Wednesday, 9 September 2026
(10.06 am)
THE CHAIR: Good morning, please be seated.
Yes, good morning, Mr Dawson.
MR DAWSON: Good morning, sir. The first witness this morning is Nicky Connor.
THE CHAIR: Thank you.
MS NICKY CONNOR (sworn)
Questions by COUNSEL TO THE INQUIRY
MR DAWSON: Good morning. You are Nicky Connor?
A. I am Nicky Connor.
Q. There are microphones in front of you. Hopefully someone has explained this to you but if you could speak broadly into the microphones they will pick up your voice for the transcript. Thank you very much indeed. As I've said to you already if you need to take any breaks or anything like that during the course of the day then feel free to ask. I'm sure the Chair will be amenable to that. You contributed to a witness statement which was provided to the Inquiry dated 8 June 2026; is that correct?
A. Correct.
Q. Could we have a look, please, at page 1 of NHST-04944. Is that the front page of the witness statement that you contributed to?

A. It is.
Q. It says that the statement was given by Dr James Cotton, who is he?
A. Dr James Cotton is the executive medical director and carries executive lead responsibility for the Inquiry.
Q. Thank you. My understanding is that the statement has been signed by him?
A. Yes.
Q. And that there were various contributors to the statement based on the fact that it covered a wide variety of different subjects, is that right?
A. Yes, that's correct.
Q. And that the contribution to the statement that you made focused on, if you put it this way, a particular subsection of a particular section. The section dealt with the documents relevant to the Inquiry's ambit which had been asked for which were in the possession of NHS Tayside?
A. Correct.
Q. And as a subset of that we had asked you, or the board, to explain to us whether there are documents that fell within that category that had at some point been destroyed, is that right?
A. Correct.
Q. And that section of the statement is split into a number

of subsections where you address, or the board addresses, or Dr Cotton addresses, a number of different types of documents which fall within that ambit and explain what of those types of documents are still available to the board, is that right?
A. Correct.
Q. And there is a subsection in the statement where the type of document that is being addressed is theatre logbooks, is that right?
A. Yes.
Q. And is that the section of the statement which you contributed?
A. That is.
Q. Thank you. Sir, just for the sake of clarity I think it might be worth pointing out, both for the witness and for people more generally, that it's our normal practice as I set out yesterday to publish statements at the end of the day when witnesses have given evidence that day related to that statement. So for example yesterday we would have published Liz Smith's statement after her testimony. Because of the way that Ms Connor has explained the statement was provided, it's our intention to lead evidence all of the contributors to the statement at various different times over the next few weeks but not to publish the whole statement until

the last has given their evidence. That's currently scheduled to be on the last day of the sessions so therefore in order to try to make clear publicly what it is we're talking about in the absence of the statement being published at the end of the day, we will take witnesses through relevant passages and that will have the result of those passages being replicated in the transcript of the proceedings such that people who take an interest can look at that at the end of the day.
THE CHAIR: Yes. Thank you.
MR DAWSON: Is that understood, Ms Connor?
A. Yes.
Q. So obviously aspects of this statement are contributions by you. It won't be published in the normal way but I'll take you to some of those passages and they will be recorded in the evidence that's being given by you during the course of today. Can I just ask you a few questions about your background. If we can go to paragraph 2.1, please, of the statement. Thank you very much. It says there:
"I am Nicky Connor, RGN, Bachelor of Nursing, MSc in Primary Care. I am Chief Executive of NHS Tayside, a position I have held since July 2024, and an executive member of the NHS Tayside Board. I qualified from the University of Dundee in 1997. I was Chief

Officer/Director of Health and Social Care in Fife from 2019 to 2024 and I have previously held senior nursing leadership roles in NHS Fife. As Chief Executive I also hold the role of Accountable Officer for NHS Tayside."

You go on to say:

"I do not and have never practised clinically within the Neurosurgical Department at Ninewells Hospital. I am also NHS Tayside's Accountable Officer, and this includes the Neurosurgery Department. I worked at Ninewells Hospital while a student nurse between 1994 to 1997, before commencing a role as a registered nurse in February 1997."

So, Ms Connor, you come from a nursing background?

A. I do.

Q. And what senior nursing roles did you hold in NHS Fife before arriving at NHS Tayside as chief executive in July 2024?

A. Thank you, I was lead nurse then I became associate director of nursing. So one of the senior nursing team reporting directly to the executive nurse director.

Q. Right and was that from when you qualified from Dundee University in 1997?

A. No, when I qualified in 1997 I worked in Ninewells Hospital within the medical department. I then moved to Fife. I worked within Victoria Hospital in coronary

care and cardiology. I moved out into the community and worked as a community nurse and then a specialist nurse and then I undertook leadership roles. My most recent role though prior to coming to Tayside was as chief officer and director of Health and Social Care which is not a nursing role within Fife.

Q. And all of those apart from the Ninewells training was within NHS Fife?

A. Yes, that's right.

THE CHAIR: I'm sorry to interrupt, Mr Dawson. Although these proceedings are actually being transcribed, some of us particularly old-fashioned people like me are actually noting what you have to say. I know it's very easy and tempting when giving evidence to speak quickly but can you just slow down a bit for my benefit if not for anyone else's, thank you.

A. Absolutely. Thank you.

MR DAWSON: Thank you very much. And you say that you worked at Ninewells between 1994 and 1997 as part of your training?

A. I was a student nurse for the University of Dundee.

Q. And did you have any experience of the neurosurgical department or of Mr Eljamel at that period?

A. No.

Q. The role that you held at NHS Fife as chief officer and

director of Health and Social Care, can you tell us a little bit more about what that role entailed?

A. I can, thank you. That role is part of integration in line with the legislation where I was the most senior officer to Fife Integration Joint Board of which there is only one within Fife but I also carried operational responsibility for delivery of all of the services that were delegated to the Health and Social Care Partnership. So that included health services, community hospitals, mental health, learning disabilities, but also included community services whether that be nursing, allied health professions. It also included services such as adult social work and adult social care.

Q. Okay, thank you. And does that then, in terms of the hierarchy which I know can be complicated, sit as a senior management role underneath the chief executive of NHS Fife, is that right?

A. In that role -- it's a complex role, it covers both the services delegated from the local authority and also from the NHS. So I was a direct report to both the chief executive of the local authority so that would be Fife council and the chief executive of NHS Fife.

Q. Thank you and you're now the chief executive of NHS Tayside?

A. I am.

Q. Can you tell us something about the main responsibilities that you have in that role?

A. Of course. So I carry, as chief executive, the overall responsibility for the leadership, the management and the performance of NHS Tayside ensuring that we are delivering safe, effective, person-centred healthcare for the population of the entirety of Tayside. In addition I'm also the accountable officer.

Q. Okay, I'll go on to that in a second. Just in terms of what you said there about the geographical spread, something that came up yesterday and I think is reflected in other parts of the statement answered by your colleagues, obviously we're predominantly interested in this Inquiry in the neurosurgical services that were offered by NHS Tayside and some other bodies and its predecessors from 1995 to around 2015. And we understand that the position is that the primary service, if you like, that's offered by NHS Tayside relates to three local council areas in that area but that acute services, including neurosurgery, are offered more broadly than that; is that correct?

A. So it might be helpful just to describe, my responsibilities are discharged through my executive team. Within that executive team there are groupings of

staff that form part of my team. So I have got professional leadership and that's the executive nurse director, executive medical director and director of public health. I then also have business enabling which is the director of workforce.

THE CHAIR: Sorry, who is that? I didn't catch what you just said.

A. Business enabling, so those that enable the business and that is both the director of workforce and the director of finance. I also then have a key set of roles which are operational leaders and that includes chief officers. One for Angus, one for Perth and Kinross, one for Dundee and one for acute services and together they make up my team.

In terms of the delivery of how services are delegated, there are some services that are delegated to these chief officers that work within health and social care purely for the locality that they serve but they also sometimes take leadership across the whole of Tayside. None of them have leadership for neurosurgical services, that is delivered within the acute services.

MR DAWSON: I see. So you have identified there I think that there was a geographical component to certain elements of those jobs. I think for chief officers I think they are the three local council areas that

I mentioned, is that right?

A. They are.

Q. So that's Perth and Kinross, Angus and Dundee; is that right?

A. Yes.

Q. And then separate to that there is a chief officer for acute services, yes?

A. Yes.

Q. And neurosurgery is delivered within acute services?

A. It is.

Q. And that neurosurgical services, insofar as provided by NHS Tayside, goes beyond those three geographical areas into a broader area; is that correct?

A. So we may well accept patients at times from outwith Tayside, is that what you mean, sorry, or do you ...?

Q. Yes.

A. We may at times and that covers a whole range of specialties by which that may sometimes happen particularly where we have boundaries with Northeast Fife and particularly where we would work with other health boards to support the delivery of healthcare across boundaries.

Q. When you were telling us a moment ago about the various different executives that work under you --

A. Yes.

Q. -- were you trying to convey that there are aspects of the delivery of services, more specifically that you wouldn't know about or be responsible for, that they would be better to ask effectively?

A. No, no, it depends on the level of detail --

Q. Of course.

A. -- that would be sought. However, the point that I was trying to make, apologies, was that as well as leading for a geographical area there are some services that they deliver for the whole of Tayside. So I gave you an example, psychological services is delegated to Dundee but it is delivered for the whole of Tayside. So I did not want it to be interpreted that they will be delivered purely for the geographical area and that's in line with the integration scheme that is published.

Q. Right, thank you. You say that you also hold a role as accountable officer for NHS Tayside, is that something that derives from your position as chief executive or is it something separate?

A. It's chief executive and accountable officer and that is part of being appointed by ministerial appointment into the board and it carries that accountability with it. So through being accountable officer I'm accountable to the board and ultimately to Scottish Government and that covers the stewardship of public resources, financial

standards, governance, risk management and compliance with statutory organisations, legislation, as well as the use of public funds.

Q. I see so -- is it fair to say that you're ultimately responsible to Scottish Government for everything that happens below you in NHS Tayside?

A. I am accountable into the board and the board has accountabilities that feed up into Scottish Government but I also have direct responsibilities to the director general.

Q. I see, but just to address my question, are you then accountable and responsible for everything that happens below you in NHS Tayside?

A. I am accountable. I think responsibility is a different thing. I discharge responsibilities through my executive team but ultimate accountability sits with me as the accountable officer.

Q. So if something's gone wrong in NHS Tayside the government can hold you accountable?

A. Yes.

Q. How do you account to the Scottish Government?

A. There are a range of ways that that happens. It happens through the annual public meetings that take place in terms of the annual performance meetings, it happens through inquiries, submitting letters and there's also

a regular meeting that happens with the director general with all accountable officers across Scotland so it would depend on the topic or the subject that was done.

Q. So you mentioned there -- just for the sake of clarity for everyone and so that I'm getting it right in my own mind -- the director general you mentioned there is the director general for Health and Social Care?

A. Yes.

Q. And that is a senior civil service position within the government; is that correct?

A. Yes, yes.

Q. And that sits within the directorate of Health and Social Care?

A. Yes.

Q. Which is the directorate through which the Scottish Government discharges its responsibilities for healthcare under the devolution settlement?

A. Yes, and I may at times also have direct communication with ministers.

Q. Thank you. I'm glad I have that right, thank you very much. I understand that the director general also holds the position as the head of NHS in Scotland, is that right?

A. My understanding, yes, chief executive of NHS Scotland.

Q. Chief executive, that's right, yes. I was interested to

know how that works as regards the interface between the overall chief executive, if you like, who I think is also the director general and then the chief executive of the territorial health boards of which you are one?

A. So as I said earlier, there is a coming together on a fairly regular basis where the director general meets with all accountable officers across Scotland and that is discharged what is called through the NHS Scotland executive group. Beyond that I think it's very clear that for each individual board the accountabilities sit with the accountable officer.

Q. Right, understood, thank you. You say that you're accountable to the government and to the board. Are you accountable to anybody else?

A. I'm accountable to the people of Tayside and I am accountable to staff.

Q. And how do you account to them?

A. Transparency, openness, sharing. We have public board meetings. We are able to show fully the matters that are being considered at board level. In terms of staff I do regular visits out and about, meeting with people, speaking to people, listening to people.

Q. Okay, that's an important part of delivering healthcare in the NHS, isn't it?

A. Vital.

Q. Thank you. Just one more question on that, just in terms of the structures. Is it the case that all chief executives across the country or boards come from a clinical background or is there variation in that?

A. There's variation.

Q. Right. Is it deemed important that you do or in fact deemed preferable that you don't?

A. I don't know that there would be a view on that. I certainly find it helpful to have that background because I have a strong understanding but I don't think it's imperative. It's not part of the job description, not a requirement of the role.

Q. Right, so it's a management function effectively, a very senior management function?

A. Yes, it's not a clinical function.

Q. Not a clinical function and you have, as I think you've described to us already in the details, other executives who sit below you responsible for clinical aspects of the board's delivery of its services?

A. That's correct.

Q. Thank you. Understood. In your experience as a senior leader and ultimate accountable officer, in what circumstances you would expect a chief executive of an NHS board to become involved in handling issues relating to the practice of a consultant like

Mr Eljamel?

A. So I guess in an organisation there's lots of layers, if I could call it that, where there are -- and if I can speak specifically to acute services within NHS Tayside, there will be the front line teams. They sit within what are called clinical care groups that have leaders there. They sit within a wider directorate and then they report into overall acute services and then it comes into the wider element of the organisation. So I would expect for anybody that we are managing matters as locally as possible until they're escalating, they will go through due process and we have policies in place that clarify levels of escalation if there are matters of conduct or capability. Particularly I think there is a role as chief executive where my team needs support or where there is sitting is reputational risks for the organisation.

Q. So I'm a patient that has an issue with myself or a family member and I want to try to work out what happened or possibly seek redress for some harm that's been caused to me or my relative and you are accountable to the public. Can I come to you?

A. I regularly receive emails and correspondence and communications from the members of the public. What I would do with that on receiving that is it would be

acknowledged and it would be passed on to a dedicated team we have around our patient experience team who would support an investigation into those matters.

Q. Because the way that you've described the service there, which is no doubt very familiar to you, the acute services and the different levels and layers, it does sound slightly impenetrable for a member of the public to try to work out how they access the accountability of a board like NHS Tayside?

A. Regularly I will receive communications from patients and we would seek to support the connections, the signposting and the direction for people to help them navigate that. I do recognise that an organisation of 14,000 people and the complexity that I described earlier regarding both integration and acute services can be challenging. That would not be unique to Tayside, that would be the position of all boards across Scotland.

Q. Thank you.

THE CHAIR: Well, do you agree with Mr Dawson's proposition which was that it might, to the outsider, seem somewhat impenetrable the arrangements he described?

A. I think there can be challenges in terms of how people know to access the service. I think that becomes what's really important in terms of the information that we

have publicly available. So we've got a website that is publicly available, we have got social media where we would share information. We have got clear policies as well that are able to support the signposting of people. So we seek to be able to make that as accessible as possible, but I would recognise at times it can be challenging for people to know where to start.

MR DAWSON: I understand that you first joined NHS Tayside as its chief executive in July 2024?

A. I did.

Q. What information was provided to you about the Eljamel situation, if I can put that way, when you joined?

A. So at that time I was advised that we were looking at that being a public inquiry, that that was a direction that was being taken forward. I was advised that we were establishing huddles, and that we had mechanisms in place in terms of supporting a level of readiness in relation to that. I was also made aware of some of the previous key reports such as the due diligence report and other previous work that had been undertaken on the build-up to the Inquiry.

Q. So the Inquiry was announced by the Cabinet Secretary in September 2023.

A. Yes.

Q. So it was already up and running, it was a thing by

then?

A. Yes.

Q. You mentioned the formation internally of "huddles", I have noticed that expression in other places. Could you explain to the Chair what those are or were?

A. Yeah, so there was a mechanism in place which was called the huddle that was led by the executive medical director to make sure that we were bringing together all of the key information. What began as a huddle has progressed in terms of governance and evolved on to becoming the oversight group.

Q. So what is a huddle then in this context?

A. It's where the key information comes together with the key group of people that require to be involved and know and they're able to share that with each other and have a central mechanism, is what that started with in terms of the Inquiry.

Q. Because I think we've encountered this already but we'll certainly encounter this as we're going on today that one of the main purposes of this Inquiry or one of its main objectives is to try to address the issue of communication --

A. Yeah.

Q. -- in healthcare and certainly the Inquiry's impression from what it's seen so far is that that is a real

issue in lots of different ways but it definitely appears to manifest itself in the sense that -- and I recognise that lawyers fall into this trap often yesterday as well -- that the healthcare providing organisations have their own language for things that can often be difficult and can be perhaps sometimes a barrier to accountability and communication. So I just want to be clear as to what these things are as we go along and exactly what you mean about things. Because there may have been occasions on which, I think perhaps reasonably, aspects of the language that's used have been misunderstood because there is really almost a different language used at times. So this is where we come across this for the first time. So would it be fair to say that a huddle is where something arises that needs NHS Tayside's attention and a group are put together to try quickly to assimilate all of the relevant information and work on a plan; would that be fair?

A. So I accept your point around how language is used and "huddles" can mean different things in different context.

Q. I see.

A. In the context of this it was the bringing together of key people in terms of the central co-ordination of the

Inquiry. The executive medical director, Dr James Cotton, who has chaired that will be best placed to tell you the detail of how that worked, but it evolved from being a huddle into being known as the oversight group to formalise that governance more.

Q. Understood. So it became a more formal group later but initially it was a huddle. Had that been set up before you joined in July 2024?

A. I would -- that feels like a long time ago so I would require you to clarify that with Dr Cotton.

Q. Okay, thank you. And my understanding is that -- we'll come back to the due diligence review in a moment, but my understanding is that one of the things that was done when the due diligence review was carried out, which was completed in August 2023 I think, was that all of the information that was thought relevant to the Eljamel affair, if you can put it broadly, was put together in something called an information log; is that correct?

A. Yes. So my understanding is that was the establishment of the key element of the team, so the patient liaison team that was put in place and elements of that included both the support for patients but also evolved into including key information logs being gathered.

Q. Yes, because you mentioned a moment ago I think that the time you joined key information was being put together

in 2024. I'm trying to understand why that was necessary when the due diligence process had put together the key information as I understood it?

A. So apologies if I misunderstood your question, I understood it to be what was I being made aware of and I gave examples of the type of information I was being made aware of. As to when the log was populated with what I'm unclear but the log also remains a contemporaneous information and the logbooks would be an example of how we continue to build that log.

Q. Okay.

THE CHAIR: Sorry, I'm not sure I follow what you mean by that.

A. So there would have been a level of information that was gathered together in terms of that but actually if we had information relevant to the Inquiry -- and the most recent submission would have been the outcome of the AAB report -- we would continue to make sure that that was registered, rather than it being a completed thing entirely at a moment in time, I think it's important that that's kept up to date.

THE CHAIR: All right, thank you.

