalf; is that correct? 18 A. Yes. 19 Q. And it contains information about -- which goes on for 20 many pages -- about the sort of training and others he's 21 been involved in? 22 A. Yes. 23 Q. In various guises and that it contains a number of 24 references to publications he's been responsible for, 25 largely in the neurosurgical field? Page 179
1 A. Yes, I was provided by -- this document largely through 2 the efforts of Mr Pat Kelly and Mrs Jules Rose in 3 understanding what the background was to Sam Eljamel and 4 there was a bit of investigation on the internet and on 5 various medical journals to establish what his 6 background had been, and you know when you see a CV like 7 this which goes on for several pages, if I remember 8 correctly, you think: well, you know there must be 9 something very impressive about this medical expert, all 10 the books and pamphlets that he produced and the more we 11 sort of dug away in the background the more we found out 12 quite a lot. 13 Q. Well, that's the sort of thing I'd like to ask in 14 relation to this document. Could we just very briefly 15 go to page 20 of this document. This comes at the end 16 of the curriculum vitae part of this bundle of documents 17 and we can see it's dated May 2009. Now if we go back 18 to the front page -- thanks Rory -- that's 19 a particularly interesting date -- 20 A. It is. 21 Q. -- because if certain evidence of which we are aware is 22 ultimately to be accepted by the Chair -- of course it's 23 a matter for him to decide -- that date around about the 24 spring of 2009 might, on one interpretation of that 25 evidence, represent a time when Professor Eljamel or Page 178	1 A. Mm-hmm. 2 Q. And it contains information about a number of 3 professional bodies of which he is a part; is that 4 correct? 5 A. That is correct. 6 Q. And it contains references as well to committees that he 7 sat on to do with the governance of others, such as 8 clinical governance committees, is that right? 9 A. Yes, that is correct. 10 Q. It would seem to suggest as at May 2009 Mr Eljamel 11 could, if one looks at this CV as a guide, be deemed to 12 be quite a daunting figure with a very significant array 13 of broad professional experience, would that be fair? 14 A. Yes, it's absolutely fair. 15 Q. And moreover that the kinds of things he had been 16 involved in meant that his reach, if you like, in terms 17 of the number of people and organisations that he 18 influenced was very significantly wider than one man but 19 in fact no doubt influenced all these committees, all 20 these educational establishments, all the students, all 21 the readers of his books and all that kind of thing; 22 is that a fair impression? 23 A. Yes, if this CV is taken at face, then you could easily 24 assume that he had very many connections not just with 25 his own professional medical governance but with Page 180

1 teaching bodies and with students, with trainee doctors 2 etc. Yes, you could easily assume that. 3 Q. So even though this looks like a very impressive 4 professional background, if hypothetically something 5 were to go awry in the professional practice of this 6 individual it would have the potential to have very 7 significant and wide consequences? 8 A. Absolutely. 9 Q. And so although it might be tempting to look at a CV 10 like this and say: goodness me, what an impressive 11 individual, another way of looking at it would be to say 12 that this man needs to be monitored as much as systems 13 should permit in order to try to minimise the 14 possibility though those wide-ranging consequences of 15 things going wrong don't materialise? 16 A. Yes, I think that's fair. I mean, let's be honest that 17 when it came to the concerns that were first raised 18 within NHS Tayside that something was wrong and he was 19 under supervision, the reason for that was not what was 20 on his CV. The reason for that was the concern about 21 what had actually happened within theatre, or within 22 medical care, aftercare, and that he was not carrying 23 out, on a professional basis, the medical procedures as 24 he ought to have done. 25 That's what raised the concerns within NHS Tayside Page 181	1 specialist advisor to the National Institute of Clinical 2 Excellence from 2008? 3 A. Yes. 4 Q. And that's a body I think that seeks to try to promote 5 high clinical standards in medicine? 6 A. It is. 7 Q. And he also indicates then in a section of his past 8 appointments one of which, the last one of course, on 9 that list is that he was a consultant neurosurgeon and 10 was elected a member of the Medical Advisory Committee 11 BMI Fernbrae Hospital Dundee in the past? 12 A. Yes. 13 Q. Also, as far as his qualifications are concerned, it 14 points out his medical qualifications but also indicates 15 that he was a fellow of the Royal College of Surgeons 16 Ireland and had been since 1986, yes? 17 A. That's correct. 18 Q. And it also points out he was a fellow of the Royal 19 College of Surgeons of Edinburgh, an accolade he had 20 received in 2003, but it notes that that was without 21 an exam, is that what it says? 22 A. It does say that, yes. 23 Q. As far as experience is concerned, he lists a number of 24 his past positions including experience in Britain 25 working in Liverpool and working in Dublin. In relation Page 183
1 and within the wider public and of course with the 2 patients. So I think the CV, from my perspective, is 3 interesting in that you know he's obviously been 4 documenting a huge number of professional links that he 5 has and things that he's written, but we then find out 6 that some aspects of the CV might not be quite so 7 accurate. 8 Q. We'll be investigating that, don't worry, Ms Smith. If 9 I could just ask you -- or get you to look at a few of 10 the entries on this which may again just help us set 11 some context. On the first page we see that the current 12 roles are set out where it says that Mr Eljamel was Head 13 of Department and Section Surgical Neurology in the 14 University of Dundee from 1996, is that right? 15 A. Yes. 16 Q. A little bit further down, about five lines further 17 down, it says he, at that stage, was the Chairman of the 18 Clinical Governance Committee Specialist Services Group 19 from 2006? 20 A. Yes, it does. 21 Q. It also says that he had been the Secretary of the 22 British Stereotactic and Functional Neurosurgery Group 23 from 2006? 24 A. Mm-hmm. 25 Q. At the bottom of that section it says he was a clinical Page 182	1 to the first three entries it talks about graduating 2 with honours in December 1982, him having an internship 3 in surgery and medicine between January and December 4 1983 and a general professional and basic surgical 5 training which he claims took place between '84 and '87. 6 It doesn't give details where those took place, is that 7 right? 8 A. It doesn't say so. 9 Q. Over the page there's one entry I think you were keen to 10 make reference to which is the one at the very top which 11 suggests that in 1995 he was a Clinical Fellow in 12 Neurosurgery at the University of Connecticut, in 13 Hartford Hospital in Connecticut. Was that the one you 14 were referring to earlier? 15 A. Yes, it was. 16 Q. And I think you referred to there being some 17 investigations into the legitimacy of that entry? 18 A. Well, I think the implication was when various aspects 19 of people that he says that he was either helping and 20 assisting or being a student of or helping to teach 21 students in, some of these could not clarify that that 22 was correct. 23 Q. You mentioned that one in particular. Were there others 24 that you understood had been -- 25 A. I think there is interest to me in what he was claiming Page 184

1 to have done with the Walton in England. And I think 2 it's very important -- and it was particularly important 3 quite late on in the Eljamel Inquiry situation -- that, 4 you know, bodies in England were being asked to consider 5 whether they should look through their records to see if 6 Eljamel had had any -- what activities had he undertaken 7 in these English institutions and that was a good 8 question to ask. 9 MR DAWSON: Okay. That would be an appropriate time to take 10 a break, sir, if that would be convenient. 11 THE CHAIR: Can I ask one basic question and I probably 12 missed an answer given some moments ago, but can I be 13 clear what the provenance of this CV is? Is this 14 something that you managed to generate as part of your 15 investigations? 16 A. Yes, but assisted by the patients who obviously were 17 very interested. And patients who suffered at the hands 18 of Eljamel quite rightly were trying to find out as much 19 as they possibly could about his professional background 20 and so I was furnished with this information. 21 MR DAWSON: Had it been found on the internet as far as -- 22 A. Some of it had been. 23 Q. Because quite a lot of the information looks to us to be 24 the product of extensive, no doubt, research on the 25 internet? Page 185	1 particularly in the FOI context? 2 A. Yes, I can. Mrs Rose was asking very pertinent and very 3 sensible questions to provide more information 4 particularly about who had oversight of Eljamel and 5 Mrs Rose had her operation, in fact she was the last 6 patient for Eljamel to operate on. And that was just 7 beyond the days where it had been fully exposed about 8 Professor Eljamel's malpractice. So she was quite 9 rightly asking the very important questions about who 10 knew what when, why was this allowed to happen? A whole 11 range of questions. I think my document details all of 12 the questions and there were a large number of them and 13 we were not getting very far in ascertaining what the 14 answers will be. So we -- and I advised her in this -- 15 that we would have to have some process through FOI 16 material to get to the necessary information. I think 17 it's fair to say, and I'm sure Mrs Rose would agree with 18 this, that sometimes when we ask very specific questions, 19 a list of questions, we might get one answer or two 20 answers but we would never get the whole raft of the 21 answers that were required. And some of these were 22 extremely important questions and I think point very 23 much to some of the -- what I would allege were some of 24 the difficulties in oversight with Professor Eljamel. 25 So I think it was that frustration and then sometimes it Page 187
1 A. Indeed and also through medical journals. When someone 2 like Eljamel will produce medical papers or academic 3 studies that's all documented in certain medical 4 authorities. So some of that was easy to find. 5 MR DAWSON: Thank you very much. 6 THE CHAIR: Thank you. 7 (3.14 pm) 8 (A short break) 9 (3.25 pm) 10 MR DAWSON: Thank you, sir. Ms Smith, we've encountered in 11 your evidence so far on a few occasions, to put it 12 mildly, issues which were experienced with patients' 13 access to documents and you've explained the role that 14 that played in the conclusions about what was going on 15 to which they were driven and which they asked you to 16 help with. You've produced to us a lot of documentation 17 I think that is on this subject, including -- although 18 we don't need to go it -- one document in particular, 19 it's a bundle of documents really that relates to issues 20 experienced by Ms Rose in I think 2022. 21 A. Yes. 22 Q. In the particular context of an FOI request. So 23 I wonder if you can remember the circumstances that 24 surrounded that but also try to tell us more generally 25 about the sorts of problems that have been experienced Page 186	1 was suggested that: well, some of that information might 2 have to come from the Scottish Government. Scottish 3 Government would tell us: well, some of that information 4 is definitely at NHS Tayside and there was just this 5 constant ongoing back and forth. And the FOI material, 6 which is absolutely the correct thing to ask for, we 7 were -- well, we know from the information commissioners 8 comments we were only getting some of the story and that 9 was a sense of very considerable frustration not just to 10 Jules Rose but to me as well. 11 Q. And obviously just for context what you mean I think 12 when you talk about using FOI is trying to use the 13 Freedom of Information legislation in circumstances 14 where a patient has been unable to access the 15 information via the normal routes. Trying to use other 16 legal mechanisms to try, in many ways, force the 17 organisation to give you the information? 18 A. Yes, that's correct and I think -- and I'm sure Mr Marra 19 and Mr Rennie would agree with this -- that we tried 20 every which way that we could to assist the patients in 21 directions that we felt were the right places to be 22 trying to draw the information from and there was 23 a constant feeling that we were not getting there. So 24 we had to try some other avenue. 25 During my time dealing with this case I was dealing Page 188

1 with three First Ministers, I was dealing with five 2 different Cabinet Secretaries for Health and seven Chief 3 Executives of NHS Tayside and that's the extent of some 4 of the timescale that this has been going on for and we 5 had numerous meetings with various people within 6 NHS Tayside and within the Scottish Government and 7 I can't fault any of them for having some sympathy for 8 the patients but were they actually dealing with the 9 real questions that were being asked by these patients? 10 We were not getting the answers. So sometimes FOI 11 material was the only way we were going to establish 12 some of that. 13 Q. So you've explained already in your earlier evidence 14 about using what I have described as the normal 15 processes to get hold of the information. You might 16 have thought that if you -- as no doubt you advised 17 patients to do -- you escalated, if you like, to the 18 Freedom of Information level and that at that point 19 public authorities would sit up and take notice and give 20 you what you need; is that fair? 21 A. One would have hoped so, yes. 22 Q. But I think you've explained that was not the 23 experience? 24 A. No, it wasn't. That was largely my demand for this 25 public inquiry which the patients had been campaigning Page 189	1 were various reasons that he believed were behind the 2 increase. Firstly, that the public trust in government 3 and agencies has been diminished. Secondly, that there 4 were too many occasions where perhaps the government of 5 the time felt that: well, if a public inquiry dealt with 6 this it takes it away off our desk and let the public 7 inquiry investigate something that we've not been able 8 to solve ourselves. But my fundamental reason -- and 9 I think John Sturrock said this too -- I think the basic 10 reason why there is an increase in a demand for public 11 inquiries is because government and its agencies are 12 not, for one reason or another, being able to answer the 13 questions that they should be able to answer and 14 therefore we are seeing this increase in the demand for 15 public inquiries on specific instances. 16 Q. Was that your understanding of how this public inquiry 17 came about? 18 A. Yes, I mean I was responsible for coming to the public 19 inquiry -- the patients had been asking me to take this up 20 for probably the best part of two years and I said: 21 well, let's continue trying to get answers from various 22 government ministers and NHS Tayside in particular, and 23 I was then persuaded that because we were not getting 24 the answers that a public inquiry was the only way, not 25 least because I think there is a trust in the public Page 191