MR DAWSON: I'll address some of those aspects with Dr Cotton when he comes along. What were you told when you joined NHS Tayside about the history of the Eljamel

affair?

A. So, it's very serious and that this warrants a public inquiry. I also know that there had been ongoing concerns from patients and understand there had also been concerns regarding both the time bar issue as well, so that was another element that I was made aware of. I understood that Mr Eljamel is not here and that this Inquiry was going to be looking into the full findings of this.

Q. And I'm imagining that when you come along as chief executive that you get a lot of information given to you but if one of the things that you're told is that a public inquiry has been announced only a few months before into an important component of the service that you deliver, affecting nobody knows how many but potentially hundreds maybe even thousands of patients that that would become something of a top priority, is that fair?

A. Absolutely, yes.

Q. And did it?

A. Yes. Yes.

Q. And the priority that it was accorded was through the process that you discussed of the huddles being formed, them doing their work and eventual that moving into a more formal group?

A. I think my involvement was more active than that. I would regularly be meeting with Dr Cotton. Also there was -- the board had an active role there as well.

Q. Did you meet with any of the patients of Mr Eljamel around that time?

A. Not immediately on starting, no.

Q. Were you aware of them being keen to meet with you?

A. I was aware that there was ongoing discussions and I was aware, I guess at that time, that there was work ongoing in relation to the time bar specifically.

Q. I'm going to ask you some questions in due course, Ms Connor, about the board's position about various aspects of what I'm calling "the Eljamel affair" so as not to exclude any particular aspect of it but I'm keen to understand whether, in formulating the board's position on the matters that the Inquiry was to look at, which inevitably must have happened and you've explained how, that whether you were a part of formulating the position if you like or whether the position was effectively a fait accompli given what had been found in the due diligence report the year before?

A. Apologies, could you clarify. I'm not sure what you're asking.

Q. I'm asking whether you were a part of forming NHS Tayside's position in relation to the matters which

would be covered by the public inquiry announced before the year that you were appointed as chief executive?
A. The matters -- so there's elements to that as well. So the matters of that, I mean that had been announced before I took up post, is the position. However --
Q. That's correct.
A. -- as we said earlier, I have been involved in the submission that has been given to the Inquiry in terms of the evidence base.
Q. So you have been involved in writing some paragraphs about the destruction of logbooks --
A. Yes.
Q. -- which happened later?
A. Yes, yes.
Q. But have you been involved beyond that?
A. I will have read the entire submission before that was submitted. In terms though of deciding what the scope of the matters were, that was prior to me taking up post.
Q. When you say -- I think we're going to run into some difficulties of language.
A. Sorry, I don't understand you, apologies.
Q. Just let me ask the question. When you say that the scope of matters was decided within NHS Tayside before you read the submission, what do you mean by "the scope

of matters"?
A. I don't think I have understood your original question. Can we please go back to that?
Q. My original question was to do with the extent to which you have been involved in formulating NHS Tayside's position on the matters that this Inquiry addresses or whether that has been done by others or was decided effectively in terms of the conclusions of the 2023 due diligence report?
A. I'm really sorry but I'm still not understanding. Apologies.
Q. You look very confused, Ms Connor. I hope my question is relatively clear. I'm just trying to work out -- the board has presented to this Inquiry a multitude of different positions about various matters that fall within its remit. That is because the recognised legal representatives have been asked to do so and they have compiled, no doubt on the senior team's instructions, the board's position.
A. Yes.
Q. I'm keen to try to explore with you a clear understanding of what those positions are today so I'm asking you whether you were involved in formulating those positions or whether those were formulated by other people?

A. The answer to that would be a mix of things. I know that the recent position for example that we took in relation to the time bar I was involved in formulating. I know that the submission in relation to logbooks I was actively involved. There's other elements that will have came from either before I took up place or key members of the team.
Q. Did you sign off the opening statement that was made at this Inquiry?
A. I was part of signing off that, yes.
Q. So when you say you were part of signing that off the answer is "yes"?
A. Yes.
Q. Could I have a look, please, at section 2.3 of the statement which was NHST-04944, zooming in on 2.3, if we could. This is just reading on from where we were. This is the section, I think, where you have written a few paragraphs just introducing yourself and then everybody else is introduced and you see Dr Cotton comes in, but just to complete that passage, you said:
"I have contributed to the responses in this witness statement request that relates to the loss of the theatre logbooks at Ninewells Hospital as I have commissioned internal and external investigations relating to this matter in Part E ..."

Then you highlight the questions you answered. Were the theatre logbooks lost?
A. The theatre logbooks were destroyed.
Q. Why did you use the word "loss" there then?
A. I think the word "loss" would have -- there is a loss. I think there is a range of matters of how things become a loss.
Q. But they were destroyed?
A. They were destroyed.
Q. And they were destroyed despite the fact that a "do not destroy" notice covering them had been issued by the Chair of this Inquiry?
A. Yes.
Q. To describe this situation as a loss could be deemed to be misleading, could it not, Ms Connor?
A. It certainly was not intended to be misleading.
Q. Thank you. And given your ultimate accountability, you're ultimately accountable for their loss, aren't you?
A. Yes.
Q. Because you made the distinction earlier, are you responsible for it?
A. So through this -- I discharge my responsibilities through my team but the findings of the independent inquiry have clearly found that there were failings

across the organisation of which I also carry responsibilities as well as accountability.
Q. Okay, thank you. Could I just, on a slightly different topic, ask you about a recent event because it's of interest to the Inquiry. I understand it was announced in parliament last Tuesday that NHS Tayside is to be disbanded; is that correct?
A. So I appreciate that was announced. That's not necessarily my understanding. My understanding is that we are moving to national reform, that they have announced there will be two boards.
Q. Yes.
A. Beyond that I am unclear on what the next steps are.
Q. Thank you. It is a bit unclear and I just wondered if you could help us a little bit more. I'll just explain a little more about what our primary interest in that is, which is: are there going to be moves that you're aware of in the medium term that will mean that the responsibilities we've talked about and the people involved will change or, as far as you're aware, will the people that we have been corresponding with about the Inquiry continue to be those who have we've been corresponding with up till now?
A. I don't know that I know enough about what's going to happen next to be able to honestly answer that question

because I don't know what the timescale for any change will be and I don't actually know what that change will involve.
Q. Okay. That's because you don't have that information yet?
A. I don't, no.
Q. Okay, I appreciate that, thank you. Could I ask to go to another document now, please, it's ELJ-00538. This is a copy of the opening statement that was delivered on behalf of NHS Tayside which I think you said you were part of signing off, yes?
A. Yes.
Q. One of the helpful sections in this relates to something we've mentioned already which is the due diligence review which took place in 2023. When you started with NHS Tayside in 2024 what information were you given about what that review had done?
A. So I was given -- and there's a copy I think within the evidence pack regarding the findings. I was advised about the outcome of the review and I was advised on some of the next steps of which that included the establishment of the PLRT team and included the establishment of further work.
Q. And did you get a briefing or did you get information about what the findings had been of the due diligence

review?
A. I read the -- apologies, I read the due diligence review.
Q. Shortly after the due diligence review was published, the then Cabinet Secretary, as we've already touched on, on 7 September 2023 announced that there would be a public inquiry into the Eljamel affair, is that your understanding?
A. Yes.
Q. It was made quite clear in his address to parliament and also in the evidence we heard yesterday from Ms Smith that the findings of the due diligence report had been instrumental in him making a decision there should be a public inquiry, was that your understanding?
A. Yes.
Q. Was it communicated to you, and has it been communicated to you, what the gaps or deficiencies of the due diligence review were thought to be such that a public inquiry would be appropriate?
A. At the time of taking up post, I am -- I can't recall that level of detail.
Q. And subsequently have you learned more about that?
A. Well, there was definitely -- there was definitely concerns regarding, I guess, honesty in terms of the probity that had been shared. There was definitely

concerns in relation to patients' experience and how -- the handling of those matters over what had been quite a considerable period of time. So the due diligence review goes into consider areas such as complaints handling, it gave consideration across a wide range of issues and that was felt to have been perhaps -- well not perhaps, felt to be insufficient.
Q. Right, thank you. But as to the -- that was the sort of general observation, that's helpful. But was there anything specific that you understood to have been within that remit to be deficient such that a public inquiry would be necessary or was it just your understanding was that there was a general --
A. A requirement for openness and transparency and ongoing concerns in relation to the public and being able to make sure that the reasons were understood fully.
Q. So does it follow from that then that your understanding was that the due diligence review had been considered by government not to have been open and transparent with the public?
A. I didn't intend that it had been -- I didn't intend to say that. What I believe is that there have been concerns over a period of time regarding the openness and transparency, not that it was the due diligence review itself.

Q. But it was those concerns that the due diligence review was designed to address, wasn't it?
A. Yes, and it's identified that there requires to be a further wider review which I trust is why the public inquiry was initiated.
Q. Could we have a look, please, at paragraph 20 of this opening statement. Here your recognised legal representatives, as signed off by you, helpfully tell us some things about this process and they tell us within a number of bullet points some of the areas that I think you have identified were covered by it. It says, in the first bullet point:
"The behaviour of individual doctors.
"Mr Eljamel was not open and honest with patients and colleagues. Whilst such behaviours are rare within the medical profession, there is a need to have systems in place to detect and act on these if they occur.
Since Mr Eljamel practised in Tayside, NHS Tayside has overhauled the governance and alert systems in place for professional governance."
In what ways and over what period does NHS Tayside accept that Mr Eljamel was not open and honest with patients during his career in the board?
A. So I would need to go back to -- I don't have the level of depth around that but it covers the period -- because

here he left the organisation in 2014, so it covers within that period there are specific examples but I don't have that level of depth from recollection.
Q. I'm not asking for a specific examples, I'm asking a deliberately quite general question about in what broad ways and over what period does NHS Tayside accept that Mr Eljamel was not open and honest with patients during his career while working in NHS Tayside?
A. The duration in which he worked at Tayside is clear. In terms of the acceptance of that, I'm unable -- I'm unable to clarify.
Q. Just to be clear so everyone understands what I'm looking at here, this is a document which sets out NHS Tayside's position --
A. Yes.
Q. -- in relation to matters that are important to the Inquiry.
A. Yes.
Q. Is that your understanding?
A. Yes. Yes.
Q. And this is a document which you signed off?
A. I was part of the sign off, yes, I signed off.
Q. Amongst others?
A. Yes.
Q. So you can't tell me, is that right, in what ways and

over what period NHS Tayside accepts that Mr Eljamel was not open and honest with patients?
A. The key finding of the due diligence review was that there were concerns regarding openness and honesty. There was also the Royal College of Surgeons report that also supports that. So that -- there is the period of time over his tenure and there's specific examples that have been explored during that period of time where concerns have been raised and concerns raised by colleagues.
Q. You say there was "a period of time over his tenure", does that mean the whole tenure or does that mean certain parts of it?
A. I'm unable just now to narrow that down.
Q. In what ways and over what period does NHS Tayside accept that Mr Eljamel was not open and honest with his colleagues?
A. We accept that there has been a finding over his tenure that requires to be part of what is understood through this -- through this Inquiry, including you hearing from people that were involved in the due diligence review and people who were in post over this tenure here.
Q. You can't tell me the answer to that question either, can you?
A. He was in post for the period of time, there are

concerns regarding that. I'm unable to narrow that down for you just now.
Q. But yet you signed on this being represented as being the board's position at the opening statement hearing at this Inquiry?
A. I did and I stand by that because if does say that the finding -- one of the findings of the due diligence report was that he was not open and honest. I don't have in front of me the recollection to narrow that down further.
Q. And this helpfully recognises that there's a need to have systems in place to detect an act on individual doctors like Mr Eljamel not being open and honest with patients and colleagues.
A. Mm-hmm.
Q. I assume you accept that?
A. I do.
Q. And you also tell us that -- or the statement told us that the systems in this regard have been overhauled since. Could you tell me how the systems of what's called "governance and alert systems" in place for professional governance were overhauled in the aftermath of the Eljamel affair?
A. Yeah, so I will be happy to give you a broad answer to that and would suggest that the clinical professional

leads who will be -- you will also be meeting with will be better placed to give the detail but there has been significant work done and significant evolution of clinical governance arrangements --

THE CHAIR: Would you mind just slowing down?

A. Apologies. There have been significant evolution of what are called clinical governance arrangements over the past kind of couple of decades of what's been done. Within NHS Tayside there's a really clear clinical governance framework, it has really clear professional responsibilities. So in addition to the executive medical and executive nurse director they have also got teams in place. We have got a committee within NHS Tayside board that specifically deals with clinical governance, the medical director has put in place very specific groups and that includes the responsible officer's oversight assurance group, which is a ROAG group, where if there are concerns about doctors, there's a mechanism for the medical director to be directly reviewing those individual cases.

We also have mechanisms in place regarding whistleblowing and we encourage speak-up within the organisation. So to make it encouraged that people can come forward, to make sure that we are then listening and learning from those and if there are concerns

regarding that practice, that's able to be considered by the relevant professional leads.

MR DAWSON: Thank you. We will get into some of the details of aspects of that including the ROAG, the responsible officer group, with Dr Cotton in due course. Given that these changes were instituted you say since Mr Eljamel practised, is the position that the board accepts -- because again this is about what you accept and what you don't accept -- that these systems with regard to clinical oversight, clinical governance and professional governance were defective at the time when Mr Eljamel was in post?

A. So I refer back to what I said a little bit ago around how clinical governance arrangements, not just within Tayside but across healthcare in Scotland, have evolved significantly over that period of time. Were the mechanisms that we have in place now in place at that time? No, they were not. And some of the findings of the due diligence review around some of those mechanisms generated that. So I think there has been a strengthening of mechanisms that were put in place. Whether they were defective at the time in comparison to what other boards would have had in place, I feel less clear about.

Q. You can't tell me whether they were defective?

A. They did not -- these concerns did not come through in as structured a governance mechanism as we have in place just now. Governance has absolutely been strengthened since the due diligence review.

Q. So what you're telling me is the systems you have now didn't exist then?

A. Yes.

Q. The systems we have now are stronger than they were then?

A. Yes.

Q. Were the systems in place at the time too weak?

A. The system -- I mean, we'd have to speak to the individuals that were there at the time who will be better placed than me to talk to the systems that were in place because I don't have that knowledge. My reflection --

Q. Sorry, Ms Connor, I'd perhaps just clarify one thing. I'm not asking you what people thought at the time, I'm asking you what the position of NHS Tayside is now and you're the chief executive?

A. So my position is that the mechanisms we have in place now are much stronger than they were before. Had those been in place, it may have enabled an earlier identification of concerns and management of concerns at that time.

Q. Do you accept, Ms Connor, that when we're standing here asking questions of you in a public inquiry, that things have got quite serious?

A. Absolutely.

Q. Do you think that one of the reasons why things might have got this serious is because the many, many patients who allege that they were harmed by Mr Eljamel and let down by NHS Tayside's systems haven't been able to get a straight answer as to what NHS Tayside accepts went wrong and what they do not accept went wrong?

A. Yes. So I accept there have been failings in terms of the -- this ability for this to have been identified and to have been addressed but I was not the chief executive who had accountability at that time.

Q. But I'm asking you -- you are the successor, if you like, of the chief executive at the time.

A. No, there's been multiple chief executives.

Q. But you are responsible for the board --

A. I am.

Q. -- that is the successor of what happened at that time; is that not correct?

A. Yes.

Q. So I'm asking you just now whether the board now accepts these things; do you understand that?

A. I do understand that.

Q. So is it your position, is the current board's position that the systems of clinical governance in place at the time were too weak?
A. I think -- yes, but I do not think that was necessarily unique to NHS Tayside.
Q. The statement goes on -- we can do this all day, Ms Connor, because I'm looking for straight answers here and a lot of the questions I'm asking you are designed to try and get straight answers. Now that's important, as you fairly accepted for patients but it's also very important for this Inquiry because what we are seeking to do is we are seeking to clarify with some degree of precision, which our lawyers have tried to introduce into our proceedings which is a good starting point, as to what it is the board accepts and what you do not. What lawyers call that is narrowing the ambit of the dispute. If you accept that things went wrong then the Chair may well be able to make a finding that in that area the board accepts it went wrong. And of course we will look at as you said the various measures that appear to have been taken subsequently, such as the responsible officer group which we will find out about in due course, but it's very important that we understand what is accepted and what is not because otherwise this Inquiry will range over enormous areas

that it need not. If we can start from a point of clarity, we can make the Inquiry useful for everyone.
A. Okay.
Q. If this level of what was described yesterday as "obfuscation" -- not my word, but Liz Smith's word -- is to continue then the Inquiry will be significantly frustrated in achieving its aims. So what I'm trying to do is to try to get that clarity and I'm hopefully fairly doing that because I'm using material which you yourself have provided to us; do you understand?
A. Yes, I do.
Q. Thank you. The document goes on to say:
"Monitoring signals of poor practice or harm.
"Whilst there were multiple ways in which signs of poor practice could appear, the way in which some of those signs were joined up was lacking, and feedback from trainees was not always seen by line managers. Since Mr Eljamel practiced in NHS Tayside, joining up of potential alerts is achieved through an Executive Director-led Safety Oversight Group which responds to emerging potential issues."
This says that signs were not joined up. I wonder if you can help me by understanding what that means?
A. In terms of -- so how we would consider that just now would be around different elements of -- so if

complaints come in, if there's also concerns, if -- all of that would be triangulated to give consideration to a range of signs. In terms of our opening statement -- and apologies, I wasn't meaning to be evasive to what you were asking -- I recognise in our opening statement, both in terms of the behaviour of individual doctors and the monitoring signals of poor practice and harm, we are accepting they were not as they should have been.
Q. Thank you. The reason I asked that question is I think this is just the way that the English works. I think what is meant here -- and please correct me if I'm wrong -- is not the signs that were not joined up but the systems of detection of poor practice that were not joined up, or "triangulated" as you put it, is that right?
A. Yes, I accept that.
Q. I think what you're trying to say is there might have been in place different systems which sought, as their ultimate aim, to detect poor practice and I suppose their overall ultimate aim to enhance good patient experience and care, but one of the problems was that those different systems of detection weren't working well enough together to be able to achieve their ultimate aim; is that what we're seeing here?
A. I accept that.