1 for, for quite some time, but I felt it was my 2 responsibility as a parliamentarian to go through every 3 possible channel that I could that I thought was 4 appropriate to get the answers they were seeking. And 5 so it was that sense of frustration that persuaded me 6 that a public inquiry was absolutely essential because 7 all the other means of trying to get to the truth had 8 been exhausted. 9 Q. That's not an unfamiliar story in public inquiries, 10 unfortunately. Do you think that is -- that you have 11 been involved in looking at public inquiries wearing 12 a different hat I know and do you think that that 13 process of failing to get the answers through these 14 escalating stages is one of the reasons why there are 15 lots of public inquiries in Scotland? 16 A. Yes, I do. I mean I come to this with a bit of 17 experience, having been on the finance committee and my 18 colleague Mr Marra was on the finance committee at the 19 time and we decided that there was a case to be answered 20 about why there was an increase in the demand for public 21 inquiries but being the finance committee of course 22 we're interested in the cost of public inquiries as 23 well. But I think just referring back to your colleague 24 John Sturrock KC when he provided evidence to the 25 committee I think he was pointing out that there Page 190	1 inquiry, not least one that is overseen by a judge and 2 witnesses are providing evidence under oath, that has 3 credibility in the eyes of the public, and I think 4 that's very important. But should we have as many 5 public inquiries? Probably not if the government and 6 its agencies were doing their work effectively. 7 Q. And by "doing their work effectively" I suppose that 8 could comprise providing good services in the first 9 place to the likes of users of healthcare? 10 A. Yes, absolutely. You know, there is a demand for 11 efficient public service. It suggests to me -- this 12 case is a classic example, where there has not been good 13 public service, in fact very difficult malpractice and 14 public service. So I think that's all part and parcel 15 of the same thing and the conclusions of the finance 16 committee -- they were unanimous conclusions of the 17 finance committee and also parliament agreed to that 18 report. It wasn't just us presenting our thoughts, this 19 was accepted by the parliament as important, that there 20 is a real issue about public inquiries that is for 21 future parliaments to investigate how that might be 22 addressed. 23 Q. Okay thank you. Could I just take you to the document 24 that you've been referring to which is ELJ-00553, this 25 goes back to FOIs and this is a publication from the Page 192

1 Scottish Information Commissioner dated 11 August 2026 2 which is directly relevant to what we're looking at 3 because it says, if we can zoom in a little Rory on the 4 first paragraph there: 5 "A new decision by the Scottish Information 6 Commissioner has found that NHS Tayside fell short of 7 the requirements of Scotland's freedom of 8 information ... law when responding to requests for 9 information about a report into its investigation of 10 Professor Sam Eljamel, the former head of Neurosurgery 11 at Ninewells Hospital in Dundee whose conduct is 12 currently the subject of a public inquiry." 13 Reading just down to the bottom, it says the 14 Commissioner's ruling finds that NHS Tayside's response 15 to those requests failed to comply with the requirement 16 of FOI law in a number of ways. He found, for example, 17 that NHS Tayside: 18 "Carried out inappropriate or inadequate searches 19 for some of the requested information. 20 "Incorrectly informed the requester that it did not 21 hold some information. 22 "Failed to provide appropriate advice and assistance 23 to the requester. 24 "[And/or] incorrectly withheld some information." 25 Now you have referred I think to a number of these Page 193	1 find the appalling situation where logbooks went 2 missing, were destroyed and that was after do not 3 destroy notices had been issued. So I'm afraid that 4 undermined some of the trust that the new procedures are 5 effective. 6 Q. Your understanding is that the logbooks were destroyed? 7 A. Yes. 8 Q. Not that they were lost? 9 A. No, I'm sorry I misspoke there. 10 Q. No, not at all. I'm just clarifying that with you for 11 other purposes. I think in your statement you use the 12 word which I'm quite keen to focus on "obfuscation" 13 because presumably within document management which -- 14 it does form a key element of all of this -- there will 15 especially with things that are historic like this be 16 circumstances in which normal document retention 17 procedures will mean that unfortunately the documents 18 that are needed are not available. But your use of that 19 word and some of your other evidence today suggest that 20 we're dealing with a very different situation it that. 21 What's the basis for that analysis? 22 A. Well, I used the word "obfuscation" where you're not 23 getting to the direct transparent information that you 24 want you might be getting other aspects of sort of 25 semi-relevant information that would surround the sort Page 195
1 phenomena having been experienced in the past. Does 2 this suggest that there is an ongoing problem with the 3 way in which document management works at least within 4 NHS Tayside? 5 A. Yes, it does and I have great respect for any 6 Information Commissioner but I think -- when I saw this 7 two weeks ago I thought it was a pretty damning 8 indictment of the way NHS Tayside had not been 9 performing its duties as would be expected from not 10 least the Information Commissioner but the public at 11 large. 12 Q. One of the statements that's frequently been made to 13 this Inquiry by NHS Tayside is it's a learning 14 organisation. In this important regard, has your 15 experience been that it has learned how to respond to 16 requests, via FOI or otherwise, as you have been 17 involved in it or not? 18 A. This would partly suggest not, that there are still 19 ongoing problems. I mean there are documents in my 20 files that -- NHS Tayside persuaded us that new systems 21 had been put in place for certain aspects and I think in 22 some part that was correct. There were new systems of 23 oversight that were put in place to try to involve 24 greater transparency and ensure there was a greater 25 check on documentation, but then not that long ago we Page 194	1 of key theme but you're not getting to the core 2 issue that you're wanting to find the information about. 3 And I think obfuscation to me suggests that there is 4 a bit of sort of delay tactic or there's trying to sort 5 of put the onus on somebody else to try to find the 6 information, and it's just -- you know, we should be 7 clear that when somebody asks for this kind of 8 information if we can't find it somebody should know why 9 we can't find it and be able to be accountable for that. 10 But most of the time we should have been able to find 11 the information because it's, you know, been part of 12 medical records and a management procedure where I would 13 like to think that the National Health Service of any 14 part of Scotland would be effective in the management of 15 that kind of information. That's what part of good 16 healthcare should involve. 17 Q. You mentioned the phrase there used was "putting the 18 onus on someone else". I think you mentioned earlier 19 there had been difficulties sometimes within you've been 20 involved in FOIs or other attempts from patients to get 21 information that there had been a sort of passing of the 22 buck between NHS Tayside and the Scottish Government. 23 If one looks, just as an example from the paperwork at 24 the sort of information Mrs Rose was looking for, that 25 sort of information as I think you've said, was quite Page 196