Q. Thank you. Now, this would tend to suggest that what systems there were did detect poor practice and it was only the fact that those signs of poor practice which had been detected were not triangulated, to use your word, that was the problem. So what is your understanding of what poor practice, on the part of Mr Eljamel, these systems detected?
A. So it would be around elements of concerns raised, whether that be from colleagues, whether that be from patient complaints, whether that -- so both of those elements would come together. So we would hear what people experienced and there would be incidents reported, there would be a range of mechanisms by which concerns would be in place. So that would be the mechanisms that we would have.
Q. I see that, but what I'm asking you is really a question of fact which is: what is it that those systems detected about his poor practice? Which signs were not joined up in the overall system?
A. I think that was the pulling together of the fact there had been complaints and there had been concerns from colleagues, there had been feedback from trainees within the system working there, pulling all of those together, which I called earlier "triangulation", would have been able to more easily identify that there had been

concerns.
Q. So, you are focusing there on, I think, the aspect of the system of detection that deals with opportunities for professional colleagues to raise concerns, both at a higher level and at a lower level, is that right?
A. As well as complaints and concerns from patients.
Q. Yes, okay, so that would be a different part of the system.
A. Yes.
Q. And those two parts needed to be triangulated with each other?
A. Yes.
Q. I don't know, can you triangulate two things? I'm not sure, but there needs to be triangulation of all of the parts of the system. So I'm just trying to get to the bottom of what it is the board accepts. If it's done an analysis which says the problem here was that there was no joined up operation, which appears to be what you're saying, it tends to suggest that it would have made a difference if the system had been more joined up; is that fair?
A. Yes. Yes.
Q. So I'm trying to work out if the system had been joined up, what information, what signs that had been detected would have been pulled together such that there might

have been a different outcome?
A. I think that is something that James Cotton, in terms of medical director who is close to this work, will be able to elaborate on.
Q. So you don't know the answer to that question, do you?
A. There is complaints. There is concerns from staff. There would have been other matters from colleagues that would have all come together. They would have been amongst the key signs.
Q. What were the concerns that were raised by staff?
A. There was concerns around the -- I guess some of that feedback that came in. I don't have the level of depth on this.
Q. Because, you see, this is quite important for us because what we're trying to work out here is whether it is the case -- and we heard quite a lot of evidence about this from Liz Smith yesterday who spoke on behalf of a wide variety of patients -- their concerns relate to the question as to whether there was information available which should have been acted on at an earlier stage because there are patients who allege -- and it's an allegation at this stage -- that the treatment they received from Mr Eljamel was sub-standard in various different ways, operative treatment, pre-operative, the way he communicated with them, over a number of years,

frankly going right back the very near the beginning of his career. Now, what I'm trying to get to here is there appears to be some acceptance here which is a helpful starting point, I appreciate that, but I think what we need is some indication as to the time period over which that acceptance applies because do you accept -- does the board accept that these signs existed and should have been triangulated from the beginning of his career or was it at a much later stage?
A. In terms of the due diligence review I do not believe that that has differentiated any specific timeframe, so accepting over the period.
Q. Over the period of his whole employment?
A. I don't have that level of detail to be specific. I don't have that, that is where the medical director may be able to provide further information, but I am accepting --
Q. But your understanding was -- sorry.
A. Apologies, I'm accepting the findings of the due diligence review.
Q. And your understanding of it is that it doesn't differentiate? Ie, it recognises that there were concerns and information about concerns throughout his employment, is that right?
A. Yes. Yes.

Q. Thank you. You mention there an executive director-led safety oversight group, that was one of the things that's happened since to try to deal with these issues?
A. Yes.
Q. Is that broadly -- we'll get the detail from others, but again is that different from the responsible officer group that you were talking about earlier?
A. It is and it's evolved further since then but essentially that would be led by the clinical -- executive medical director with the other executive nurse director being part of that and that is a mechanism by which is evolved on to be called a clinical governance oversight group but at the time it was a safety group that gave oversight of matters regarding clinical governance and patient safety across the organisation.
Q. And again, its function therefore -- this is a group that's come in since the Eljamel tenure period, yes?
A. Yes, yes.
Q. And its function focuses on that very specific issue which has been addressed here which is the triangulation of the different services, is that right?
A. It covers a range of things. It covers all things clinical governance and patient safety but one of the

things that that would enable, and it does enable, is the consideration of what all of these things look like together. What we also have in terms of how reports are presented is called an SBAR report, but what accompanies that is supplementary information --

THE CHAIR: Sorry, an SBAR report meaning?

A. SBAR, situation, background, assessment and recommendation.

THE CHAIR: Hang on. Situation?

A. Situation. So, in a nutshell what is it we're exploring. Then background, what is the background to that. The assessment of whatever the matter is in question and then what does it recommend.

But what it has, in addition to that, is it asks for key information regarding what that means for quality, what it means for workforce, what it means for finance, what it means for equality. So it brings a requirement to bring that key information forward. I think that also supports when people see information to support the triangulation. But the very nature of having this key group and having that oversight across the whole of the organisation means that when things are coming forward, even if it comes forward at different times, there is the ability, that organisational memory, the records that are held of these being formally minuted and they

also then report now through to the executive group that I chair and they report on as an executive medical director and executive nurse director assurance report into the committees of the board. So that takes what was described in the opening statement even further in terms of ensuring that we have stronger governance in place.

MR DAWSON: Sir, that would be an appropriate moment for a break.

THE CHAIR: Yes, thank you. 15 minutes.

MR DAWSON: Thank you.

THE CHAIR: Right, everybody, we'll have a break for 15 minutes. I can't see the clock but that will take us to a little after 11.20. Thank you.

(11.08 am)

(A short break)

(11.25 am)

THE CHAIR: Thank you. Please have a seat. Thank you, Ms Connor.

MR DAWSON: Ms Connor, I mentioned at the beginning speaking into these microphones. It can be quite tricky but if you can try your best. I think you can sense when your voice is picked up by it or not. But if you can be careful because there are people listening and some are on a hearing loop so just to make sure they're picking

up everything you say. It can be tricky, I understand, but if you can try that I'd very much appreciate it.

So we were in the opening statement and were at page 6 now. It's ELJ-00538, at page 6 please, Rory. So this section of the opening statement relates to the subject of guidance to ensure consistency in governance processes and it says, in the first sentence:

"There was variability in the organisational response to signs of poor practice within the system."

Can you help us with what evidence there is of that?

A. So we -- I fully accept the findings that have been presented here in relation to the due diligence review and finding that variability in terms of response.

Q. Do you know what time period this relates to?

A. My understanding is it's over his tenure.

Q. Over his whole tenure from 1995?

A. That would need to be -- that would need to be clarified but my understanding is there's been concerns identified from early on in practice that came forward.

Q. Thank you, and then it goes on to say that some complaints did not lead to formal investigation using governance processes. So again just to clarify because we talked earlier about there potentially being two streams through which broadly complaints could come. One through a complaints system that might be designed,

say, for patients or patient relatives and you talked as well about another aspect of this where concerns or complaints could be raised by colleagues. Do you know which aspect that relates to?

A. Yes. My understanding is that some complaints not leading to formal investigation relates to patient complaints and level of supervision etc takes the complaints regarding colleagues further on.

Q. Right. So the particular aspect of this that's highlighted as a failing, which appears to be accepted, is that when complaints were made in some cases that didn't lead to the formal investigative processes that were in place being triggered; is that right?

A. I think that relates to both patient complaints but also, as it's described further on in that paragraph, the professional governance concerns being raised. So I think it relates to both when it's raised by staff as well as when it's been raised by patients.

Q. Right and it also says there that there was a variation in response times in that area. Again, is that across the board or is that related to a particular time period?

A. I think it's across the board.

Q. It then goes to say that:

"Once multiple signs of poor practice were

considered together in 2013, decision-making related to Mr Eljamel practice was delegated too far down the organisation."

So the first thing about that is that sort of chimes with something you were saying earlier about the triangulation. Was it then the case that -- does this identify that in 2013 there was a triangulation that meant that action was taken? Is that what "the signs of poor practice being considered together in 2013" means?

A. I think it looks like it's suggesting that it doesn't have the appropriate level of seniority of oversight to have been able to have a look at those different concerns that came together but, yes, there were multiple signs in 2013.

Q. But the first half seems to be a factual statement, we'll get onto the second half in a second, but the first half seems it identifies that in 2013 something happened.

A. I accept that.

Q. And I'm just trying to understand is that related to the evidence you gave earlier about the triangulation of the systems? Because it sounds like it is, the multiple signs of poor practice picked up by these various systems do appear to have been triangulated because we know in 2013 that something did happen; is that right?

A. Yes, yes.

Q. And the position I think was that there had been a failure in the triangulation of those services over the whole tenure of his career before that point?

A. I think there's been a failure, yes.

Q. Because that's one thing we do know is that in 2013 something was done, there was a step taken. The Royal College of Surgeons invited review happened, but it also says that even at that time, "decision-making related to Mr Eljamel's practice was delegated too far down the organisation". Can you help us with that understanding, where that should have been dealt with, where in fact it was dealt with and why that was an issue?

A. Yeah, so what I would expect is that there would have been executive oversight if there is concern regarding our consultant's practice as to -- in terms of the delegation, I think that goes back to what I said earlier about the different spans and layers that there are within an organisation and that meant it didn't have the appropriate executive oversight, which is a gap.

Q. Right. So we know that in 2013 what happened was that Mr Eljamel was placed under a period of clinical supervision and that an invited review was instigated with the Royal College of Surgeons of England. So

that's what I meant when I said did something happened?

A. Yes.

Q. And is it that decision-making that's been talked about here when it was delegated too far down the organisation? There should have been executive involvement in those decisions being reached?

A. I think there is -- yeah, I would require to refresh -- I would require to refresh myself regarding who took that decision in terms of the commission to the Royal College.

Q. So there's also the question of the supervision which is something that we're interested in.

A. Yes.

Q. I'm wondering -- tell me if you can help me with this -- that what it means here is that the supervision and the level of the supervision that was entered into was delegated too far down the organisation?

A. Yes, that's what it suggests to me too.

Q. Yes, and I think you were saying there that the problem with that was that you would expect there to be executive level involvement in something that serious and it appears that there wasn't?

A. Yes.

Q. And the --

A. So I was just going to say I would require to

familiar -- I would require to be familiarised regarding the chronology that was there because I'm unable to say exactly who commissioned the further review just now, I'm not able to say that. So I wouldn't want to suggest there was not, but my understanding, absolutely, in our opening statement is that we are accepting that there was failings in terms of the level of supervision and oversight and the pulling together.

THE CHAIR: Could I just ask one point which may be a very obvious one to you, not necessarily to everyone. When you speak of "executive oversight" in this context, what do you actually mean by that and what practical difference do you, in your own mind, anticipate that that would have?

A. So for me just now that would be back to what we spoke about being that ROAG earlier, where the executive medical director would be leading, understanding those concerns and being able to both triangulate and inform the next steps. That's something we knew was not in place at that time.

Q. Then we go on to read that the board's position is that restrictions placed on Mr Eljamel's practice in 2013, which we just touched on:

".. were not adequate and decision-making was not sufficiently well documented. The level of supervision

decided upon was not proportionate to the concerns being raised at the time and once implemented was not monitored effectively. During the period of Mr Eljamel's employment, there was an absence of an advanced process of professional governance from concerns being raised to their being acted upon, and in ensuring clear documentation of decisions made."

It goes on to say that there is now a process in place through the ROAG group that we have touched on. So there's a number of different aspects to this. In what way does the board accept that the restrictions placed on Mr Eljamel's practice in 2013 were not adequate?

A. The restrictions -- so I completely accept that they were not adequate, I take that position as the board and I think that Dr Cotton will be best placed to talk through the professional observation of that.

Q. Okay, but there should have been a higher level of restriction placed on what he was allowed to do and what he wasn't allowed to do?

A. Yes, yes.

Q. And also another aspect of this, which we'll come back to because it's a very important theme, is the decision-making was not sufficiently well-documented. So does that relate to the decision-making around the

level of restrictions?

A. Yes.

Q. Rather than it being a more wide-ranging comment? I think in that context it does relate to restrictions?

A. In that context it relates to that, yes.

Q. So you accept that the restrictions placed on Mr Eljamel's practice in 2013 were not adequate and they weren't strong enough, yes?

A. Yes.

Q. But when this was being looked at in 2023, which I think informs your position now, your position is that the decision-making around that was not sufficiently documented?

A. Yes.

Q. So how do you know restrictions placed on his practice in 2013 were not adequate?

A. In terms of fully accepting the findings in relation to the due diligence review and the advice and assessment that I have been given.

Q. Okay. So it also says that the level of supervision decided upon was not proportionate to concerns. Now, again, that would tend to suggest that there would -- there should have been a higher level of supervision put in place, yes?

A. Yes.

Q. And what do you know of the concerns that were raised at that time, so in 2013 when these decisions were being taken, to understand the level to which the supervision needed to be proportionate?

A. Again, I would take advice from the executive medical director in relation to supervision being placed on doctors.

Q. Okay, and what appears to be a more general statement follows, which is:

"During the period of Mr Eljamel's employment, there was an absence of an advanced process of professional governance from concerns being raised to their being acted upon."

Now that would tend to suggest that the absence of an advanced process existed throughout the period of his employment; is that correct? I think you've already accepted that?

A. Yes.

Q. And there was also, over that period, an absence it would appear of ensuring that clear documentation was put in place of decisions made?

A. Yes.

Q. Could I just pause on the documentation point because this is an area of some difficulty, as I know you understand. It is important that clear records are kept

within a health board, isn't that right?

A. Yes.

Q. And that doesn't just -- that applies to patient medical records, doesn't it?

A. Yes.

Q. But it also applies, as I think this context relates to, to what one might describe as administrative records?

A. Yes.

Q. Because there are lots of reasons for that but they relate, to an extent, to the accountability that you talked about earlier, doesn't it?

A. Yes.

Q. Because it's important, where decisions are made, that there is clarity at the time around what decision was taken?

A. Yes.

Q. But also around why decisions were taken, yes?

A. Yes.

Q. So that ultimately any of the bodies to whom you are responsible, which I think you said were the board and the government and the public in your area, if they wanted to know what decisions had been made and how, and by whom, this documentation should exist to enable them to find that out?

A. Yes.

Q. And so if a patient group were attempting to try to find out what had happened that might have had a bearing on what they perceived to be a bad clinical outcome for them, they should be able to come to a health board and be given documentation that tells them the answer to that?
A. Yes.
Q. And they shouldn't have to engage the support of a member of parliament to help them to do that?
A. Agreed.
Q. They shouldn't have to resort to statutory systems of document recovery that effectively will force the board to give them the information they need?
A. Yeah, so there would be different mechanisms by which different types of information can be requested, whether that be subject access requests or Freedom of Information requests. They are processes that are standardised that are in place which actually gives exactly what you're talking about, it gives a really clear: when was this asked for, what happened and what response was given back. So I guess there are levels of process that are in place that would be followed but I would expect us to be following the processes and I would be expecting us to give patients information that they require regarding themselves.

Q. And to be able to give them that information, I accept whatever the appropriate level of request is --
A. Yeah.
Q. -- then that would have to exist and be clear and in writing?
A. Yes. Yes.
Q. Could we go, please, to paragraph 61 of this document which is at page 17. It says here that:
"NHS Tayside remains sincerely sorry for the distress experienced by parents of Mr Eljamel. It is acknowledged that NHS Tayside failed to put in place sufficient measures to safeguard patients once concerns were raised about Mr Eljamel and this placed the safety and wellbeing of patients at risk."
In this regard it's important, isn't it, when boards or public authorities give apologies that they are meant; is that correct?
A. 100%, yeah.
Q. And that they are clear as to what they cover?
A. Yes.
Q. Can you tell us what it is that you were trying to convey when this apology was no doubt instructed to be put forward to the Inquiry?
A. Yeah, so it probably covers a range of the bullet points that we've already just discussed there, that there have

been failings identified over a period of time that were not acted on and I -- and those failings have caused distress. I've had engagement directly with patients and understand the level of trauma that this has caused for people. So that apology covers the fact that we accept the full findings that we've outlined within this opening statement.
Q. So obviously there's an apology and there's sincerity around that with regard to what the outcomes have been for patients, the distress and their various consequences. But I think does the apology attempt to try to say that this was something for which NHS Tayside was partially responsible --
A. Yes.
Q. -- because it failed to have in place sufficient measures to safeguard their well-being?
A. Absolutely accept that there was failings within NHS Tayside over this period.
Q. And those failings are the sorts of things that we've discussed including the absence of a proper, professional and clinical governance system, yes?
A. Yes.
Q. Over the entirety of Mr Eljamel's employment?
A. Yes.
Q. And a failure to triangulate different systems of

detection of poor practice, again over his whole employment?
A. Yes.
Q. Thank you. One of the things that one sees frequently within the documentation, the policy documentation that has been provided by NHS Tayside, is the assertion that it is a learning organisation. What is meant by that?
A. So being a learning organisation we recognise that whilst things should not happen, things do happen. And what we would -- I would expect is that we adequately investigate those things, we take the learning from those and we make sure that they're embedded to seek to ensure that that does not happen again.
Q. Is that just an assertion or does that actually happen?
A. That is absolutely what we would be seeking to deliver. It's a core -- fundamental, I believe, to how NHS organisations and boards should be operating that when something has happened we take learning from it and we embed it.
Q. So it's an aspiration?
A. No, I believe it is how we seek to practice. Whether we always get that fully correct, there are times when things happen again and they should not, but there are also times when we're able to take action and fully embed those. So I don't think it is fully just

an aspiration but I think there are -- and there continues to be, in any learning organisation, further strengthening that can continue to be delivered to make sure that things do not repeat themselves.

Q. So just to take an example. One could go on any of these areas but you talked about the failures, the documentation suggests there were failures in relation to properly documenting the decisions that were made at a governance level relating to Mr Eljamel. I think that's accepted?

A. Yes.

Q. And that there were various reviews, including the due diligence review which were undertaken which sought to try, in part, to learn from that and make things better?

A. Yes.

Q. And the ultimate objective of that would be to be able, as you've said, to provide clear written documentation of what had been going on to patients or others that had a right to know?

A. Yes.

Q. Is it the case, Ms Connor, that the recent history even under your tenure of failings relating to documents indicate that it's learned absolutely nothing from that?

A. Would you like -- I would welcome just understanding clarity of what it is you mean?

Q. You need me to explain to you what failures there have been --

A. No, no, I'm just asking is there a specific failing that you are --

Q. Well, I'm kind of assuming that you're aware of the failings. If we were to go through them it may take some time but there have been, for example, multiple data breaches.

A. Yes.

Q. You're here today to talk about the destruction of logbooks relating to these very patients.

A. Yes.

Q. There are have been innumerable reports of patients being unable to access medical records or other administrative records relating to them. I could go on.

A. No, no. Thank you for clarifying.

Q. All of these, I think, have arisen largely over your tenure and I'm just trying to link together the acceptance here which is understood about there being failings relating to the creation and retention of documentation which was not available at the time of the 2023 review and indeed seems to be accepted wasn't properly created at the time relating to decisions that were made. Does the fact that these problems persist in such frequency suggest that the board has in fact,

contrary to its aspiration, not learned in this regard?

A. There's an absolute commitment from NHS Tayside board to ensure that we have very strong information governance systems in place. Patients and the public should absolutely expect from us that we are keeping their information safe and that we're able to provide that information. As such, the board has placed such gravity on it that it's set in as a corporate objective for this year and there has been a review of wider learning that this means for information governance within the organisation. A further action plan that has been put in place -- I don't know whether this will be covered later or you want me to expand now, but I will being a learning organisation means that you are continuing to seek to learn and when things go wrong continue to learn those, be open about them, be transparent about them and seek to make the improvements and embed that.

Q. Okay, thank you. Could I just go to page 6 of the document, please. There's another important aspect of the opening statement that I'd like to ask you about which very much impinges upon areas that we're interested in. Down at the bottom, the last paragraph, "communication with patients". It says there that -- this is again, going back to -- going back to the section where there's an explanation

being given as to the outcome of the 2023 due diligence report and what the NHS Tayside accepts of that. It says:

"Communication with patients affected by Mr Eljamel's practice.

"The communication with patients throughout the process was of variable quality, fragmented, and generally poor. There had been no central coordination to ensure a truly person-centred approach. Where concerns were raised by patients, the issue was managed through a small subset of the Acute Management Team. There was a lack of visibility within NHS Tayside, no governance routes to assure and scrutinise and no indications of reporting of improvement through action plans." (As read)

Now, I was just interested to understand that where it says the communication was poor "throughout this process", again, as I've asked you before, what time period does that relate to?

A. I think it relates to the full tenure.

Q. Full tenure of Mr Eljamel?

A. Yes.

Q. As we said before. So just as well because again, communication is a very important theme in this Inquiry and it is important to understand which aspect of

communication we're talking about because when you deal with a complex organisation like the one you lead there are lots of different communications streams and I'm sure you'd understand, you'd accept that they're all very important. So are we talking here about the communication by Mr Eljamel himself or are we talking about a corporate level communication, if I could put it that way?

A. I think that -- I think there has been failings in corporate level communication. I also think other parts of the document that we've discussed today covers concerns about Mr Eljamel's failings and communications, so I think they're both. But here, I think we are talking about the organisational response to communication.

Q. Right, but it is -- based on what you've said I think do you accept that Mr Eljamel's communication was of variable quality, fragmented and generally poor?

A. Yes. I accept the concerns that we covered earlier regarding that, yeah.

Q. And as to the corporate response, if you like and the corporate responsibility, does this statement mean that -- does it cover communication by the board of what it knew about Mr Eljamel's poor practice?

A. I think it covers -- it covers the response -- so by the

board, yes, it covers the response that we have given being able to ensure that we are engaging with patients and that they're being heard at the most appropriate level in the organisation and that feeds into the triangulation I think again earlier.

Q. Let me just try to tease this out because it is quite complicated. I'm just trying to understand which aspects of the communication you're accepting were of varying quality, fragmented and generally poor. We've covered Mr Eljamel, his communication with patients. What you're talking about there is the communication in response to complaints being raised, so for example whether they were handled properly, whether people knew what stage they were at. Is it being accepted that aspect is fragmented and poor?

A. Yes, yes.

Q. There's a slightly different aspect of communication that I'm trying to speculate as to whether that might be included within this which is you mentioned earlier that there was a poor triangulation of information that was available within different systems about poor practice on Mr Eljamel's part and I think you've said that that existed throughout his career?

A. Mm-hmm.

Q. Is that correct?

A. Yes.

Q. I'm interested to know whether this acceptance of poor communication relates to an acceptance that the board did not adequately communicate to patients about what it knew of Mr Eljamel's poor practice?

A. Yes.

Q. Yes, that might be a feature of the lack of triangulation perhaps, is that right?

A. I think that could be a feature of triangulation but it also could be a feature of escalation.

Q. I see, yes. It -- the fact is that that information communication was not communicated adequately?

A. Yes.

Q. But you are then trying to help us with the reason as to perhaps why that happened, which I think this is saying here is because communication with patients about Mr Eljamel happened in this small subset of an acute team?

A. Yes, and some of the key actions that were therefore taken was the establishment of the patient liaison response team to make sure that we were able to -- so one of the outcomes there was to recognise a gap in terms of people's concerns, that ability to recognise when more than one person has raised a concern and to draw all of that together, which I think also feeds into

the triangulation.

Q. Yes, thank you. And just on that patient liaison response team, that was something I was going to ask you about more generally but you've touched on it a few times. I was just quite keen to note, it's described in the statement, we don't need to go to the passage, it says:

"Patients with long-running concerns have a single point of contact to build improved relationships and understanding of concerns to achieve a more consistent and person-centred approach." (As read)

This is one of the mechanisms that the board has instituted, as I understand it, to try to deal with the problems it accepted existed before, is that right?

A. Yes. Yes.

Q. We weren't really aware of the precise workings of that team, though I had heard of it so I was interested to explore with you, is that a response team that just exists for the Eljamel patients or does it exist for any patient?

A. No, they have absolutely supported people beyond Eljamel. It was established with this key purpose in mind but what we have in place is a complaints process which will work for a number of people and we can either deal with the complaints informally or we can deal with

them formally but then there are a level of concern by which we have a team that is able to support, particularly if things will be over a period of time, to make sure there is continuity into the organisation, taking a trauma-informed approach with people.

Q. So I could see how that would definitely apply to the Eljamel patients --

A. Yes.

Q. -- who are in an identified group, if you like. Indeed perhaps a number of different groups group themselves together. So they all come together and say: we are the Eljamel patients, we would like to speak to a single point of contact, and they now have that; is that right?

A. Yes.

Q. But as to other patients who may also benefit from this single point of contact because of the difficulties in accessing information that they need elsewhere, who can access it? Can any patient in NHS Tayside access it, or is it only for particular groups like the Eljamel group, for example?

A. Yes. So we would go through our normal complaint processes in terms of informal and formal complaints. I am aware there are other patients beyond Eljamel that have also sought and received support from this team.

Q. Okay. Thank you. I think there are perhaps details of

how that works in other places that we can pick up with other people but that's very helpful general context.

Could I go, in this document now, to page 1, paragraph 2. This is again the same document but just earlier, the opening paragraphs. It says here that:

"NHS Tayside recognises the importance of this Inquiry for many patients of Mr Eljamel and their families. It understands that the Inquiry will be a difficult time for many people. NHS Tayside wishes to extend its sincerest apologies to all patients who have suffered because of the treatment they received from Mr Eljamel."

One of the things that frankly -- well, this Inquiry, but to be perfectly honest with you, Ms Connor, this moment offers is an opportunity, is an opportunity for clarity around what it is that NHS Tayside apologises for. You've accepted that apologies need to be sincere and they need to be meant and need to be clear what they cover. So rather than probing the particular wording here I wonder, in light of the testimony that you've given about things that are accepted by NHS Tayside, whether you might like to explain what it is that the board would like to apologise for?

A. Yes. So the board fully accepts that there have been failings. Fully, we have covered within the opening

statement a range of those failings. We've also covered, I think in the discussion that we've had here just now, that that extends beyond those individual failings. It also covers in relation to communication. There is also recognising the impact of this on people and the distress, as you say, and the trauma that people have experienced we're deeply sorry for. I also recognise, and we covered it within our opening statement, that that is not purely a historic thing and I am personally sorry for the impact of the logbooks on patients, recognising that should not have happened and recognising that it did.

Q. And I assume also, given what you've accepted earlier, that the apology would cover the accepted failings of the systems within NHS Tayside to pick up poor practice on behalf of Mr Eljamel over the entirety of his career?

A. Yes.

Q. Thank you. Another area that I'd like to cover with you relates to an aspect again that comes up, the starting point I think is -- it says at paragraph 4, where it says:

"NHS Tayside knows that it failed to react appropriately and acted at an adequate pace when there were concerns raised at Mr Eljamel's clinical practice." (As read)

I think we've covered that:

"Again, in this regard, it let down its patients. NHS Tayside understands that patient trust and confidence has been eroded because of the actions of Mr Eljamel and its own failures to ensure its systems of oversight and supervision of Mr Eljamel were adequate." (As read)

The aspect of that that I'd just like to pick up by extension to what we've just discussed already is the importance of recognising -- and I ask whether you recognise this -- that it's not only the failings of Mr Eljamel and the systems at the time, if I can put it that way, but the possibility that further failings can, in light of that context, have a significant compounding and exacerbating effect on the outcome?

A. Yes.

Q. Do you recognise that?

A. I do, I accept that.

Q. And is it accepted therefore that the failings that have gone on and are ongoing, which you've accepted on behalf of NHS Tayside, have compounded and exacerbated distress and poor outcomes for patients?

A. I accept that. I have met directly with patients and they have explained to me directly the impact of trauma including the most recent logbook incident and there is

no doubt in my mind that that has eroded trust and had a significant impact on patients for which I am deeply sorry.
Q. And the other aspect, which I think you mentioned there but is certainly mentioned in the statement which is important I think is the fact that this sequence of events, leading even up to today, has eroded the trust of patients in NHS Tayside. Do you accept that?
A. I accept that.
Q. It's important, not just as a lofty principle but for real practical reasons for many of these patients, that their trust in NHS Tayside is maintained?
A. Yes.
Q. And would you accept that it's particularly important because a lot of them continue to rely on NHS Tayside and its services for care because they suffer from various physical and psychological problems in connection with which they're entitled to expect to receive care?
A. Absolutely and I would want -- I absolutely do accept that and I would want to build confidence with patients. Part of that I hope began in terms of the discussions we've had directly, both with a group of patients but I have also had subsequent individual conversations with patients and seek genuinely to be accessible and open

and willing to have conversations.
Q. That's appreciated. Thank you for clarifying that. Because where trust has been eroded -- in a general sense but in the specific circumstances of these patients as I've outlined, where trust has been eroded it must be rebuilt?
A. Yes.
Q. And do you consider this process and your attendance here today to be part of that process?
A. Yes.
Q. Thank you. You have come along also today and helped clarify that you provided some helpful evidence in the board's written statement about the way in which the board has handled the situation of the destruction of the logbooks. I'd like to ask you some questions about that. You've provided quite a lot of information about what has happened.
A. Yes.
Q. But also what has been done to try to deal with what has happened, which has been helpful.
A. Yes.
Q. The starting point I'd like to take to this is that a health board is entitled to operate its own systems of document destruction or handling in accordance with broader government guidance and its own policies, is

that right?
A. Yes.
Q. But what causes a particular issue with relation to these logbooks is really two things which are related. One is that they have been destroyed in contravention of an order not to destroy them by the Inquiry; is that accepted that that happened?
A. Yes. That is accepted, yes.
Q. Secondly, the reason that is connected is it has eroded significantly any lingering trust that patients have in NHS Tayside because a major part of the trust that they retained related to the ability of this Inquiry to get to the bottom of what had happened which is something that has been, perhaps to an extent, undermined by this action?
A. Yes.
Q. And therefore this is, I think -- would you accept this is something that the NHS Tayside board has taken extremely seriously?
A. Absolutely.
Q. And you have instigated a number of processes to try to find out what happened?
A. Yes.
Q. But also to try to work out how things might work better in the future?

A. Yes.
Q. And those processes I think have been motivated both by a desire to provide an explanation to the Inquiry?
A. Also our patients, absolutely.
Q. That would have been my next question.
A. Yes.
Q. But to the Inquiry?
A. Yes, absolutely.
Q. And to patients?
A. Yes.
Q. And ultimately to try to restore trust?
A. Yes.
Q. And faith that such things won't happen again in the future?
A. Yes.
Q. You have instigated a lot of processes, as I've said and we'll look at some of them in more detail in a moment, but would it be fair to say that you haven't really involved the Inquiry in the processes that you've instigated?
A. In terms of the -- the Inquiry were notified of this ahead of -- or as a part of the opening submissions. In terms of the sharing with the Inquiry --
Q. There's a point that's actually in your favour. In fact we were notified about it before that through your

recognised legal representatives.
A. Yeah, yeah.
Q. But the public announcement I understand was through your instruction.
A. Yeah.
Q. So to be fair, you did actually tell us before that but carry on, sorry.
A. No. But also in terms of when the independent review has published that has been -- that was shared with the Inquiry pretty much as soon as it had gone through the board processes. So in terms of making sure that the Inquiry was aware, both of that investigation outcomes and those next steps, that has been shared with the Inquiry.
Q. But you would have understood, would you not, that the Inquiry itself would be undertaking an investigation of what had happened?
A. Yes, but the board and myself as accountable officer required also, from the point of view of board's governance, to ensure that we were fully able to review and understand and take forward that learning and to offer that helpfully to the Inquiry.
Q. And did you tell us that you were going to do that?
A. You were notified, as you said, through the Inquiry that this had happened. I think we've been really clear

since this became more publicly available at that time that we were going to undertake a full investigation into that.
Q. Did you tell us you were going to instruct an independent review?
A. I don't know if I -- I don't know if we communicated directly with the Inquiry on that specific matter but that was something that we were very clear of publicly. Apologies if we should have notified the Inquiry directly of that.
Q. Because it might be suggested, it might be suggested, that by undertaking your own reviews you sought to usurp the Chair of the Inquiry's right to reach conclusions about what had happened himself?
A. Absolutely not. I consider that this independent Inquiry will be helpful to understand the board's findings of which the Inquiry will identify their own position on having considered everything at the hearing totality.
Q. That was not the intention --
A. Absolutely not.
Q. Because there is something of a pattern emerging from the evidence that this Inquiry has heard that when something goes wrong the instinct of NHS Tayside is to try to investigate it itself and not involve external

agencies. Would that be a fair characterisation or not?
A. No, I mean I think that if we look at the incident in relation to the logbook that the first stage was fact-finding. It was entirely reasonable that there was an internal investigation into that. I did not accept the findings of that investigation and then that has led on to a wider, more independent investigation.
I think -- I felt that was really important for a range of reasons. One, being able to be of entirely objective with it. But two, going back to what you said earlier around a trust and confidence within NHS Tayside and my hope was that by having an independent review of this we would be able to evidence that we were not marking our own homework, so to speak. We had somebody else able to have a look at this and that those findings would be generated independently.
Q. But you did initially conduct an internal review?
A. Yes, yes I -- I consider that appropriate, yes.
Q. And in fact the independent report finds several failings in the internal review?
A. Yes, and that's why we did not accept the full findings of the internal review and it extended to a wider independent review.
Q. But you accept that the Chair of the Inquiry is fully entitled to undertaken an investigation into this himself?

A. Absolutely, yes.
Q. And he will make findings, if he wishes to do so, on what happened?
A. Yes.
Q. And who is responsible?
A. Absolutely.
Q. Thank you. When you provided material to us related to this, were you keen that the names of individuals who had been involved internally would not become public?
A. We applied the same principles that we would with data information regarding junior staff. The reason for that is that I am, as accountable officer, accepting that this was systemic and the independent review found no individual failing of individual people. So I was keen that our frontline, junior staff were not included but all of our staff at a more senior level are included.
Q. So you wanted -- your starting point was that the internal investigation had found that no individual had been in any way to blame for anything that had gone wrong?
A. No, apologies if that's what I have said. What I meant was in terms of the independent review, which is what -- is that what we're talking about just now --
Q. No, the internal review.
A. Apologies, I thought you said independent review.

Please ask that question again. I answered it from the point of view of independent.

Q. The starting point for your approach to your request that names would not be made public of individuals was I think, on the basis of your evidence, your assumption that the finding of your internal review was correct that no individual was in any way to blame?

A. Yeah, the outcome absolutely of the internal review found there was no conduct or capability or further actions for any named individual.

Q. And I think what you told us that is one of the reasons why you suggested that there would be no need for individual's names to be part of the publication of any of the material that the Inquiry was looking at?

A. Yes.

Q. But of course the Inquiry could take a different view, couldn't it?

A. Yes, it could.

Q. So the Inquiry does need to look at the individuals' actions and try to work out whether they may not be wholly to blame, because I know you accept some responsibility, but they may be partly to blame?

A. I entirely accept that the Inquiry would seek so do that. I guess there was something about our staff, some of whom are very junior and working in the front line

and we are recognising that -- we're accepting accountability for this, but I entirely accept the Inquiry's right to be able to decide.

Q. Okay. What are theatre logbooks?

A. Theatre logbooks are a record that carries key information regarding operations that occur in a theatre.

Q. You've provided us in this statement and other documentation with a sort of list, if you like, of various information that might be contained within a theatre logbook. Could we go to paragraph 114.35 of NHST-04944. Sorry, a slight technological hitch. (Pause). So this is part of the -- to go back to this from the beginning, it's part of the NHS Tayside's statement and this is amongst the paragraphs that you wrote, yes?

A. Yes.

Q. So it's one of the sections where you're explaining documents that may be limited in what you have and this is the logbook section, yes?

A. Yes.

Q. So you're telling us there the sorts of -- the operation details that were captured within the logbook and you give us a list. And then the next paragraph please, Rory. It says:

"Through work led by NHS Tayside's Health Records and Theatres Departments, it has been determined that much of the information normally detailed in theatre logbooks is also normally contained in operation notes within patient records. It is understood, therefore, that much of the information lost when the theatre logbooks were destroyed should be available within operation notes. However, not all relevant patient records remain in existence."

So I think the issue that people may have with that statement is the word "normally". Because in the particular circumstances of the Eljamel patients they have been told -- many of them, I understand, have been told by NHS Tayside that some or all of their medical records, including operation notes no longer exist?

A. Yes.

Q. So whether it might normally be the case isn't really relevant, is it?

A. No, I accept -- I absolutely accept that for patients some information here will have been lost and that is not acceptable.

Q. Yes, and in fact it might go further than that because it might in fact be the case that parts of these logbooks which would have been crucial in those circumstances in ascertaining information about the

nature and the circumstances of their operations, which for many of them is precisely the reason why they're here; is that accepted?

A. Yes. Yes. Yes.

THE CHAIR: Sorry, Mr Dawson, could I just clarify then what exactly was the point of this paragraph?

A. So at the time -- there's a further piece of work that I would be very happy to provide to the Inquiry which I believe the Inquiry has been notified is ongoing is notes reconciliation. So what we're able to say here is give the broad response to how that's going to be but recognising, in terms of the relevant records not being in existence, that would be through destruction in line with our retention guidance. But what we have done is a piece of work to do notes reconciliation.

So phase one of that was to identify the logbooks that we hold and assess what patient procedures are documented in there and the phase two is to assess the possibility of reconciliation with the information that may have been in the logbooks from the other records that we hold for patients. So the piece of work that we are trying to do is to -- well, not trying to do, the piece of work that we are doing that we will provide to the Inquiry once complete has been able to identify who -- and we'll be able to provide this information to

patients as well -- who have got all of their procedures documented, who have got some but not all of the information present and where is there no data. And we'll be able to provide that level of granularity which I believe will be helpful to both patients but also helpful to the Inquiry.

MR DAWSON: I was going to come to that reconciliation exercise later about which we heard relatively recently but just while we're on the subject, I'm struggling slightly with its concept. Because if you have no operation record in your medical records and if the theatre log has been destroyed, how can we know what detail has been lost by the former as opposed to the latter?