1 specific -- 2 A. Yes. 3 Q. -- to do with the circumstances in which she underwent 4 her surgeries in 2013 and could only have been answered 5 by medics or NHS Tayside? 6 A. Yes. 7 Q. Was your experience in that that the buck was passed to 8 government to suggest they might know the answers? 9 A. No, not that they would know the answer but that they 10 would be able to ensure NHS Tayside would be able to 11 provide the answers. 12 Q. I see. 13 A. By this time the Eljamel case was a very big public 14 issue and it was essential that both Scottish Government 15 and NHS Tayside were working in the same direction to 16 ensure that we got answers to these questions and 17 I didn't feel at some occasions that we were -- in 18 a situation where they were working together, that it 19 was being passed over to somebody else, passed back 20 again, eventually coming back to me and I would then 21 have to go back. As Jules Rose would evidence, some of 22 the questions that were being asked might be answered 23 but they wouldn't all be answered and within the ones 24 that weren't answered there would be some key nuggets of 25 information that we needed to establish who was Page 197	1 associated with public inquiries that you set out? 2 A. About a year before it was in fact announced by the 3 Scottish Government that they were going to have 4 a public inquiry. And obviously there were lots of 5 demonstrations outside parliament about this public 6 inquiry but I believed I had responsibilities as 7 an MSP to try every possible avenue that I could as 8 a parliamentarian to get the answers for these patients 9 and I became so frustrated in my efforts that I felt 10 that the patients were quite right in making that call 11 for a public inquiry and so I was relieved when 12 eventually that announcement was made. 13 THE CHAIR: So that would be the middle of 2022? 14 A. Correct. 15 MR DAWSON: I wondered, Ms Smith, whether that might have 16 been coincident in time with the publication of the 17 Scottish Government's review of unresolved and 18 outstanding concerns regarding Professor Eljamel which 19 was the Scottish Government's investigation published 20 in May 2022. Would it have been around about that -- 21 A. Yes, that was around about the same time but I don't 22 think that was just the issue that determined my support 23 for a public inquiry, I think there were other aspects 24 as well. Specifically that as I say my own frustration 25 was building and I felt I had the case work to Page 199
1 responsible for what had happened. 2 And so this -- and that's obfuscation to me as well 3 because you're not answering directly what somebody has 4 asked and it was just that frustration that, you know, 5 when I put this to a Cabinet Secretary for Health, as 6 I did on four or five different occasions, they implied 7 that they agreed with that but we still didn't get the 8 answer and then they said that they would go and find 9 out from NHS Tayside. We would get a letter from 10 NHS Tayside, but some of that was never forthcoming. 11 And I think there's an occasion where the NHS Tayside 12 had agreed to a meeting with some of the patients and 13 I think we asked for that three times and it never 14 happened. You know that's obfuscation to me as well. 15 Q. You've mentioned already the process you went through or 16 advised patients to go through to get to the point of asking 17 for a public inquiry by exhausting other avenues. 18 I think the evidence that you've provided suggests that 19 the public inquiry was being called for by patients 20 since at least 2015. Indeed, Ms Cherry in her opening 21 statement on behalf of the patients suggested it might 22 in fact be 2014, but you've explained this systematic 23 process that you advised them to go through. When was 24 it that your view became: okay, enough is enough, we 25 need to have a public inquiry for the sorts of reasons Page 198	1 demonstrate why I had every right to demand a public 2 inquiry and obviously I had a lot of discussions with 3 the patients at the time and they were very helpful to 4 me in persuading me why they felt that, you know, enough 5 was enough as you rightly suggest. 6 Q. You mentioned a moment ago the fact that you had had to 7 deal with a number of different Health Secretaries over 8 the years and a number of different First Ministers 9 I think and probably also I would imagine with Tayside 10 a number of Chief Executives and others as well? 11 A. Yes. 12 Q. I think you've explained that they all were sympathetic 13 towards the position but couldn't provide the answers; 14 is that a fair summary? 15 A. Yes, that is a fair summary and I don't think I found 16 any of them who were unsympathetic to the cause of what 17 the patients had suffered but the long and short was 18 they weren't providing us with the support at some time 19 and the answers that we were trying to establish. 20 Q. And just to focus in on that time period where you say 21 that your view that a public inquiry was the right thing 22 to do, around about the middle of 2022, the Cabinet 23 Secretary for Health at that stage was Humza Yousaf; is 24 that right? 25 A. That's correct. Page 200

1 Q. And the Cabinet Secretary for Health who eventually 2 announced that public inquiry on 7 September 2023 was 3 Michael Matheson? 4 A. Yes. 5 Q. Could you clarify for us, in that period where you were 6 campaigning for that outcome, who was it that you were 7 dealing with and what was your experience of the 8 interaction in response to your now support for such 9 cause? 10 A. I had two meetings with Humza Yousaf before when he had 11 been Cabinet Secretary for Health and then once when he 12 was First Minister and then we had -- 13 THE CHAIR: Sorry, two meetings as Health Minister? 14 A. Yes, as Health Minister, yes, correct. And then there 15 was a situation where jointly we had a meeting with 16 Michael Matheson and that was, I think -- I think 17 I'm right in saying that six MSPs turned up to that 18 meeting so there were other MSPs who by this stage were 19 interested in that. 20 MR DAWSON: Yes. 21 A. But you know we eventually had meetings further on down 22 the process after the public inquiry had been announced. 23 We met with the Cabinet Secretary for Health and we also 24 met with the First Minister. 25 Q. I'd be interested to try to understand from your Page 201	1 I was receiving from either First Minister's questions 2 or health questions, of which you have a copy, the tone 3 was beginning to change to be almost hinting that there 4 might be a change in government approach. And that 5 change was undoubtedly around that time of the 2022 6 report. 7 Q. The 2022 government report? 8 A. Yes. 9 Q. So effectively as I understand it, that 2022 to 2023 10 period straddles Humza Yousaf being the Cabinet 11 Secretary for Health and then Michael Matheson? 12 A. It does. 13 Q. But would it be fair to say that there had been a start 14 of a move towards it in 2022 when Humza Yousaf was still 15 the Cabinet Secretary or was it really more under 16 Michael Matheson's leadership that that became the case? 17 A. I think it was a bit of both. I think at First 18 Minister's questions there was a bit of a move as well 19 I felt and that was obviously Humza Yousaf for a short 20 period of time and then John Swinney and I think there 21 was definitely a softening of the tone that maybe this 22 is very much bigger than we thought it was and there was 23 tremendous courtesy -- I can't fault them in the way 24 that you know they responded to my concerns, nor can 25 I fault them on the fact that when we were in a meeting Page 203
1 perspective of having been someone amongst others who 2 was involved in that process, what your impression was 3 of the Scottish Government's thinking at around that 4 time and who it was, if you like, who was exceeding 5 perhaps gradually towards the idea of a public inquiry. 6 The reason for that is the explanation given publicly by 7 the Scottish Government when the Inquiry was actually 8 announced focused very much on the outcome -- or the 9 content of the NHS Tayside due diligence review which 10 had come out only a matter of weeks before the 11 announcement was made. I'm interested in sort of trying 12 to probe the idea as to whether that report was perhaps 13 the straw that broke the camel's back in a process that 14 was moving that direction anyway or whether it was 15 that report and its outcome that was the reason that 16 that Inquiry was announced? 17 A. I think there's a strong indication that that report was 18 seminal in making up minds because the due diligence report 19 presented the public with identifying so many problems 20 and I think that certainly was beginning to get quite 21 a lot of coverage in the media apart from anything else. 22 And by this time we knew that there were more and more 23 patients coming through that the volume of patients 24 who -- of patient complaints I should say, was very 25 substantial. And I think if I look back at the answers Page 202	1 if we eventually got it organised they were sympathetic 2 and took it seriously, but I think that the scale of 3 what was being uncovered not just in obviously the 4 malpractice issue but what had not happened in terms of 5 due diligence of the oversight, I think that was 6 beginning to send shockwaves through the Scottish 7 Government. 