A. Yeah, so what we had is a list of roughly -- of procedures of roughly 3,800 procedures from operation notes. What we were able to do is go through all of that information and be able to say, for the logbooks that we do still have, what information is within there. For the logbooks that we don't, be able to have a look at what's contained within the records and for that list that you just showed me, what of that information do we have but in some other means.

Q. So that might show, as I understand it, you might be able to say: let's look at one of the logbooks we do

have. In that, we can see it has this sort of information. It tells you about the operation and some of the things that you've listed in the statement. And then you could look at the notes and you could say: oh look, all of that stuff is already in the note so it didn't look anything has been lost. That might be a hypothetical situation that might occur, yes?

A. So I guess the motivation for that was to not accept a broad position that we may or may not have it, to recognise how important this is for our patients in terms of their story and to make sure that we had gone through and be able to provide the information that we do have to patients.

Q. Okay, could we just go back to the question. I understand the motivation behind what you're doing, I'm just wondering whether it's actually going to help. That's what I'm trying to get to.

A. Okay.

Q. So I'm hypothesising with you a situation, a situation where you look at the other entries in the logbooks that we do have and you say: this contains this sort of information and then you go to the medical records and go: oh, good news, all that sort of information is already there, so that's good, we haven't lost anything. Could that be a hypothetical case that could happen?

A. I hope for some patients we're able --

Q. Yes, that would be a good news story, wouldn't it, that we don't appear to have lost anything? What I'm focusing more is on the type of patient that I have described, who don't have the record to compare with. What would you say to them about what has been lost, not in the generality but in the specifics of their case?

A. I would be saying: I'm sorry and we don't know precisely --

Q. Because there's a very particular case that I can put to you because we heard evidence about it yesterday and that's -- evidence was given by Ms Liz Smith on behalf of a patient called Mr Pat Kelly and what she told us this was an area which had concerned him for many years and there were particular aspects of his records which he had, for particular reasons, an interest in which you had never been able to find. And those particular pieces of information related to concerns that he had a basis for developing over the years about what precisely had happened in his surgery and what he wanted to know was principally, amongst many other things I'm sure, was Mr Eljamel actually at his surgery, and who else was at the surgery? Now, there were a number of reasons for that. It was to do with the fact that he suspected that Mr Eljamel may not, in fact, have carried out the

surgery at all and he also suspected that someone else may have done it but he didn't know who that was and he was also interested who might be a witness what happened. They all seem to me to be reasonable questions but as I understand it the reason why he was interested in these matters is because none of those pieces of information are in his medical records.

So if I could take that example, if that's easy enough to follow, if there were a theatre log relating to a patient like Mr Kelly the theatre log would contain the information he wanted, wouldn't it?

A. Yes, if it had been entered, yes.

Q. Yes, because that's the sort of information -- I mean, I have looked at the logs that you've provided and I think one thing that it always does is it tells you who was the surgeon that did the surgery and alongside that, who else was present. So that's precisely the information that Mr Kelly, and as I understand it numerous other patients, want to get. And the reason they want to get it, if they had been able to get it through their own medical records, frankly we might not be here but the reality is that that's exactly the sort of information that Mr Kelly would have about his particular case in his theatre log, yes?

A. Yes.

Q. But he is not going to get now because that theatre log has been destroyed?
A. Yes.
Q. And given the broad context, which I am assured by my colleagues is the position, that that sort of situation applies to a number of patients, this is an absolutely disastrous consequence for the legitimate desire of these patients to get to the bottom of what happened to them?
A. I absolutely accept that. I accept how serious this is and the gravity of this impact for individuals.
Q. Another aspect, the aspiration here I think is that the exercise that you've instructed, the reconciliation exercise, will go some way towards dealing with the current situation and working out, well, we haven't perhaps lost as much information as we thought. But what we will always have lost is a particular type of evidence. My understanding, and tell me if your understanding is different, is a theatre log is compiled contemporaneously to the operation?
A. Yes.
Q. It's compiled, I think by necessity, by people who aren't scrubbed up and part of the operation?
A. Yeah, there'll be a team that's there that all have different roles in the room, yes.

Q. Absolutely, but there will be a surgeon who will obviously be scrubbed up, as they say, so in the sterile field?
A. Yes.
Q. There will be other perhaps junior surgeons, there might be a scrub nurse, all of whom are participating in the surgery, yes?
A. Yes.
Q. And somebody else would be noting down the salient features that go into the theatre log, yes?
A. Yes.
Q. There aren't really necessarily any clear rules, I think, around who ultimately puts the information about the surgery into the surgical note or the patient notes. It could be a variety of different people, is that right?
A. I am unclear of that level of detail of what happened in a theatre, but I would imagine it can be.
Q. So if that is the case, so for example I would imagine in many cases the surgeon himself will write a note after it or he might delegate it to a junior to say: could you write up the notes of that surgery for me. And whoever has put it in would sign it; is that the usual practice?
A. I am not close enough to know exactly the clinical practice that takes place within a theatre, after a theatre, but that is something that one of our clinical leads will be able to answer.

Q. Would you be prepared to accept --
A. Absolutely.
Q. -- as a hypothesis that that does happen? It doesn't seem out of the ordinary?
A. I am prepared to accept the different -- yes.
Q. So if that was a standard -- on the hypothesis that is a standard practice --
THE CHAIR: It might be thought to be implicit in the name itself, "a logbook" is something you would log as a contemporaneous record.
MR DAWSON: Well, what I'm trying to get at, sir, is something slightly different from that. What I'm suggesting is it is probable, if not certain, that the note in the log will have been prepared at a different time to the note put in the patient records?
A. Yes.
Q. It will have been prepared more contemporaneously to the operation than the note that will necessarily be written at a certain remove because people will have to come out of the theatre and go and write it up, yes?
A. Yes.
Q. And it is likely, at least on the hypothesis I have presented, highly likely that a different person will have compiled the theatre log note to the note which is contained within the medical record?
A. I accept that as a hypothesis. I am not close enough to know who signs it off.
Q. Is it not logical that if it's being prepared contemporaneously to the surgery it can't be prepared by the surgeon?
A. Yes, I am accepting that.
Q. So therefore even -- in any case it appears that we must have lost a contemporaneous source of evidence that would have been useful?
A. Yes.
Q. A potentially corroboratory source of evidence from a different individual that would have been useful?
A. Yes.
Q. And in some cases the only evidence of what happened in their surgery?
A. Yes.
Q. Thank you. There's one other aspect of this which I feel I have to draw to your attention which is related to the Independent Clinical Review. At the time when the occasions you discussed at the opening statement hearing at which the public airing of this issue was addressed, we received correspondence from

Professor Wigmore who is in charge, as you know, of the Independent Clinical Review, setting out his concerns about the consequences. And he actually told us a little bit about what theatre logs are because they're not in any way particular to Tayside or particular to neurosurgery, they're very commonly used; is that your understanding?

A. Yes.

Q. What he has brought to my attention, which I think is important to raise with you, is that he considers the absence of this material may be a significant detriment to the ambitions of his process in being able to answer the legitimate clinical questions being posed by patients. Were you aware of that?

A. I'm certainly aware that if we are unable to provide the information, that patients would have known as their only source in there and unable to provide that, that has an absolutely detrimental impact for patients and I can accept that has an absolute impact on the Independent Clinical Review.

Q. Because, to be perfectly frank, it has been very much at the forefront of the Inquiry's and Professor Wigmore's mind from the start of the conception of the two processes that we knew from the start that there were missing records.

A. Yeah.

Q. And that it was important as much evidence as could be assembled reasonably to solve the important question of what actually happened should be put together. That is why, for example, it was very important that patients be able to put in an applicant statement detailing what their perspective on things was. But in this area this is precisely the sort of thing where patients like Mr Kelly don't know what happened, do you understand that?

A. I do.

Q. And therefore the loss of this evidence to both processes, in cases like Mr Kelly's and as I understand it many others, is extremely serious?

A. I absolutely accept the seriousness. My sincere apology to the Inquiry and to the Independent Clinical Review as well as the apology that I provide to patients.

Q. We heard yesterday in Ms Smith's evidence, in a section where she was detailing the various stages that had been gone through in getting to the point of trying to find answers then build it up through different levels and eventually getting to a public inquiry, that the absence of documents was an enormous part of why the campaign for a public inquiry carried on the way that it did and she explained that she had tried to persuade campaigners

not to jump straight to the public inquiry because I think she didn't think that would be very realistic but to go through various levels and process using the different mechanisms then ultimately she was persuaded, in around the middle of 2022, that it was time to put her support behind a public inquiry.

But she explained that throughout all of that process the absence of documents had been an integral part of why people, and many people, kept coming back to ask her questions which she thought she should take forward because it was the absence of when things had gone wrong clinically, when people asked for an explanation, the absence of documents was what had triggered their suspicion that something must be going on that people weren't prepared to tell them. Do you understand that concept?

A. I do.

Q. And do you understand that to be the background as to how we got to that point?

A. I understand there to be absolute concerns regarding, as you've outlined throughout this questioning, around people being able to understand access and that transparency.

Q. I think sometimes it might be thought that document management is the sort of administrative exercise that

doesn't play a very important, substantive role in any organisation. Is that the position of an NHS Tayside?

A. No.

Q. Is that the reason why things like the destruction of the logbooks happened?

A. The independent review found there was a range of failings that took place of which I own and accept. What we have in place is there is obviously the national code of practice regarding records management. That's not just a "good to have". There are statutory duties we hold as an organisation that we take very seriously and we have policies in place for delivery. Being able to ensure that every one of those policies are implemented across the organisation would be a challenge. So gaps in application, I guess, of policy and of that national practice can absolutely result in issues such as the logbooks going missing.

Q. But I think this is really the nub of it which is that might well happen in an organisation of that scale but surely it shouldn't happen in relation to this sort of situation --

A. Absolutely should not have happened.

Q. -- when document management issues, significant document management issues, were at the very core of why the public inquiry was announced in the first place?

A. Yes.
Q. So is it not self-evident that from day one of you arriving at NHS Tayside it should have been your highest priority to make sure that, in order to deal with what you accepted were the serious matters being addressed by this Inquiry, you made absolutely sure that special measures were taken to ensure that no Eljamel-related document could be destroyed under your watch?
A. Yes.
Q. I understand that the patient groups or certain groups of patients have called upon you to resign?
A. Yes.
Q. What is your position on that?
A. My position on that is that I am not intending to resign as a result of this. When this was brought to my attention I took both immediate -- and I have taken sustained actions to ensure that this was taken forward, that it was delivered and we have now got an absolutely robust framework in place for the delivery of this going forward which we are sharing across for further learning across other areas in Scotland. But I absolutely accept the accountability for this.
Q. You're accountable for this then?
A. I am accepting, as the accountable officer for the organisation, the accountability that I hold to ensure

that the systems, processes, policies and structures are in place and embedded. I was not responsible for the individual actions that took place nor was I directly involved in the destruction of the logbooks but that does not negate the responsibility that I hold and discharge through my team to ensure that the logbooks were and other records are kept safe.
Q. So you're nominally accountable but you're not actually accountable?
A. I am accountable as the accountable officer for NHS Tayside.
Q. Thank you. Sir, I have a number of other questions for Ms Connor relating to the logbook issue. It may be, however, that the details of what I feel I would need to go into would be assisted if we broke early for a lunch break which may have an overall benefit as some of the answers that have been given already will cover, I think, some of the areas that I intended to cover in some more detail. So if that would be an appropriate moment, in light of those considerations, we might perhaps break for lunch now?
THE CHAIR: Break for the usual 45 minutes would take us to 1.15, if that would --
MR DAWSON: That would be very helpful. Thank you, sir.
THE CHAIR: Thank you. Ms Connor, we're going to break now

for lunch. Can I just mention something that I will generally do over the lunch break for a witness still giving evidence, and I'm sure you understand the reasons for it, but to keep matters regular we ask that you don't discuss your evidence over the lunch break and we'll resume again at 1.15.
(12.31 pm)
(The short adjournment)
(1.21 pm)
THE CHAIR: Please have a seat. Thank you. Just before we resume can I just say something briefly. I recognise, of course, the strength of feeling generated by evidence of the kind that we are hearing but it is very important that the conditions are such that we hear the witness's best evidence and indeed that as a matter of fairness the evidence of all witnesses are listened to with consideration.
So can I ask for your help with that as I now invite Ms Connor to come back into the hearing suite.
Thank you, Ms Connor, just a reminder that you're still under oath and Mr Dawson will have some more questions for you.
MR DAWSON: I just noticed that somebody wasn't here but not essential for our interaction. So, I'd just like to ask you some questions. We were on the topic of the

logbooks in a general sense and you have sent us a lot of documentation about all of this and it's very helpful to help understand but I think it's important that we go through some element of the detail of it with which I know you're familiar just to give a clarification for people who are listening as to what appears to have gone on and the actions that have been taken by the board as a result.
Could I start, please, by looking at a document NHST-01485.
Could we go to the last page, please, which is page 4. Now quite often when we get documents from organisations there are chains of emails and they've been quite hard to follow through but they tend to work like this where you start from the back and have to work through to the front. This was some documentation that was sent in, in connection with the NHS Tayside statement and it appears to be an email which you can see there between Pamela Johnston and I think it's an Alison Dailly and it is dated 24 April 2023.
What it says is:
"Dear all, could you please provide assurance that all medical notes of patients who have had contact with Professor Eljamel have been retained and have not been destroyed or had sections of said notes removed?

Dr Johnston also requires assurance that these medical notes will continue to be held on retention until further notice due to the ongoing investigations pertaining to Professor Eljamel." (As read)

Now, I think this is not a document that was produced either in connection with the sections that you have completed nor was it a document -- it's a document which pre-dates your involvement, I think within NHS Tayside but I just wanted to point to it as part of the picture because it's dated April 2023 and it appears, as I understand it, to be someone from the medical director's office, in fact the medical director herself I think it may be, Dr Johnston, asking for the care to be taken in the retention of medical records because of ongoing investigations. Does that appear to be a correct context to --

A. I don't have that in front of me but, yes, I recognise what you're talking about and yes it does.

Q. Thank you. The reason I wanted to bring that up was whether that reference to medical records would not -- or records of patients would normally within Tayside be thought to include things like theatre logbooks or whether that would be a term of art that would mean something different?

A. I think, in fact in terms of the independent review what

was found was there confusion regarding terminology and confusion regarding responsibilities in relation to that. Without a patient record some interpreted to be the record that related to only that individual, whereas a logbook contains information across a range of people. However, we look back to both policy and the code of practice for Scotland it contains information that would make it relevant and I think -- and that's absolutely a point of reflection.

Q. Yes, okay. Understood. But in receipt of this do I take from what you're saying this would be understood to mean the patient's medical records, the sort of thing I'm picturing in a folder but may now exist in electronic form and that would exclude logbooks; is that correct?

A. Again, another finding from the review was that there was the health records and there was the responsibility that was held regarding logbooks which was held within theatres. So again that clear responsibility and who hold that responsibility for all information was one of the findings and one of the things we needed to address.

Q. Yes, this is important not just for this issue but the Inquiry's wider consideration of document management because as we've ascertained there was information related to patients and their operations within the

theatre log, correct?

A. Yes.

Q. But the theatre log contains multiple entries relating to multiple patients, yes?

A. Yes.

Q. And they are, I think from the documentation we've seen, stored, importantly, separately from what one might describe as an individual patient's records?

A. Yes.

Q. And in fact, rather than being stored in I presume the medical records department or something like that, they are stored within the office to the neurosurgical theatre; is that correct?

A. That's where they were stored, yes.

Q. Thank you for that. Could I then just take you through some aspects of the statement which you did write which helps us with the chronology as to what actually happened. The statement, please, at paragraph 114.26.

So just because we're not publishing this, I'm just going to read out aspects of this but really just to get the chronology. In that paragraph it says that:

"On 28 August 2025, a verbal request was received into NHS Tayside Health Records Department from Police Scotland Operation Stringent (the police investigation to Mr Eljamel), to seize theatre logbooks

containing information regarding the surgical practice of Mr Eljamel dating from May 1995 to November 2014. This was followed up by Police Scotland with a formal request in writing from Operation Stringent on 24 September 2025 ..."

And we've given that document reference number NHST-04671.

So what happened at that time was a request came in, in connection with the police investigation about the recovery of records. Is that right?

A. Yes.

Q. And one thing I just wanted to ask you about that, is there any, as far as you're aware significance to be attached to the fact that is dated from May 1995 because my understanding is that Mr Eljamel started working in October 1995?

A. I'm unable to answer that, sorry.

Q. Yes, it's the police who have asked for that so it may be that that's matter for them to answer?

A. Yes, apologies.

Q. Thank you, not at all. And effectively this triggered, as I understand it, an identification that there were a number of logbooks which were over eight years old held in the theatre suite pertaining to the theatre in which Mr Eljamel would usually operate, is that correct?

That's the next paragraph 114.27; is that right?
A. Yes.
Q. So what's the significance of the eight years?
A. The retention policy period for --
Q. So what we're looking at here is -- I mean obviously at this time when the request was received anything of this nature would be more than eight years old because Mr Eljamel stopped working in December 2013, is that right?
A. But the logbooks themselves may not be over eight years old because the logbook itself is not pertaining just to Mr Eljamel.
Q. Right, but it would have been necessary for the logbook to have continued up until 2018, which was eight years before the request, for it still to be have been retained?
A. Yes. So the logbooks were identified, went back to the 1960s and they should have been retained at that time for that period of time, yeah.
Q. So the logbooks as I understand it, because we have seen some, they cover various different time periods. It depends how many operations are covered in the period. Sometimes there's an awful lot of operations and they cover a relatively short period, sometimes the same number of pages, if you like, can cover a longer period

because there are less operations, is that right?
A. Yes.
Q. But in effect it was identified that there were logbooks relating to this request by the police?
A. Yes.
Q. At paragraph 114.28, it says:
"On attempting to locate these following the verbal request from Police Scotland on 28 August 2025, it was discovered these logbooks had been removed from their location on 28 July 2025 and added to the confidential waste stream to be destroyed."
So in trying to comply with the police request it turned out that in fact some of the logbooks had been destroyed on 28 July 2025?
A. Yes.
Q. As I understand it, I think you've already clarified for us, that these were held within, is it, an office which is the office for the theatre where Mr Eljamel typically did his operations historically?
A. The senior charge nurse's office adjacent to the theatre, yes.
Q. Right, so because of the fact, I think, that different times of surgery would go on in that theatre, it's not a neurosurgery office particularly but it's an office associated with the theatre itself?

A. Yes.
Q. Okay, thank you. Can I just ask whether you can help me with a particular point of detail brought to our attention by Professor Wigmore. He informed us that it's normal for surgeons to carry out operations within particular theatres where they are routine operations but that it can often be the case that in emergency situations they can carry out surgeries in whatever theatre happens to be available in the emergency situation. Is that a practice which you recognise as being one that would have been adopted in Mr Eljamel's time, as far as you understand it, or from your understanding of surgical practice now?
A. So what you describe to me makes sense but I think it would be the medical director who will be able to explain more how --
Q. The reason I asked the question, Ms Connor, is nothing particularly sinister, it is just that that fact raises the possibility that there could be documents like theatre logs held in similar situations relating to other theatres. Would it be something the board would be prepared to do to investigate whether these theatre logs might contain entries relating to Mr Eljamel in other places other than the office associated to the theatre which he regularly used?

A. One of the actions that I put in place was to address just that and we've called it "forensic walkabouts" but there's been a review in terms of the entirety of acute services and across corporate services and across our Health and Social Care partnerships to identify if there is any further information that could be relevant to this Inquiry or Mr Eljamel.
Q. Can you undertake that those searches will include those sorts of places in light of the suggestion I have made to you --
A. Yes.
Q. -- that he might have operated in different places?
A. It's used in every department within acute services.
Q. So that will cover every theatre?
A. Yes and beyond.
Q. That's very helpful, thank you, but to be fair it does seem natural that that's the place you would go because that would be the place, if there were such records in the theatre in which he tended to operate in his routine surgery, that would be the most likely place to find it?
A. Yes.
Q. So is that the thinking here?
A. Yes. Yes, that was the routine theatre that was used and as a result of the forensic walkabout there was no further information found within the organisation.

Q. Given the fact that the location of these ultimately destroyed documents was in an office which served a theatre in which he did most, if not all, of his operations, how difficult would it have been for NHS Tayside to issue a bespoke instruction to that office to seek to secure Eljamel-related documents?

A. That could and should have been done.

Q. Because of the association of that office with his work?

A. Yes. I think absolutely. On reflection there should have been more bespoke communications that took place to the areas that were of highest risk within the organisation.

Q. Because you said earlier, and this seems to be a fair comment, that these sorts of things sometimes go wrong across a large organisation?

A. Yes.

Q. But we're talking about here is a situation in which precisely the sort of place where you might have found Eljamel-related documents has been the place where they were and from which they were destroyed?

A. Yes, and the actions that were taken at the time were multiple. It was to a discussion with my executive team with an ask for them to discharge responsibilities for the areas of responsibility that they have. It was also to send the communication across the whole organisation

and it was also to make sure that we were focused on that. The independent review found though that that was not sufficient in terms of securing and providing the level of assurance and protection to records that should have been in place.

Q. The point I'm trying to get to, Ms Connor, is whether it would be fair, despite the generality of those systems and how they operate more generally, in these circumstances that a bespoke approach could have been taken to contact those who worked in the very places where Eljamel-related records were most likely to be found?

A. Yes, I absolutely accept that.

Q. Is that part of the work that you intend to carry out going forward?

A. Yes. So as a result of the independent review there were 15 recommendations. We've accepted all of those recommendations in full. What we now have put in place is called a "do not destroy compliance framework". It covers an end-to-end process in terms of delivery. It means there will be the appointment of a single executive lead. There will be a compliance group that is brought together to do an exact assessment of what should happen in the organisation when a DND is received. That framework seeks to support both communication and escalation arrangements. Its covers

the training for staff, it covers how senior management assurance will come in place and it covers our wider information governance around asset registers and knowing the information we have held. This has all been put together in terms of a very clear framework which covers our governance structures, how it's activated, communication and how it's monitored and assured. And that has been approved in the past month by our committee and board.

Q. Thank you for that. Am I correct in assuming that none of that existed before?

A. These are a direct result of the recommendations, these were found to be gaps and failings in our processes.

Q. Okay, thank you. And I think as you have accepted already, the documents were destroyed in contravention of the Inquiry's do not destroy notice. The document reference for that is ELJ-00534.

A. Yes.

Q. And at paragraph 114.30, if we could scroll down a little, in the statement. We're going back to the statement, paragraph 114.30. Thank you very much. It says:

"The destruction of some of the theatre logbooks was despite a DND Notice in place from The Eljamel Inquiry which had been received on around 11 October 2024. The

DND Notice had been shared with all Executive Directors on 18 October 2024 [document reference NHST-04506]. An all-staff communication was sent out on 8 November 2024 to the organisation ..."

THE CHAIR: Sorry, we appear to have lost it. (Pause).

MR DAWSON: Thank you. I'll go back to the beginning of that. 114.30 says:

""The destruction of some of the theatre logbooks was despite a DND Notice [do not destroy notice] in place from The Eljamel Inquiry which had been received on around 11 October 2024. The DND Notice had been shared with all Executive Directors on 18 October 2024 [document reference NHST-04506]. An all-staff communication was sent out on 8 November 2024 to the organisation regarding the Notice with instructions to comply [NHST-01592]. Thereafter, later in November and again in December 2024, the Notice was reiterated to key employees of NHS Tayside who it was thought may have relevant information ..."

And that's NHST-04495. This was the correspondence I think you referred to earlier as to how it had been sent around directors initially and then all staff that this was a notice which had been received which required to be complied with, is that right?

A. Yes.

Q. Was one of the findings of both of the internal and external reports that effectively the people who were involved in destroying this basically didn't read such communications?
A. Yes.
Q. And is it part of the system which you intend to implement that there will be a more targeted approach because, to be fair to busy medical professionals if they receive multiple emails of this nature a day, it might be entirely predictable that they won't be able to read them all?
A. Yes, I absolutely accept that. On taking up post, I followed the established processes of bringing it to my executive team with the expectation they would follow that through within their areas and also in terms of a wider staff communication. But it was indeed a finding and it is absolutely within our DND compliance framework which I'd be very happy to provide to the Inquiry so that you have a copy to see everything that that includes.
Q. Indeed, if we don't have that already, I think that would be very helpful to see that in terms of trying to understand what learning and what subsequent action has been taken.
A. Yes.

Q. And indeed, the process after that point is set out at paragraph 114.32, where it says:
"The DND notice was immediately re-shared on 9 September 2025, NHST-01697, with all members of staff across the organisation in a vital signs email communication." (As read)
What is a vital signs email communication?
A. So there's regular staff bulletins issued. A vital signs is a staff communication which is intended for all staff to read and it also comes with a notification on it asking that managers would print and display that within their departments as well.
Q. And you say, at 114.33, that:
"A high-level report was initially commissioned by the Chief Officer of Acute Services which outlined the background and assessment of the circumstances of the destruction of the logbooks and was provided to the NHS Tayside Eljamel oversight group [which you mentioned earlier] on 12 September 2025, NHST-04504, and discussed by the Chief Executive Team (CET) on 15 September 2025, NHST-04724." (As read)
And you go on to say:
"It was identified that the theatre logbooks contained high-level information of the types of operations performed, including staff in attendance and

equipment used. The information was recorded manually in hard-copy books and held in the theatre suite for ease of access and review. This process was superseded by the introduction of the Opera theatre management system brought in by phased implementation in 2012." (As read)
So what happened in the aftermath of this was the "do not destroy" notice was re-shared, yes?
A. Yes.
Q. And there was a high-level report commissioned by the cap commissioned by the chief officer in acute services, who is that?
A. That's Lynn Smith.
Q. Thank you, and that high-level report gave information about the sorts of things that would be included within theatre logbooks and therefore the types of information that we discussed earlier that might be lost?
A. It also raised concern that these had been lost and that was considered by the oversight group. So it was initially a fact-finding on finding out that this had potentially happened at that time. It was the director establishing fact.
Q. Just in case you know the answer, there's a mention there of a system, the Opera theatre management system,

is that an electronic system or something like this?
A. Yes, but again, I would ask that you ask the clinical colleagues --
Q. Yes, it's quite a point of detail. Thank you.
Paragraph 114.37, you go on to say that:
"Following a discussion on the circumstances of the loss of the theatre logbooks led by the Senior Information Risk Owner (SIRO), at CET on 15 December 2025, NHST-04724, initial actions were agreed to mitigate further risk and it was agreed that a full investigation should be commissioned to establish more detailed facts of the incident. This was primarily an investigation into people and their actions and therefore it was agreed that the NHS Scotland workforce policies investigation process was most appropriate applying a just culture lens." (As read)
The investigation was commissioned by [you] on 18 September 2025, NHST-04697 to NHST-04740:
"It was completed on 30 October 2025." (As read)
So, you decided at that stage, after the initial report, to commission a full report which took place within certain existing investigative frameworks?
A. Yes.
Q. Thank you. And at paragraph 114.40, it says:
"The Operation Stringent theatre logbooks

investigation under NHS Scotland workforce policies investigation processes ..." (As read)

Which I think is NHST-04507, so a report was done, an internal report, which you've provided to the Inquiry?

A. Yes, that is -- sorry, it didn't move on to 114. Yes, that was the investigation, the internal investigation, yes.

Q. The one that you had investigated?

A. Yes.

Q. I understand. And it says at paragraph 114.41:

"The investigation disclosed that an unknown number of hard-copy theatre logbooks which would have contained certain information relating to Mr Eljamel's surgeries during the period 1995 to 2013 were destroyed on around 24 July 2025." (As read)

The aspect of that I just wanted to focus in on was you mention there -- I think as I understand it the process looked at a sort of deductive reasoning process to try to work out: what logbooks do we have, therefore what logbooks do we not have? Is that right? Is that how the periods during which we don't have the logbooks were identified?

A. Apologies, could you please ask that again? Sorry.

Q. Yes, I'm just trying to work out how it is that we know

what periods the logbooks cover that were destroyed?

A. That is down to understanding that the logbooks had dated back to 1960 and it's down to knowing what logbooks we had left based on the Opera system being implement.

Q. Right, so does that mean that within the Opera system there was some sort of record as to what logs were there?

A. No, I don't think so.

Q. No, so again -- because at one stage in the documentation I think it says that 40 logbooks were lost?

A. Yeah.

Q. How do we know that?

A. That's the reason it says an unknown number. The estimate of 40 was based off how many you would fit within a confidential waste bag and how many confidential waste bags we know were disposed. We do no not know the number of logbooks that were destroyed.

Q. I see, but I think the assumption has been made when you take 1995 as your starting point when Eljamel started and 2013 as the end-point when he stopped operating in Ninewells Hospital and you take the logbooks that we do have, you've assumed that the ones in all the other years and all the other periods have been

destroyed?

A. Yes and assuming that that will cover the period that Mr Eljamel practised.

Q. Yes, indeed, so we're not going back to 1960 we're just starting in 1995?

A. Yes.

Q. And you've tried to estimate the number that you think would have been used based on what we discussed earlier about the length and number of surgeries and how many you fit in a waste bag and that came to 40, we think?

A. Yes, I think that was based on how many waste bags there were and how many you would be fitting within the waste bag.

Q. How did it come to be that some of the theatre logbooks were destroyed and some were not?

A. There was a freedom of information request earlier within the year, a logbook was provided and as there is time for people to respond, that was kept there. So that's why it was known that there was theatre logbook and there were some that were there.

Q. So some of the logbooks had effectively been removed from the area to respond to a freedom of information request, is that right?

A. There was a logbook -- that's how the team knew that there was information available. As to how the others

were there, I'm not actually sure. I don't know.

Q. I think you've produced to us a number of logbooks for this period.

A. Okay.

Q. And I think the reality is that you've deduced, as I've just pointed out there, that there are certain periods for which the logbooks appear to have gone missing but some remain?

A. Yes.

Q. And I was keen to try to work out -- because I have looked at some, so they definitely exist -- I'm trying to work out how it is that some did not get destroyed in this effort in accordance with the policies to get rid of them, but is that something somebody else will have to help?

A. Yes, I don't know the answer to that.

Q. Okay, thank you. You go on -- we've discussed this to a certain extent already, but you go on to say that the logbooks were destroyed in accordance with certain policies. When you talk about -- and indeed government guidance that we've referred to already. In effect, what -- does that mean that they were destroyed as if they held no special status?

A. So, can you --

Q. Yes, paragraph 114.44, it says there:

"The individuals involved believed they had carried out the disposal and destruction of the logbooks in accordance with NHS Tayside's Health Records Strategy and Management Policy [NHST-01539], its Health Records Operational Guidance & Service Operating Procedures [NHST-01483], and Scottish Government guidance [NHST-01484]. These indicate that documents such as the theatre logbooks are required to be retained for a minimum of eight years from the end of the year to which they related, at which time they are eligible for destruction."

So the assertion there is people thought that they were simply applying the general policy?

A. Yes.

Q. But these were not documents --

A. No.

Q. -- to which the general policy applied because they were documents to which a do not destroy notice applied?

A. Yes, and I think that goes back to a feeling that has been described regarding how the communication took place regarding the DND, whether people understood it at all levels in the organisation, whether we did a targeted approach, but they did not know.

Q. The targeted approach may be one thing but perhaps also the extent to which it was highlighted to them as

being something of particular importance?

A. Yes.

Q. Because it's all very well to send emails to busy medical professionals in a targeted way, ie picking the ones you think it applies to most, but if it's amongst, as we find out in the report, various other emails perhaps it would be overlooked, the main message here is that these documents don't fall within the policies?

A. Yes.

Q. And that is, from this paragraph, you've helpfully told us they thought that they did?

A. Yes.

Q. If you look at paragraph 114.47, please. This is the passage I was referring to earlier about what we still do retain. It might be helpful for people to understand this:

"NHS Tayside still holds hard copy logbooks for the relevant theatre for the periods March 2000 to June 2007 ..., 7 May 2013 to 21 October 2013 ..., 21 October 2013 to 14 April 2014 ... and Theatre Registers for 27 November 2006 and 20 November 2007 ... These documents have been provided to Police Scotland in accordance with its request."

A. Yes.

Q. I think they have also been provided to the Inquiry.

A. Yes.

Q. So these are the ones within the period that still existed?

A. Yes.

Q. And you mentioned something about there being something, a logbook falling within the freedom of information request, but you can't help us as to why these ones exist and the others don't?

A. No, my connection with what had been done is how did we know there were logbooks in place. So we knew the logbooks were there as part of a previous discussion that had already taken place and that's -- when the people went to have a look at what was in place and what was not there, we recognised that things had gone missing.

Q. So how did you know that the logbooks were there?

A. Because there's -- on the investigation the senior charge nurse was able to confirm that they were kept there.

Q. But there was no record of them as such?

A. No.

Q. Like an inventory or audit --

A. No. So that's another gap that has been identified through the independent review, that we did not have information asset registers fully in place. That is now

in place.

Q. And there's mention there of there being some theatre registers for a period between 2006 and 2007. Can you help us with what they are?

A. Again, I think I would value a clinical person being asked to distinguish between that record.

Q. I'm not going to go through the detail of the investigation because we've already touched on some of the main conclusions and indeed, they're helpfully highlighted in your commentary in the statement. One aspect of it which I think is picked up in the subsequent independent report is that the statement contains -- this is NHST-04507 contains a number -- sorry, the report contains a number of statements from individuals who are, to some extent, involved in the destruction to try to fact-find what they could tell us about the circumstances of their destruction.

One aspect I think is of particular interest which relates to there being passages in the report -- we can go to them if you need to, but we can perhaps deal with them in the generality -- where it was suggested that the documents had been destroyed by individuals working within that department, physically sent away for destruction if you like, but that they had done so on the advice, the specific advice that they had sought

from the medical records department. My understanding is that, despite there being conflicting testimony about that, that the report accepted that specific advice about the destruction of these logbooks had been taken from the medical records department. Is that your understanding?

A. My understanding is specific advice was sought. Where there is a mixed or a difference of opinion is whether it was made clear the relevance of those logbooks.

Q. Right. Okay. By whom, to whom?

A. The individuals who sought the request to a member of the health records team.

Q. But it does --

THE CHAIR: Sorry, I'm being slow here. Mr Dawson, by that should I understand you to mean there's a differing recollection as to whether the medical records department were told what these records were and with whom there was a connection?

A. Yes, the individual, it wasn't -- the individuals phoned and sought advice regarding finding these records and what should they do with them, but it was not said nor was it recognised that it was relevant to Mr Eljamel's practice.

THE CHAIR: Thank you.

MR DAWSON: But they did seek specific advice about it?

A. They sought advice on the destruction of records that they'd found. It wouldn't be normal to find records dating back as far as they did.

Q. Yes, what I'm trying to highlight is that that might be deemed to be a responsible thing for them to have done when they were in a state of confusion or doubt what to do with them?

A. Yes, absolutely I would expect that.

Q. And the precise place where you might expect to find accurate information about what to do and the precise individuals whom you might think would seek all the information they need to be able to give accurate advice about what those individuals should do with these historic records is the medical records department, isn't it?

A. Yes, but it was not made clear, the relevance of these logbooks. I totally accept that there is learning and reflection from that.

Q. I accept that you accept that there's learning and reflection required. I'm just trying to establish, effectively, the circumstances because as I think we're at one to say that the testimony is slightly unclear on this, but my understanding of the conclusions is effectively that specific advice about the destruction of these logbooks was sought by the people working

within the office, yes?

A. Yes, it was.

Q. It was sought from the medical records department?

A. Yes.

Q. The medical records department appear to say that they weren't entirely clear as to what the records were, is that right?

A. Yes, they dealt with it as a general inquiry.

Q. Yes, but they knew that the request was coming from the office next to Mr Eljamel's operating theatre?

A. I would accept again though, based on the communication and the dissemination of that information, one of the other learnings we have taken is if there is turnover of staff, induction, how do you not do these once and make sure this is fully embedded in the organisation. So I'm accepting that as a system issue.

Q. Because what I'm trying to explore here is whether, in circumstances where it would appear staff who work in the office took the responsible course of seeking advice, whether your earlier posited theory that you can't disseminate information really to everybody really applies because all you needed to do was make sure that the medical records department knew that the Eljamel documents were not to be treated in the generality of the systems and that if responsible people, like those

working at the office, contacted the medical records department that they could disseminate that information or take care to make sure that they had all of the information they needed to know whether it applied?

A. What we are doing with the actions that we've put in place around when a DND comes in and having a compliance group and the response framework and the clear communication and escalation framework means that that will be addressed in terms of everybody who is relevant being completely sighted on that and making sure we have that in place going forward.

Q. Thank you. As we discussed on a few occasions already, you subsequently commissioned, I think, an independent report, is that right?

A. Yes.

Q. And why was that done?

A. I was not satisfied with the findings of the internal review. On reading it, I was unable to see what the system issues were. I felt it left -- what would the word be -- inconsistencies and this is such a serious matter that it required to have a further review.