8 Q. Okay so one aspect of this which I wonder might relate 9 to the softening we're keen to try and understand is our 10 understanding in April 2023 there was a move towards 11 having something in the nature of the Independent 12 Clinical Reviews -- we're going to investigate exactly 13 whether that is what it ended up being -- but as 14 I say the due diligence report by NHS Tayside came out 15 in around August 2023 and by the 7 September 2023 there 16 had been a move towards having a public inquiry but also 17 retaining the Independent Clinical Reviews. Do you 18 recall your understanding of what the clinical review 19 side was to be when it was first announced earlier in 20 2023? 21 A. That those people who felt they had a case with Eljamel 22 on that one-to-one and very confidential basis would be 23 able to have their own clinical situation reviewed and 24 I think that's absolutely right and proper actually and 25 I know there's a very welcome reception to that amongst Page 204

1 many of the patients. And there are patients there who 2 are extremely private about the difficulties that they 3 encountered and find it difficult perhaps to articulate 4 some of the issues that they suffered and have 5 appreciated the opportunity, especially with 6 Professor Wigmore, to undergo these clinical reviews. 7 But I think the overall concern was growing about the 8 extent that the due diligence of the oversight had not 9 been effective and that was definitely sinking in 10 I think with Scottish Government ministers. It took 11 a long time but I think it was sinking in. 12 Q. Had it been -- I understand the two different elements 13 obviously quite intimately but the clinical side and 14 then the more systemic side. Had it always been part of 15 the patients' campaign that they wanted this two-step or 16 two processes or had it been something which the 17 government had given them, as far as the clinical side 18 was concerned in spring of 2023, but they said: well, 19 what we actually want is a public inquiry? 20 A. I think it was inherent in the circumstances because 21 quite rightly they had suffered tremendous physical and 22 psychological harm. Naturally they wanted to know why 23 this had happened and in many case why this had 24 happened after warnings and they want answers about why 25 it was allowed to continue for such a long period Page 205	1 A. Indeed, sir. 2 Q. And what was your view/the view of the patients on whose 3 behalf you were advocating about the retention of the 4 two processes? The reason I ask that is there's 5 an impression from some evidence there might have been 6 a degree of confusion as to why there needed to be two 7 processes. 8 A. Yes, I can understand that up to a point but I think, as 9 you rightly said a few minutes ago, there are really two 10 issues -- they're very strongly connected to each other 11 but there are two issues here. The first is the medical 12 malpractice but the second is why it was allowed to 13 happen. And so I believe that there is a very strong 14 case for not just the public inquiry but for 15 Professor Wigmore's clinical reviews and I think my 16 reaction, certainly from listening to what patients are 17 saying, many of them are very grateful for that 18 opportunity to talk about their actual individual 19 medical cases, but as you rightly said that was not 20 going to be enough to answer the most important 21 questions about why it was allowed to happen. 22 Q. And as regards the systemic issues with which you were 23 keen there should be a public inquiry for some years, 24 did you have the impression that the Scottish Government 25 had a clear list of what those issues would be? Page 207
1 without anybody being held accountable. So I think the 2 two go hand in hand, but I think the scandal for me is 3 not just about Eljamel's horrible medical malpractice 4 and all the dangers that he has put upon his patients, 5 it's about the oversight or lack of oversight especially 6 when concerns were raised. That's the nub I think of 7 the concern among most patients. 8 Q. So logically, I'm taking, it must have been your 9 position earlier -- your and the patient's position 10 earlier in 2023 that, although welcome, the clinical 11 reviews were not sufficient as they would never address 12 that aspect? 13 A. Correct. 14 Q. And do you know why it is that Michael Matheson 15 effectively changed his mind on that and decided that 16 there should be a public inquiry shortly before 17 7 September 2023? 18 A. I got the very strong impression that the government 19 ministers were pretty shocked by the report that came 20 out that you mentioned whereby it was quite clear that 21 there were inadequacies within NHS Tayside. I think 22 that was a big shockwave to the government. 23 Q. As I understand your evidence, had that not been what 24 you and patients had been telling them for some years 25 before that? Page 206	1 A. In some respects I felt they had but not in the detail 2 that I thought was going to be sufficient to be able to 3 address all the circumstances of what had happened. 4 Governments are busy, they have loads of other things to 5 think about and there was Covid at some aspects of the 6 Eljamel situation and you make a little allowance for 7 some of the delays that happened in 2020, 2021 8 particularly, but I never got the impression until very 9 much later in the day that the Scottish Government 10 really saw this right at the top of the agenda and 11 I think credit to the campaigners but credit to my 12 parliamentary colleagues who assisted me in pushing it 13 right up there because we believed it was a matter of very 14 considerable public interest. 15 Q. To continue on the theme of documents but in a slightly 16 different context you mentioned having had not as many 17 or as quick meetings with the Scottish Government as you 18 might have liked but there have been some as 19 I understand it? 20 A. Yes. 21 Q. And who was the Cabinet Secretary with whom you first 22 managed to get a meeting on behalf of the Eljamel 23 patients? 24 A. I think if we go back through the different Cabinet 25 Secretaries for Health, including the late Jeane Freeman Page 208

1 who I found very helpful in some respects and I think 2 perhaps Jeane Freeman was the one who commissioned the 3 report -- the investigative report. 4 Q. The one that reported in 2022? 5 A. Yes. So from that angle I felt that we were -- I had 6 a very brief meeting with Nicola Sturgeon when she was 7 Health Secretary -- that's obviously going back a long 8 period of time -- when Eljamel came up in the 9 conversation about various other things but she wasn't 10 responsible for the other meetings that I had because we 11 met obviously with Michael Matheson, we met with 12 Humza Yousaf when he was Health Secretary with 13 Jeane Freeman, with Neil Gray, so there was a long list 14 of Cabinet Secretaries for Health. I met with them all 15 at some stage, some with patients but some with 16 colleagues and some privately myself. 17 Q. As far as meetings of that nature were concerned, were 18 you aware of whether the Scottish Government 19 officials/civil servants minuted those meetings? 20 A. There were certainly civil servants in the room and 21 I think it's the understanding I have and I think my 22 colleagues would agree that there were civil servants 23 there who were doing their duty in terms of 24 taking minutes and therefore these minutes should be 25 available. Page 209	1 that was a decision taken freely by the Chair of the 2 Inquiry? 3 A. I wasn't sure, I'll be quite honest. I felt very 4 strongly that there should be no circumstance where 5 patients -- you know, as you say it's all about 6 patient-centred inquiries and Lord Weir has always, in 7 all his public utterances, been very careful to assure 8 patients that you know they are at the centre of this 9 Inquiry and that's absolutely right and proper and 10 should be. And I didn't feel if they were going to be 11 moved online that that was going to be acceptable, 12 particularly as we'd obviously had two information 13 sessions of this Inquiry when they were free to attend 14 and I think it's important that they can attend but 15 I wasn't sure, I got the impression that this decision 16 to -- well, there was a problem about the room etc, but 17 at the time I thought maybe Lord Weir had had to take 18 the decision because he was forced into a circumstance 19 where this room was not operational and if there were 20 safety concerns I could understand that but that 21 concerned me. So I wasn't entirely sure what had 22 happened. 23 Q. I'm not in any way seeking to criticise you in this 24 regard because I'm aware I think quite precisely of the 25 amount of information that would have been available to Page 211