Q. Can you -- because it was you who ordered the independent report, is that right?

A. Yes.

Q. And can you help us with what particular aspects of the

internal report you were dissatisfied with?
A. Yeah, so the findings -- there was conflicting statements in it which meant I could not understand fully what was happening. There was something about the scope and us being able to identify what is the learning that we would be able to provide more broadly.
Q. Okay, and when did you commission the report, the independent report?
A. That was discussed -- so I received -- I received the draft of the internal investigation on 31 October. I arranged a meeting with the director of people and culture who was the person in agreement with me in asking for that to be done, led to the commission, the direct commission, so that's Elaine Watson led the direct commission of that work. I was then arranging to meet with the director of acute services and had a meeting in the diary. They were subsequently -- had started a period of sickness absence. Therefore it was discussed later in November. The actual commission going out was after that.
Q. And is it an accountancy firm that did the report?
A. It was -- yes. It was an audit firm, yes.
Q. Thank you. It's NHST-05239. Can we have a look at some aspects of this, please. Could we go to page 23, please. We're really going to need to zoom into this

about aspects of the clinical governance system relating to Mr Eljamel having not been dealt with at the appropriately senior level; would that be fair?
A. As I described earlier, on receipt of the DND I worked on the established processes that were in place which was to discharge through the executive team and to do the wider communication across the organisation. What the recommendations of this independent review has found is that we did not have a named executive senior responsible officer, which we do now have in place, that we did not have a standard process for dealing with this and to make sure, as we covered in our earlier discussion around the targeted approach that was in place, all of that has been covered by the DND compliance framework that we now have in place.
Q. Thank you. I assume it was part of the commission you gave that they should look at the internal investigation itself?
A. Yes.
Q. In relation to the conclusions on that, could we go to page -- paragraph 9.4.2, page 28, please. Again, it says here -- this is to do with the analysis of the internal investigation, its methodology, evidence and conclusions. And one of the observations is:
"While we recognise the relevance of the individuals

because it's quite small. This is paragraph 8.5.11. So this is in a section of the very detailed report which is dealing with its various actions which I think it should suggest this is the responsibility of the DND notice which comes a bit earlier but in this particular paragraph which is the last one in the section, it says:
"The reliance on assumptions, rather than structured assurance, monitoring or leadership oversight meant that the DND notice was not operationalised effectively, despite its legal significance. This contributed directly to the circumstances in which the theatre logbooks were destroyed."
Now, it was that aspect of the lack of leadership oversight that I was keen to explore with you. What did you understand that to mean?
A. That goes back to the -- closing the loop, the assurance loop, and making sure that what we have identified to be put in place in terms of the communication was put into operation.
Q. Okay, and who are the leaders that ought to have done that?
A. That would be through myself and then through the executive team and the directors.
Q. Right. I wondered whether that statement was reminiscent of some of the concessions you made earlier

who were interviewed, we consider that the investigation would have been strengthened by including more senior staff whose oversight, decision-making authority and organisational knowledge could have provided further understanding of governance arrangements and contributing factors. Specifically, the internal investigation interviewees were limited to those directly involved in the disposal of the logbooks who were largely clinical staff focussed on delivering patient care, without examining the role of executive and management-level staff who held responsibility for cascading the DND notice and ensuring that all relevant teams understood and implemented it appropriately."
Again, that appears to be an observation made by these independent assessors that there was a failure in leadership?
A. There's two parts to that. One would be I appointed an executive director to lead the internal investigation into that and it goes back to the concern that I raised earlier regarding not being able within the internal review to find the systemic learning because it did not go wide enough in terms of being able to understand that.
Q. Okay, and is it the case that steps are being taken to remedy that going forward?

A. All of this is included within -- remedy what, sorry? Apologies.
Q. Remedy the precise issue I have just highlighted, that there was a lack of senior involvement and investigation which could have provided further understanding of governance arrangements and contributing factors?
A. Yes. So an independent review addressed one that in the media. The moving forward, the DND compliance framework will make sure there's named executive leads and accountabilities are clear.
Q. Okay. Could I go to page 31, please, 9.7.2, which I think gives some indication as to your position as regards the internal report. Page 31. It says there -- this is again about the internal investigation:
"The Chief Executive [that's you] told us that the internal investigation report lacked critical detail. [I think you told us that already]. They stated that the report did not provide enough information to allow the reader to fully understand the sequence of events or form a complete picture how the failings interconnected. Key elements were missing, making it difficult to 'join the dots' and understand the systemic nature of the issues."
That, I think, remains your position today?
A. It does.

Q. That's why you commissioned this report to some extent?
A. Yes.
Q. One of the things that we heard in the evidence of Ms Smith yesterday was that patients were concerned that when serious things happened within NHS Tayside there was an effort to cover them up. Are you aware of that being a concern amongst the patient body?
A. Absolutely, concerns about transparency.
Q. Yes, and I understand it to be your evidence that the efforts that have been made to look into this important issue have been to try to mitigate in the opposite direction, to try to improve openness and transparency?
A. Yes.
Q. Yes. The external report is very detailed and thank you for providing the copy and people can look at that later. But it does tend to indicate that there are significant problems, in particular relating to senior leadership, both in relation to the events which led to the destruction of the logbooks but also in connection with decision-making around investigating it internally. Do you think that it would be fair for patients to take the view that this is the sort of material which would bolster an impression that NHS Tayside involves itself in cover-ups?
A. No.

Q. Why not?
A. Because I believe we've been completely transparent in relation to both the purpose of the investigation which was taken, the concerns that these logbooks have been destroyed extremely seriously and making sure that we were openly and fully sharing this. That's why it was put on our public website, that's why there was a press release, that's why we've shared the action plan.
What, I guess building on your wider point there around NHS Tayside and the wider learning, I gave reflection to what this meant in terms of wider learning beyond just the logbooks and what that meant in terms of information governance and took a range of actions. One was around the strengthening the leadership and accountability and I realigned executive responsibility for information governance within the organisation. I have appointed a dedicated senior information responsible officer who is an executive director, I have confirmed and strengthened Caldicott guardian arrangements and I've introduced deputy roles to make sure there is cover at all times. I have also made information governance responsibility of the executive team very explicitly through objectives that have been set with each director.
In addition to that, I have reviewed what

organisational capacity there is and prioritised recruitment to a new head of information governance and cybersecurity, additional capacity within the information governance team and I have enhanced governance and assurance. That means that there is explicit reporting to the executive team, the clinical governance committee and the audit and risk committee in relation to information governance, and that includes a dedicated report from the SIRO and the Caldicott guardian.
Q. What's the SIRO?
A. The senior information responsible officer. It's one of the key roles as part of our responsibilities in relation to information management.
Q. Thank you.
A. In terms of the wider ownership of information, priority was placed on developing an information asset register which is now fully in place. Made sure that we've got information for asset owners who have named accountability and that will include the visibility both what is held, where it's held and who is responsible for it. And then finally, it is about that improvement and cultural change and the piece of work that I commissioned to do that wider piece of work with an information governance maturity assessment, a review

of all information governance frameworks and policies, the board, under my recommendation, has made information governance a corporate objective for this year meaning there is executive director oversight of this, as well as executive oversight, and we have introduced training awareness and leadership development. All of that is seeking to provide a culture of proactive information share-ship in risk management and seeks to take it beyond the logbook issue, of which we now have the DND compliance framework in place, into ensuring the strengthening of information governance across the organisation.

Q. Thank you for that. You read that out obviously?

A. I had taken some notes which I spoke to you about beforehand.

Q. Yes, they were written by you?

A. Yes, 100%.

Q. Those efforts that have been put in place are understood and obviously we'll look at the detail of that in due course. None of that will bring any of the logbooks back though, will it?

A. No.

Q. None of that will assist, I think, in the erosion of trust we've identified amongst the patient group?

A. I accept that.

Q. None of that will help address the deficiencies Professor Wigmore has identified will now exist within his ICR process?

A. I agree.

Q. And we have lost a considerable body of evidence that would have been extremely important to this Inquiry, have we not?

A. I accept that the independent review is absolutely clear that this should not have happened and I want to reiterate my sincere apology to former patients, families, to the Inquiry and to the Independent Case Review, I said earlier.

Q. Thank you. Will efforts be made, as part of the ongoing processes, to try to identify in light of the assessment that's been made of the dates we talked about earlier, which patients are actually potentially, or that you accept are affected by this? Because it's not everyone.

A. No, that I believe is the reconciliation work that we spoke about earlier.

Q. Right, it's part of that?

A. Yes, and that will be able to be communicated directly with patients and be able to be shared with the Inquiry and the Independent Case Review. We will be absolutely happy to share that.

Q. Thank you. Can the Chair of the Inquiry have any faith that future orders or requests made by him will be obeyed by NHS Tayside?

A. Yes.

MR DAWSON: Thank you very much. Those are my questions, sir. That brings that to the end. We now need to have a break to allow core participants to propose questions, but before that I'll ask you a question I ask all witnesses which is: is there anything you'd like to add at this stage?

A. What I planned to add at this stage was my sincere apology. I believe I have just said that but I would like that formally noted on record. Also as chief executive officer and as accountable officer, I accept accountability from the organisation and I am absolutely committed to ensuring that we learn and we drive that forward.

I hope what I have described here has showed that since these circumstances came to light we have accepted the findings in full, implemented significant improvements and strengthened our governance, our records management and our assurance arrangements. And my commitment is NHS Tayside will continue to learn from these events and be open and transparent and do everything possible to prevent this happening again or failings of this nature.

Q. Thank you very much.

A. Thank you.

MR DAWSON: Sir, probably a short break now.

THE CHAIR: Yes. We'll have a short break now, Ms Connor. I remind you not to discuss your evidence in the meantime.

(2.13 pm)

(A short break)

(2.24 pm)

THE CHAIR: Have a seat, thank you.

MR DAWSON: Thank you, Ms Connor. This is a section in which I ask you some questions that have been proposed by others. Just a few things.

We talked earlier about different circumstances in which huddles or oversight groups had been put together to deal both with a response within NHS Tayside to the Inquiry generally but also in response to the compilation of the board's position in relation to the document destruction issue. The question I have been asked to put to you is whether the meetings of these huddles or groups are minuted?

A. There is a record taken. It is chaired by the executive medical director, he will be able to give you that precise information.

Q. Good, thank you. And you mentioned earlier, when I put

to you the proposition that the logbook destruction response might in some eyes be deemed to be consistent with a cover-up, that one of the things that you had done was to publish the internal report on the website; is that right?

A. The independent report, apologies if I said internal, I meant independent.

Q. It was the independent report. Was the internal report published?

A. No, that was under workforce policies related to -- so no.

Q. So that wouldn't ordinarily be published?

A. No, that contains confidential information regarding individual members of staff.

Q. I understand. When the independent report was published, did that have any restriction applied to it, in terms of names being blanked out or other information?

A. A very small redaction with the junior staff, as I explained earlier, but not senior staff.

Q. Yes, just to be clear the context in which you and I were discussing that earlier related to the proposition that names should be redacted from the Inquiry for materials. What we're talking about now is your own redaction which you're free to apply to

documents you are publishing yourself.

A. Yes.

Q. So it's slightly different but it's actually related to the same topic, there was the same reason for seeking those redactions?

A. Apologies if I have caused confusion. I accept the Inquiry's position to decide what's redacted. As NHS Tayside, we were not publishing the names of junior staff.

Q. I asked you some questions this morning about what information had been made available to you when you joined NHS Tayside as the chief executive about the Eljamel affair and you told me that you'd been given the due diligence report I think and that you read it, is that right?

A. I read it I have read it as part of -- in terms of taking up post, I don't recall a specific full handover but I recall being advised of these things that were in place and then read those.

Q. Because obviously, as is set out in many places but amongst others Term of Reference 12 of this Inquiry, there is a significant history of reviews, some internal, some external, into different aspects of the Eljamel affair which predate the due diligence review. Were you given copies of any of those?

A. I was aware -- I don't think I was provided -- I don't recall being provided with specific copies.

Q. To give an example of one that we heard yesterday from Ms Smith was published at a particularly important moment in the movement towards a public inquiry, the Scottish Government report of outstanding concerns relating to Mr Eljamel which was a Scottish Government report published in 2022. Do you recall being given a copy of that?

A. I don't recall specifically, apologies.

Q. Okay, do you think you would have been?

A. I don't recall being provided with that, I don't recall it. It doesn't mean -- I just don't recall it.

Q. So you think you probably weren't, is that what you're saying?

A. I think so, but I don't recall.

Q. I think you've told me already that the due diligence report was something that you were directed toward?

A. I was aware, yes.

Q. Thank you. There's another aspect of a report we looked at earlier, I'd like to ask you some more detailed questions about. This is back to the independent review, which is NHST-05239. It's just a particular aspect of this. There are a number of different strands to this report but one particular thing that I have been

asked to follow up with you that I didn't earlier. We're at page 20 of this document and we're in paragraph 8.4.1. So there's an acronym in here which is "PLRT", which is the patient liaison team we were talking about earlier, I think, isn't that right?

A. Yes.

Q. I think in this passage what's happening is we're getting a summary of the independent inquiry's findings about efforts that had been made quite early on to try to secure documents that might be related to the Eljamel affair within NHS Tayside, is that right?

A. Yes.

Q. So what it says at paragraph 8.4.1 is:

"In November 2024, as part of efforts to gather information relating to Mr Eljamel, the PLRT team contacted 40 individuals across NHS Tayside. Forty key individuals contacted included staff responsible for Neurosurgery, the area that Mr Eljamel worked. In total only nine responses were received of which three refused to complete the template. The remaining thirty-one non-responses indicates a disengagement from staff and a lack of organisational readiness to identify or report records relating to the Inquiry. Interviewees shared that before this point NHS Tayside did not hold an information asset register of information held by

departments across the whole of NHS Tayside and therefore this was an attempt to gather details of information relating to the Public Inquiry."

So just to pause there. What that tells us, I think, is that efforts were made in about November 2024 to try to contact key individuals within the organisation to tell them that they should secure Eljamel-related information and documents, yes?

A. Yes.

Q. And that it says that an information asset register -- sorry, an information asset register of information held by departments across the whole of NHS Tayside was not held at that time. Do you take that to mean that there was not, in November 2024, a central repository of Eljamel-related information?

A. The organisation did not have in place a consistent information asset register which is a requirement for us in terms of good records management. What was contained was not comprehensive enough and this report, in terms of the asked-for information, the fact that it was not followed up for the nine responses to make sure that that brought through the assurance is a failing. What we've put in place now in terms of our compliance framework will address that.

Q. Okay, but just to be clear, this information asset

register, is that a more general requirement which serves the purpose of a kind of inventory of all the documents you hold or is that something specific to the Eljamel document?

A. No, it would be both. We would expect that we would have an information asset register that related to Eljamel. I think it's been different language used in different places around logs and other things. My understanding is that means the same thing. But it is a requirement for us as an organisation more generally to have that in place.

Q. And the information asset register, do I have it right that its general purpose is effectively a huge list of everything you hold, is that right; a kind of inventory?

A. Yes, it allows to us have that information, yes.

Q. So just to take some specifics out of that. One of the actions that was taken as a result -- or in connection with the investigation which led to the due diligence review report was the creation of an Eljamel information log, so we're told in the report. Does this tend to suggest that by this point that information log no longer existed?

A. No, I don't think so. That would not be -- that would not be my interpretation of that.

Q. It is perhaps more just to do with the general point

that you make, that you don't generally have this. So you don't have an inventory generally of all the documents you hold but also you don't have a specific Eljamel one; was that correct?

A. Back to the confusion of language, I think what would have been met by having the log would also fulfil what was required in relation to an information register. I think it's a use of language and part of the learning that came out of the independent review was that we put in place the information asset registers across the organisation. So I think it's a mix of language.

Q. Okay. We can maybe ask some of your colleagues as to what information asset register specific to the Eljamel documents may exist because I know others have more responsibility in that area?

A. Yes, I think Margaret Dunning, as SIRO at the time, and Dr James Cotton who chaired the huddles and oversight group.

Q. Thank you. But another specific part here is that these 40 met with 31 non-responses.

A. Yes.

Q. So this is in connection with effectively an important message being sent that: we need to know what you've got and you need to secure that and 31 of the 40 key; individuals didn't even respond?

A. Unacceptable.

Q. Yes. Could I just look at paragraph 8.4.5. This relates specifically to the neurosurgery secretary, who I'm assuming is accountable for what's held and the actions relating to documents held within the neurosurgery department; is that correct?

A. I'm not familiar with the detail of that individual's role.

Q. Okay, it says:

"The Neurosurgery Secretary responded to the PLRT email but refused to complete the template. We understand the secretary worked in the Neurosurgery ward. An initial response from a Neurosurgery Secretary acknowledged that the department held relevant documentation but expressed the view that it was not their responsibility to provide it. PLRT subsequently escalated the request to a more senior member of the Neurosurgery ward team, the Administrative Services Supervisor (Neurology, Neurophysiology & Neurosurgery). Emails confirm the initial response from the Administrative Services Supervisor (Neurology, Neurophysiology & Neurosurgery) confirmed there were no records held. PRLT told them of notes known to be held in Neurosurgery ward from earlier document repository work for the due diligence pre-Public Inquiry on

Mr Eljamel and the response came back from the Administrative Services Supervisor (Neurology, Neurophysiology & Neurosurgery) confirming that approximately 4,000 operation notes were retained. This suggested to us that a proactive search may not have been undertaken, and departmental ownership of the records was not being taken."

So in relation specifically to the records held within neurosurgery, it appears that again there were significant issues with getting the relevant people to comply with this important request?

A. Yeah, I think it absolutely goes back to the point made earlier around the responsibility that I hold for ensuring that we had the systems, processes and communication in place across the organisation. Again, this has translated into a key finding from the independent review around those 15 recommendations and is contained within the compliance framework.

Q. But the main thing we discussed earlier, I think, was trying to put into place -- or you've been trying to put into place systems to try to make sure that the tentacles, if you like, of the DND notice -- notification process reach where they need to reach. But this suggests something different, which is a kind of wilful refusal to comply with it. If you're sent

a template saying: what documents to do you have? And 31 out of 40 people don't reply, or if you're sent something within the specific department in which Mr Eljamel worked and your response is it's not your responsibility to comply with this request, this is a different problem, isn't it?

A. It is not acceptable and that is where there should have been senior and potentially executive oversight of where this reported to, in terms of how this return was received.

Q. It's perhaps in light of that, not surprising that paragraph 8.4.6 goes on to say:

"There was no indication that staff undertook broader searches for additional documents or conducted local verification of what records were held. This demonstrates an absence of responsibility at departmental level for understanding or reporting what information existed within their areas."

I mean it's hardly surprising that people wouldn't go above and beyond when they're not even prepared to deal with the basic work they're given; isn't that right?

A. Yes. The DND framework will address this going forward but it's also partly why I commissioned the forensic review, to make sure there was an executive-led

walkabout and review across all areas.

THE CHAIR: It would be interesting to look at all of that in due course but I think what Mr Dawson is perhaps getting at is that whatever systems you put in place there has to be a culture of compliance where that seems to have been absent, on the face of what's in front of me at the moment. Do you agree with that?

A. Yeah, I would agree and that's why what I described earlier, in terms of the wider information governance work, focused on culture as well as systems and processes.