1 Q. Did you get copies of the minutes of those meetings? 2 A. No, but in the circumstances we wouldn't expect 3 necessarily to get all the detailed minutes of these 4 meetings but these can be sourced and it's a matter of 5 record I think that -- it is our understanding that 6 civil servants were present and taking notes. 7 Q. Could I ask you about -- you asked a question on 8 12 March in Parliament, on 12 March 2026, relating to 9 the postponement of the hearings in this Inquiry and you 10 asked the First Minister at First Minister's questions: 11 is the First Minister as appalled as I am that the 12 former patients of Sam Eljamel who were allowed to 13 attend in person the first and second sessions of the 14 public inquiry to hear what was being said in evidence 15 we were told yesterday that that would no longer be the 16 case for session 3 and they would have to listen to the 17 Inquiry's proceedings online? Does he agree that that 18 decision is completely unacceptable? Is it contrary to 19 the principles of a patient-centred and trauma-informed 20 approach? When were Scottish Government Ministers first 21 made aware of that decision? 22 Obviously there was a significant amount of concern 23 which you expressed to the Inquiry about that decision 24 and that's entirely understood. But what I was keen to 25 know was when asking that question had you assumed that Page 210	1 you about it at the point where you asked that question. 2 What I'm quite interested to know, however, is what it 3 is that the Scottish Government told you as a result of 4 that question or otherwise about what the problem 5 actually was? Because of course it's entirely 6 understandable that patients whom you represented wanted 7 to know more and we totally understand that, however, 8 the government could have given you more information at 9 that point I might suggest and I'm wondering whether 10 they gave it to you? 11 A. I thought they could have given me a lot more 12 information because it then transpired that there had 13 been some problem with the council and about the 14 availability of this facility and I think many people in 15 the media were a bit taken aback by this decision as 16 well because I think there was a bit of incredulity if 17 there's a really big public inquiry, why is there a room 18 problem? You know, that just didn't quite sink in and 19 didn't seem to be entirely accurate. But it was quite 20 clear that there was a problem but the conversation 21 I had with Neil Gray at the time, he intimated to me 22 that there was an issue about the local council and how 23 this building would be leased and I didn't feel we got 24 the full facts about that. 25 Q. Okay. If I could just read out what the First Minister Page 212

1 told you in response, he said: 2 "I understand the significance of the point that 3 Liz Smith raises but as I understand it the decision 4 that's been taken by Lord Weir who is the Chair of the 5 Inquiry. Liz Smith will know the obligations that I am 6 under in terms of the Inquiries Act 2005. The Chair of 7 the Inquiry must be free to take the decisions they 8 decide to be appropriate for the running of the Inquiry. 9 They should certainly not be subjected to interference 10 by Ministers and they certainly will not be subjected to 11 interference by me, whatever my personal sympathies are 12 on the issue. As Liz Smith knows, just last week I met 13 those who were affected by Eljamel and had 14 a constructive discussion with them. I have to respect 15 the independence of Lord Weir's Inquiry. It would be 16 thoroughly inappropriate for me to intervene on any 17 matter of that nature." (As read; not shown on screen). 18 Would it be fair to say in his response, Ms Smith, 19 that the First Minister rather gave the impression that 20 the decision-making in this regard had been that of the 21 Chair and the Chair alone? 22 A. Yes, what you have just read out, in terms of the 2005 23 Act that is correct, that you know it is a matter that 24 the government can interfere in issues that will be 25 decided by the appointed Chair of the Inquiry. That is Page 213	1 inquiries is one that we're interested in hearing from 2 you on as well and of course both yourself and Mr Marra 3 sat on that, and you've already given some evidence 4 about what you heard from Mr Sturrock KC and his views 5 which I think you accepted about why there are so many 6 public inquiries and difficulties in that regard. 7 One of the things that is of interest because this 8 Inquiry is almost introspectively looking at why it 9 itself was created which is why I have been asking you 10 these questions to try to illuminate that a little bit 11 further, but in many ways it's interesting to understand 12 what the understandings were within the committee 13 because it looked at public inquiries in some detail and 14 indeed looked at systems abroad as well as in Scotland. 15 A. Indeed. 16 Q. I'm interested in understanding what the committee 17 broadly made of the evidence it had about the extent to 18 which its recommendations about limiting, at the start, 19 the budget and timescale for an inquiry might interfere 20 with the essential principle of an inquiry's 21 independence? 22 A. I think it's a very interesting question. I mean, the 23 evidence that we took particularly from some 24 jurisdictions abroad was quite compelling in a way that 25 they limit the timescale for any particular public Page 215
1 correct, that's a correct summary. But I think given 2 that there were specific issues about why this building 3 could not be used, and obviously there were problems 4 about the lease, about the local authority, I think 5 perhaps they could have given us a little more information 6 about what exactly had happened. 7 Q. I'm sure you know, Ms Smith, because you follow these 8 matters in detail that I have, in minute detail, set out 9 now two hearings exactly what's happened in this regard. 10 A. Indeed. 11 Q. In light of what you now know about the underlying 12 reasons for the proposal and the Scottish Government's 13 responsibilities as tenants of this building, do you 14 think that the response of the First Minister was 15 entirely candid? 16 A. No, I don't actually. I think what he said was correct 17 up to the point of the interpretation of the 2005 Act 18 but that was a general tone. But obviously there were 19 very specific issues which, as you have pointed out, you 20 made clear. I think we could have had more information 21 at the time. 22 Q. Connected to that general area -- I have asked you a few 23 questions already I don't want to dwell on it too much, 24 but the subject of the Finance and Public Administration 25 Committee report into the cost-effectiveness of public Page 214	1 inquiry and therefore the cost of that public inquiry is 2 not necessarily as extensive as it might be if you let 3 the time run on and I think up to a point there is 4 an interesting debate about that, but -- and I think 5 it's a big but -- there are really big public inquiries 6 like this one whereby I think it is very important that 7 you -- particularly as it's on quite a long historical 8 period, where you -- the judge would not necessarily be 9 able to come to a full comprehensive conclusion without 10 very extensive time with witnesses, particularly if it's 11 a situation like this where there are so many 12 stakeholders involved. And therefore you could ask the 13 question: if you don't allow the time to take place with 14 that in mind, do you hear all the evidence that is 15 necessary to come to the right conclusion? 16 So we had this put to us, quite interestingly 17 actually by witnesses who represented New Zealand and 18 Sweden, and we also looked at some situations in England 19 and there was a case -- I think, from the Finance 20 Committee's point of view, there is -- we are 21 responsible for scrutinising the fiscal side of 22 Parliament and there was a real concern that the cost of 23 public inquiries is way up to £260 million over, you 24 know, quite a short period of time that increase has 25 taken place. And therefore that begged the question Page 216

1 about why that cost had risen and why in essence there 2 was this increasing demand for public inquiries. And 3 that really focused our mind I think as a committee to 4 try to provide the evidence about what we thought was 5 causing a lot of concern there. 6 And then I can well understand the administration 7 costs that go along with a public inquiry. I fully 8 understand and I'm very grateful to all the people in 9 your team who do the support work with bits of 10 documentation and filing and that's essential. But 11 naturally witnesses need to be represented legally and 12 if that goes on for a long period of time, the legal 13 fees obviously increase understandably and sometimes 14 these legal fees were getting pretty big and so there 15 was a bit of a concern in the Finance Committee that, 16 you know, public inquiries -- and if you do allow them 17 to extend to whatever timescale the judge decrees then, 18 you know, that could go on for quite a long period of 19 time. And you know there have been calls -- I can think 20 of four or five former colleagues in the last session of 21 Parliament who were wanting to put forward motions for 22 a new commissioners and the reason for wanting new 23 commissioners was because they felt that some of the 24 public agencies were not doing their job properly and 25 that I think is all tied up in the same sort of Page 217	1 authorities within Scotland about that. Do you take 2 a stance -- would you have to change any of the 3 legislation in the 2005 Act, for a start? You know, 4 does that have to be reformed? That's one question. 5 Then: do you have to have a situation whereby public 6 inquiries are controlled in terms of their timescale and 7 should they all be judge-led, or can you have a mixture 8 of public inquiries, some that are judge-led and some 9 that are much less legalistic, if you like? 10 And so I think there's lots of arguments going on 11 about that but you know if I'm a member of the public 12 I want to know that a public inquiry is going to be able 13 to answer the questions that the, in this case, patients 14 have been asking for a long time who have tried all 15 sorts of other means. And so public inquiries are 16 absolutely necessary sometimes to get to the root of the 17 truth of what happened. 18 Q. Because based on even the experiences you raised in 19 parliament about this Inquiry earlier in this year, it 20 should perhaps be apparent that chairs of the inquiries 21 do not completely control how much inquiries cost in 22 particular relating to things like tenancy of a property 23 which might be used? 24 A. Indeed. 25 Q. So therefore to set those financial limits or to set Page 219
1 argument. 2 Q. Thank you. So to understand there's a couple of 3 elements there. Would you say that it was either you 4 and/or the committee's view that for "inquiries like 5 this" as you've put it those sort of limits shouldn't 6 apply? 7 A. I would argue that -- I'm not sure I could speak on 8 behalf of all the committee members but I think there 9 was quite a strong feeling that -- I think there was 10 this dilemma about trying to ensure that the costs of 11 public inquiries were at least under control. I think 12 that was a strong commitment within the committee 13 members but also that we had to get to the answers and 14 I think the public feel quite strongly that public 15 inquiries should have a judge who leads the whole 16 inquiry because there's great respect for a judge in 17 that situation and that witnesses are compelled to give 18 evidence under oath which I personally think is very 19 important. So there's a big debate about public 20 inquiries, I don't doubt that for a minute, but there is 21 a cost problem. 22 Q. Was it assumed -- and I can understand if one reads the 23 statute why it might be -- that the Chairs of inquiries 24 have a complete control over how much they cost? 25 A. Well, it was some interesting divisions within the legal Page 218	1 time limits does, I think, rather work on an assumption 2 that the Chair is completely in control of those matters 3 which I think perhaps we've discovered, would you not 4 agree, is not the case? 5 A. And I think that's correct. I think one of the 6 interesting debates that we had in the first sessions we 7 took is that for some public inquiries -- and I think it 8 was Lord Hardie who said this to us -- there was a lot 9 of duplication of some of the facilities in servicing 10 that goes into a public inquiry that, you know, every 11 time that a public inquiry is set up you have to go 12 through the whole process of setting up all of the 13 administration of that. And he was making the point 14 that actually you could probably get some economies of 15 scale to try to combine some of that administrative 16 background that's so important and you know I think he's 17 got a good point there. But I'm no expert in you know 18 how these costs are administered but I do think 19 parliament is going to have to take a view on how to 20 proceed with public inquiries. 21 Q. I think it was perhaps Lord Hardie who said that, 22 Ms Smith, not least because he wrote an entire 23 chapter in the Edinburgh Tram Inquiry report on exactly 24 that subject? 25 A. Indeed. Page 220

1 Q. Did you ascertain in the investigation whether the 2 Scottish Government had done anything to take into 3 account of what you'd set out in so much detail in that 4 report? 5 A. No, we didn't get any information about that side of 6 things. I think our timescale for the public inquiry 7 was actually in itself a little bit limited because you 8 were doing a lot of things relating to the budget, 9 fiscal framework, all sorts of things. But I think we 10 had four or five evidence sessions with the legal 11 profession, all of them extremely interesting, I may 12 say, and we tried our level best to get to the nub of, 13 you know, if there were going to be cost savings where 14 might some of these cost savings be made and Lord Hardie 15 was very direct in his evidence about that. 16 Q. Thank you. Those are all the questions I have for you, 17 Ms Smith. As will become the tradition at the end of 18 this part of the evidence, I'm going to ask you now 19 whether there's anything that you would like to add? 20 A. No, sir, I don't think so. As you probably can tell 21 from my evidence, I'm just very keen that one day we'll 22 get to the truth about what happened and why so many 23 patients feel so badly let down and nobody has been held 24 accountable. 25 MR DAWSON: Thank you. I'm afraid you're not quite off the Page 221	1 know about, and again for others it might be helpful to 2 contextualise it. When a Scottish public inquiry is set 3 up the statute makes clear that there are jurisdictional 4 limitations on what a Scottish Inquiry, as it's called 5 in the Act, can look at. And it can only look at 6 matters within the remit of the Scottish Parliament, ie 7 which are not reserved to the Westminster Parliament 8 under the devolution settlement. 9 As I know you know, there were significant concerns 10 expressed by a number of patients that as a result of 11 this being a Scottish Inquiry there were certain bodies 12 which fall within Westminster's exclusive jurisdiction, 13 including for example the General Medical Council and 14 the Health and Safety Executive, that would not be able 15 to be investigated in the same way as other bodies like 16 NHS Tayside. So that in that context which I know you 17 understand you are aware of there having been any 18 consideration given at any stage within Scottish 19 Government of seeking to have this Inquiry made into 20 a joint Inquiry which would have enabled that full range 21 of bodies to be examined? 22 A. Yes, on an informal basis I completely understand the 23 legislation and Mr Marra and Mr Rennie and myself, we 24 wrote on behalf of the patients regarding the Terms of 25 Reference that we were slightly concerned that HSE and Page 223
1 hook yet. We'll have a short break now and there'll now 2 be an opportunity for the core participant legal 3 representatives to suggest some further questions which 4 hopefully won't take too long. 5 THE CHAIR: Well, that necessarily means that it's perhaps 6 unclear how long that will take, but if those in the 7 public gallery just bear in mind that it's probably 8 sensible not to travel too far from the hearing room and 9 you can let me know when we're ready to resume. 10 MR DAWSON: Thank you, sir. 11 (4.15 pm) 12 (A short break) 13 (4.22 pm) 14 MR DAWSON: Sir, just for the sake of clarity for those who 15 are in attendance this will be a normal pattern whereby 16 at the end of my questions we'll have a short break, as 17 I explained this morning, and then the core 18 participants' legal representatives are afforded the 19 opportunity to ask further questions in addition to the 20 ones they've already proposed. So that's for everyone's 21 information the process we've gone through. 22 Ms Smith, to return to the subject area of calls for 23 a public inquiry, there's one area I have been asked 24 a question about which I had actually intended to ask 25 myself but I forgot. I know this is a subject that you Page 222	1 the General Medical Council could not be investigated on 2 the same basis that some others might be. The reason 3 being, particularly with HSE which you know in future 4 parliaments I'd like to see a bit of further work done 5 on this, because there is a responsibility through 6 Westminster when it comes to HSE's operation but when 7 it's a specific medical issue or a health matter that 8 has to be investigated by another health board, HSE does 9 not by statute have the right to do that. But there was 10 deep-seated concern, and I appreciated that and as did 11 my colleagues, that if you were looking as one of the 12 core issues within this public inquiry that the 13 oversight had not been effective and HSE does have 14 a role to work with other bodies like HIS in Scotland -- 15 and in a letter that Jeane Freeman had sent to me she 16 made clear that HSE does have a responsibility to look 17 at various issues there -- there was a concern that the 18 oversight of some of the health organisations would not 19 necessarily come to the attention of the public inquiry 20 unless HSE and the General Medical Council could be 21 properly investigated. But in his letter back to us 22 Lord Weir made it clear that it is within his remit to 23 call witnesses who might provide the assistance that is 24 required in answering some of these key questions and 25 I hope that that might be the case in the future because Page 224

1 I think there are some genuine questions that were 2 raised by patients when it came to HSE and to the 3 General Medical Council, but you know the legislation of 4 2005 is very clear about that. 5 Then just in relation to what the Scottish 6 Government might have done with the Westminster 7 Parliament, there were moves made by MPs, by 8 Richard Baker being one, to make the Westminster 9 Parliament aware of some of the issues that might 10 actually be common to some aspects of public inquiries 11 south of the border. Particularly at the time when it 12 was revealed that Eljamel might have had connections 13 with other hospitals south of the border, there was 14 a very clear reason why it might have been appropriate 15 to delve further into that because obviously that could 16 have some way of uncovering some of the most important 17 material. 18 So yes, we were aware of some of the -- letters were 19 written. It was Wes Streeting who was the Secretary of 20 State for Health at the time and that discussions had 21 taken place on that. And the Scottish Government wasn't 22 shutting that down but -- it's not a matter for me but 23 I think there is a strong case that in some cases HSE 24 and the GMC do have a role to play on this. 25 Q. Just to focus on the time periods, my understanding Page 225	1 despite the fact that there were certain things that HSE 2 could not do by dint of legislation but they set out 3 very clearly why they felt they had a responsibility 4 when it came to patient safety about what might be 5 required. And that's where I have sympathy that if Lord Weir 6 has the powers to call witnesses that might obviously 7 address that problem. 8 Q. Just to be clear, I know you'll understand but just for 9 the sake of people who are listening, it would never 10 have been within the Scottish Government's gift to 11 announce an Inquiry that went into these areas, that's 12 right? 13 A. Yes. 14 Q. But the Scottish Government could have sought talks with 15 the UK Government to try to see whether they would like 16 to enter into a joint inquiry arrangement? 17 A. Indeed. 18 Q. For the sake of clarity we will be hearing oral evidence 19 later in this session from two representatives of the 20 GMC. We have a written statement from them in this 21 section and we also have a written statement from the 22 HSE as well as very voluminous documentation, I can 23 assure you, from them which either has been or will be 24 disclosed to our core participants in due course. 25 A. Thank you. Page 227
1 certainly is the time period you were talking about 2 there when Mr Baker was writing letters and that sort of 3 thing was in the period after this Inquiry had come into 4 being? 5 A. Yes. 6 Q. So it would still be open to the Scottish Government at 7 that stage to say: well, we could now make it into 8 a joint Inquiry and you said they weren't shutting that 9 down? 10 A. They weren't shutting it down. 11 Q. What about in the period before this Inquiry was raised, 12 was there anything available to you that the Scottish 13 Government considered the possibility of a joint inquiry 14 before the Inquiry was actually announced? 15 A. Not to my knowledge and that was not part of any formal 16 discussions I had had. We were probing on the HSE 17 situation and to a lesser extent on the GMC but did it 18 come to formal discussions about -- before the Inquiry 19 was announced about trying to have a joint basis to 20 this? No, not in terms of formal discussion. 21 Q. When you say you were probing about HSE and GMC that was 22 before the Inquiry and subsequently? 23 A. Yes, correct, and in Mrs Rose's evidence and also in 24 Mr Kelly's evidence, they set out the reasons, very 25 strong reasons why they felt that HSE did have a role Page 226	1 Q. Thank you. That's everything, sir. 2 THE CHAIR: Thank you very much. Ms Smith, it's obvious 3 from your evidence that you have been a prominent and 4 valued representative of many patients in connection 5 with this matter and it's in that context that I'd like 6 to thank you very much for coming to the Inquiry this 7 afternoon as its first witness and to share not only 8 that evidence but also your insights and reflections on 9 the matters about which you've been asked. I'm very 10 grateful to you. You're now free to go. 11 A. Thank you. 12 THE CHAIR: Now I take it that there are no other matters 13 that I need to be undertaking this afternoon? 14 MR DAWSON: That's correct. 15 THE CHAIR: Thank you very much everybody. We'll see you at 16 10 o'clock tomorrow morning. Thank you. 17 (4.32 pm) 18 (The hearing concluded) 19 20 21 22 23 24 25 Page 228

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