Q. Because obviously at the end of the day, the Chair will require to provide a view on document management systems within NHS Tayside and may wish to make recommendations and obviously the steps you've taken will be relevant to those. But in trying to assess, as he requires to do under Term of Reference 14, the adequacy of these systems these -- the evidence you've given in this regard and these sorts of features that an independent body has arrived at really show, I think do they not, that the document management system within NHS Tayside, before the changes that you're telling me that you wish to implement, is completely broken?

A. It's not wishing to implement. I have implemented those changes that I have described, so they have been put in

place. I recognised that there were concerns. I have recognised and accepted that there were failings and have put measures in place. Those measures are overseen by non-executives, through both the audit committee and the board.

Q. I think it's characterised your evidence today, Ms Connor, if I may say so, that you're keen to tell me what you're wanting to do to fix things, which is laudable, but I'm asking you questions about what it was that needed to be fixed. What it was that needed to be fixed was a system of document management that was completely broken?

A. I accept that there were failings, absolutely accept there has been failings within that and that has been addressed through -- in terms of the -- for the DND element, through the compliance framework and has been addressed through the wider information governance work.

MR DAWSON: Thank you very much indeed for your time.

A. Thank you.

THE CHAIR: Ms Connor, that is now all the questions that you're going to be asked. It's now the end of your evidence and with my thanks for you coming into the hearing suite to give that evidence, I can tell you now that you are free to go. Thank you.

A. Thank you.

MR DAWSON: Sir, I think it would be appropriate at this stage -- we do have another witness for today that we're hoping to complete. I think it would be very helpful for everyone if we had another short break to try to get that witness in and try to make sure that everything is running as smoothly as --

THE CHAIR: Right, let's take 15 minutes, everybody, and we'll resume again at 2.55.

(2.40 pm)

(A short break)

(2.52 pm)

THE CHAIR: Yes.

MR DAWSON: Sir, the next witness is Mark Egan.

THE CHAIR: Thank you.

MR MARK EGAN (sworn)

Questions by COUNSEL TO THE INQUIRY

Q. Good afternoon.

A. Good afternoon.

Q. You are Mark Egan?

A. Yes.

Q. Mr Egan, when I'm asking you questions and you're replying, if you can try to speak as best you can into the microphones -- I find them a little tricky -- just to make sure everybody can hear who are hooked into various systems. If you could do your best with that it would be very much appreciated.

You are the current chief executive officer of the Royal College of Surgeons of Edinburgh?

A. Yes, that's right.

Q. And would it be acceptable for me to call it "the college" during the course of my examination? Is that what you would call it?

A. Yes.

Q. Thank you. And the college received a Rule 8 witness statement request from the Inquiry; is that right?

A. That's right.

Q. And a statement was written by you in response?

A. Yes.

Q. And could we have up, please, RCSE-00028. Is that your statement?

A. Yes, it is.

Q. Could we go to page 59 please and although it's blanked out for restriction purposes, is your signature underneath that?

A. Yes, it is.

Q. And the statement I think is dated 23 March of this year?

A. That's right.

Q. And is it the case that the contents of the statement is true as far as you're concerned?

A. Yes, they are.

Q. Thank you. Could I please ask to go to paragraph 1.1. So it should come up on the screen in front of you, Mr Egan. You say there:

"I am Mark Egan, currently serving as Chief Executive Officer of the Royal College of Surgeons of Edinburgh ... I was appointed Chief Executive in June 2023 following a period of Interim CEO from December 2022 to June 2023 and have overall responsibility for the college's governance, strategic leadership, and oversight of professional standards."

What are your responsibilities as chief executive and if there are any differences in the interim period?

A. So I am the overall executive lead for the college so I have a number of directors under me that deal with examinations, education and faculties, membership and communications, resources, which covers a number of back-office functions, digital enablement, and stakeholder -- partnerships and stakeholder engagement. I am group CEO so I also have overall responsibility to for our commercial arm, Surgeons Quarter, although the relationship is a little bit more arm's length compared to my responsibilities for college matters and I'm also a director of Surgeons Quarter board.

So in that I work very closely with the trustees, the college council and the college office-bearers who are the clinician volunteers who provide the professional leadership for surgical and dental matters and my job was to help them set the strategy for the college and to ensure that the executive machinery behind the scenes delivers the strategy, year on year.

Q. Obviously in this Inquiry we're interested in clinical matters, in particular clinical matters arising in the field of surgery, and I think you've already identified that your responsibility is running the college and the executive side, whereas there are also a number of other people involved who are on the clinical side. Could you tell us a bit more about those individuals?

A. Yes, so the college has a president, and five vice-presidents who are the office-bearers, collectively the office-bearers, so they provide the professional leadership of the college. They're also trustees and they obviously are a council of -- we just changed the number, but it's around 25 surgeons and a couple of dental surgeons. And they lead the college's engagement with various clinical matters as they come up. So a lot of policy issues, relationships with other surgical colleges both in the UK and internationally. They would hear reports and guide the debates around matters that come from surgical specialty boards that look more in

depth at the ten surgical specialities. So there might be various issues come up around a whole range of matters of professional standards and surgical practice. There's a similar structuring, to a slightly lesser extent, that works on the dental side as well.

Q. Right, okay. Can I look at paragraph 2.3 please. It says there:

"In my role as Chief Executive Officer for [the College], I steer the College's strategic direction and operations, encompassing surgical training, examinations, and international fellowship programmes. I oversee standards and regulatory frameworks to ensure patient safety, professional integrity, and public confidence, while implementing models to support global exam delivery."

There's a couple of aspects of that I would be keen to explore which are of general significance to our remit. What is the remit of the college with regard to the overall aim of ensuring patient safety?

A. So the college has just very recently published a new strategy which puts patient safety right at the heart of things. That updates a previous strategy that had similar aspirations, although differently expressed. There are a variety of ways in which the college supports patient safety. We are a historic standard

setter, often working along the other UK colleges, so with standards of surgical practice curricular for different surgical specialties, ultimately derived from recommendations that come up through the college structure. We set -- again, often with our sister colleges elsewhere in the UK, we set the examination frameworks. We QA those exams and we administer those exams. So those are the primary form of assessments for surgeons at different stages in their careers.

We also provide education that supports both those assessments but also provides continuing professional development in other areas, so for example around robotic surgery and new developments in surgery, it would be the colleges that take the lead in proposing the sorts of education that would be needed at different points in time to help surgeons develop the capabilities they need, as the tools of the trade change. So those would be the main factors there.

Q. So by trying to contribute to higher quality surgery, that serves the ultimate aim of patient safety?

A. Yes. We also have a patient safety committee which focuses on the systems, systems approach to patient safety. So looking behind the individual incidents to try and understand what systems contributed to difficulties. There's a whole variety of things. It

could be to do with ergonomics, for example, it could be to do with what are called human factors and the college, the RCS Edinburgh pioneered work what's called non-technical skills for surgeons, so looking at communication, communication in theatre, taking things away purely from the technical quality of a surgeon when undertaking an operation, to their role in managing and leading a team in the theatre and in the ward to manage patients more effectively.

So that committee takes a particular interest in those factors and encourages other parts of the college, whether it's the education side of things, for example, would be good example, to develop new courses in that area and to ensure that those courses remain current and in tune with current academic thinking in this area.

I should also mention another part of the college's role is around accreditation of facilities and accreditation of courses to offer the opportunity for different institutions, academic institutions for example, that are offering training in different contexts to be assessed in order to attract the college badge essentially, to say that the standards being met are standards which the college feels are at the highest standard required for whatever they're doing. And that accreditation programme is quite significant as well.

Q. Right, and does CPD fall within the accreditation?

A. It can do yes, and the college offers CPD for courses or conferences that other people might want to run and we have a short course accreditation as well as accreditation for portfolios, courses and programmes.

Q. So just to separate out these various things, you're saying there's an education and accreditation function, there is a system whereby people can sit examinations in surgery as they progress through their career, as you said. And also there is, it seems, a sort of research function in relation to the creation of standards perhaps which you mentioned?

A. We wouldn't use the word "research" because with a research institution, we don't undertake research ourselves. But there will be -- the college, especially through the surgical specialty boards, will debate and make recommendations which ultimately would be for the GMC to adopt, if we're talking in the surgical context, around what the standards should be, particularly around curricular. So what level should people be at different points in their career. It's not set by the colleges, it's ultimately a regulatory matter but it's the colleges, through those specialty committees and through the joint committee on surgical training, which is where the intercollegiate conversation happens on

these things, that will make those recommendations.

So I wouldn't -- it's not academic or medical research as such it's a process of establishing best practice through the community of professionals who gather for that purpose.

Q. Thank you for making that distinction. I suppose what I'm getting at is really people within the college coming together trying to set appropriate best practice standards that are then issued in various different areas, you told us. That's not research in the technical sense but it's bringing together of knowledge and experience to try to have a result which increases standards, I suppose?

A. Correct.

Q. And you mentioned -- as far as the standards are concerned, you mentioned I think that they would be in different surgical areas, is that right?

A. Yes. So there are ten specialties and if you look at the curricular, that's how things are organised. And there are specialty boards within the college and within the joint committee on surgical training, there are specialty advisory committees which are effectively making the -- setting the standards for the GMC to authorise because it's ultimately the regulator which signs these off. So we tend to think of things in terms

of those specialties. Of course, in some areas there are standards that are required for entry to higher training in surgery, so that would be set around the MRCS exam which is the entry exam, if you like, to a surgical career. So those would be more cross-cutting because that comes at a point before people have chosen formally their specialties.

There are also other areas -- non-technical skills, for example, that apply across the board, they're not specialty-specific. But a lot of surgery is quite specialty-specific obviously in terms of the operations that are performed but also in terms of how they're performed. Some involve robotic equipment, laparoscopic equipment, some don't. So it's a fairly -- obviously there are some quite considerable differences in the way in which surgery is performed.

Q. And of, I think you called them specialist areas, there were ten I think?

A. Ten specialties, yes.

Q. And one of those is neurosurgery; is that correct?

A. Yes, that's right.

Q. And just to understand. So you mentioned there that there would be standards that would be issued that would perhaps be specific to a particular specialty and would involve whatever it is that was deemed to be best

practice in that area but there would be also be standards that would be issued that would -- perhaps in these non-technical skills areas, that would be sort of sitting over all of them, would apply to all of them, is that right?

A. Yes, that's right.

Q. And in the non-technical skills area which you mentioned, things like communication, ergonomics, which I can understand might apply to all surgical fields, or many, you mentioned I think that the college had been particularly involved in looking at that area and setting standards; is that right?

A. Yes, that's right.

Q. As far as standards of that type are concerned, is that a relatively recent phenomenon? In terms of when was it that standards started to be set by the college in that regard?

A. So I believe so. So there is a committee which is associated with the college for clinicians who are the faculty, for the NOTSS -- we call it the NOTSS course, that's the non-technical skills for surgeons course. That celebrated its 20th anniversary a year or two ago. It was a coming together of academic research from Aberdeen University, with collaboration from Edinburgh University. And the college is probably best seen as

the delivery partner for that. So it's an interesting example where the standards were developed. Actually there was academic research involved in that. The standards were developed in university contexts and then a partnership with the college to further develop it -- obviously because the college could provide active surgical faculty, people who were current surgeons who could be involved in that work, and a delivery partner in terms of being able to actually deliver courses in different contexts.

My understanding -- because this pre-dates my involvement in this area, but my understanding is that that was novel at the time around 20, 22 years ago and it broke new ground. And in the discussions that take place there still is that sense that it is new, particularly internationally, but I think -- and this is going slightly beyond my direct experience -- but I believe it's been built into some of the curricular in various contexts. Certainly things like communication skills are built in more than perhaps they were in the past.

Q. So there's a cross-pollination then between the different areas in the sense that standards might be fixed by discussions in partnerships with universities but then the outcome of those would be incorporated

within the training and the accreditation side?
A. Yes.
Q. And you mentioned -- we were talking there about non-technical skills but as far as the technical skills are concerned, do I take it from the relative novelty of the non-technical skills that it was the technical skills that would be the areas in which standards would have been set previously?
A. I think historically that's the role the colleges have always played is to set and drive up standards in technical skills. Obviously as changes -- advances in medical practice have occurred quite rapidly over the last couple of centuries, the colleges have played that part in both attracting people who are doing research separately into what those techniques might be but also in setting those standards and ensuring that they're properly assessed. That's the core role of the college over a long period of time.
Q. I'm just trying to get an impression for our understanding as to what -- obviously in the field of neurosurgery that we're looking at, what in broad terms without getting into the details, the sort of standards -- the technical standards in a field like neurosurgery might look like. Would they be standards that would set out how you go about carrying out

a craniotomy?
A. Well, that's probably gone beyond my direct experience. I would imagine. I think where you're looking for standards, you would be looking principally at the curriculum because for the curriculum for the fellowship exam essentially would set the learning and experience -- well, the learning and skills that are required for somebody who is a day one consultant in that field. So without looking it up, it's a fair assumption that those types of procedures, how you perform them, would be absolutely central to the curriculum. But I'm not a surgeon so I wouldn't want to be --
Q. I'm very conscious of that and just trying to ask you about how these things work in broad terms, Mr Egan. We're particularly interested, in this Inquiry, in the period of Mr Eljamel's work in NHS Tayside which is from 1995 to towards the end of 2013 and I'm interested to know whether the college would be a place that someone could go to try to find out best practice, certainly in the technical sphere, about how one should be doing things based on the accumulated and cumulative knowledge of the college. Would that be the sort of thing that would be provided to someone who might turn to the college?

A. Yes. I mean there's a library which provides access to all manner of resources around all the different specialties. There's a community of fellow practitioners who are attracted to the college because they're interested in surgical training and in the setting of standards. So I'm not familiar with -- if we went back to 1995, I'm not familiar with the internal structures of the college at that point, but if you looked at that time now there is a surgical specialty board on neurosurgery, so that would be certainly where you would go for advice and potentially resources, educational resources, these days its podcasts, that kind of thing, around the latest -- both the latest developments in neurosurgery but also basic skills in neurosurgery. A lot of focus is on helping people come into surgery and develop their skills before they reach their point of being a fellow.
Q. But it would be a source of information, if one wanted to know what is the best way to go about doing this aspect of a particular surgery, there would be likely to be either standards, information or access to other people that might be able to help you with that?
A. Yes, I should say so, yeah.
Q. Yes, thank you. That's very helpful. The other aspect of the paragraph we were looking at that I was

interested in -- I'm interested in all of it, but the particular points I wanted to make to you, we talked about public safety, public confidence. Could you tell us what it is that the college does to try to promote public confidence? I'm particularly interested in the extent to which the college has a public-facing role or it promotes public confidence in the same, perhaps indirect way, you say it promotes patient safety?
A. Yes, it's primarily the indirect way. It's by the setting of the highest standards, by setting exams which are quality assured to the highest standards which are intended to -- in terms of the fellowship exam, and to ensure somebody who has passed that exam has the knowledge you would expect of a day one consultant and to provide a range of resources, as you mentioned in continuing professional development, which would help the public, all of us, to feel that somebody who is involved in the college, if they are their surgeon, has been trained to the right standard. So it's primarily that.
We do have -- we do undertake some advocacy work around all sorts of aspects of healthcare. You know, we contact the government about things. We respond to consultations, we're involved in work around things like the modern hospital programme, looking at the design of

theatres and position of theatres and so on in new-build hospitals. But that is less -- we're not a campaigning organisation in that way and we don't position ourselves in that sense. It is more indirect.

Q. So there are various ways in which you try to exercise that function indirectly. You mentioned there being part of government initiatives. In your statement you talk about the advisory role which you have. That presumably means that where there are contemplated government legislation or other initiatives which in some way impinge or touch upon surgery that you would be an obvious place to come to try and get advice and input on that in consultation processes and that sort of thing, or perhaps even more actively than that?

A. Yes, absolutely. With consultations, for example, we will often circulate the consultation paper to college council, to the relevant specialty board, to ask members -- I think there's an example in the evidence where you can see that in action, where people have obviously contributed their views and that's reflected back from our staff team into that consultation. And there might be other activity around that as well. But I would say that we are not primarily in the space of wanting to lobby and get ourselves on the front pages of newspapers and that kind of thing. That's a lesser

aspect of the role. Important, but not in the same vein. It's not principally where we see our concern to patient safety.

Q. Because as I understand the college is not a regulatory body?

A. That's right.

Q. The surgeons are regulated by the GMC?

A. Correct.

Q. And although, as you have already mentioned, there can be a degree of overlap I suppose between the two functions, there is a clarity that they're the regulator and you're not, I think?

A. Yes. I wouldn't say there's an overlap, there's a clarity. At the end of the day it's the GMC which decides whether or not you can practice, it's the GMC which is able to suspend you from practice, it's the GMC which can put conditions on your practice.

The college is there to set standards, to set an exam. We will say whether somebody has passed that exam or not, but that is not a guarantee that you would then get on to the specialist register as a consultant. And our role after that really is -- we do not have a role after that, in a sense, that once the exam has taken place, it's the GMC which is the regulator.

Q. When you say it's not a guarantee, is it a prerequisite?

A. Yes, in this country to be a consultant surgeon you have to have passed the exam but you also have to have completed your training. There's another pathway into the specialist register which is for people who have not followed the training route and so it is -- which is a portfolio assessment where the surgeon would indicate, through a range of different ways, that they've reached the standard that's required of that day one consultant. So you can, as I understand it, it is possible to become a consultant at the moment without having passed the fellowship exam but it would be a very difficult route to take. For the vast majority of people, they are surgeons, they complete their training and they pass the exam. And it's those two things together which lead then to the sign-off by the GMC.

Q. So you need to have the exam pass but you need to have other things as well?

A. Well, the exam pass is a knowledge test, ultimately. There's a little bit more to it because the exam does feature what are called OSCEs where you visit different stations to deal with different scenarios and so there you might assess someone's ability to communicate to the patient, to grasp a situation quickly. It's not simply a test of book knowledge, if you like. But the point of the sign-off of the training pathways is that's years of

experience. So a surgeon will have had to have got a certain number of operations under their belt which will have been recorded as part of that to be signed off through that training process.

So it's a combination of the two. The knowledge that's tested through the exam and then the training pathway. As I say, there's now a portfolio pathway which is a separate process, but effectively it looks at the same sorts of things. You have to provide evidence that you've got the training requirements, that you've got the experience required and you've reached the right level of knowledge.

Q. I see. Just to return momentarily to the public confidence aspect, there's one aspect of the statement that comes quite late on in the statement I was interested just to explore with you. I understand that is it the case that -- taking the various passages together, that the college is not a complaints body if something has gone wrong with a surgeon that's a member or a fellow, is that right?

A. Yes, not in respect of if something's gone wrong in their practice in a hospital or somewhere out there. We would -- if we were in receipt of such a complaint, we would have to refer it either back to the Trust's complaints procedure or to the GMC as the regulator as

the college doesn't have a role in dealing with those individual complaints that come through. We don't get very many but that wouldn't be our practice.

Q. What I'm envisaging is a situation which presumably doesn't happen -- or not very often -- where a patient wouldn't ordinarily be able to approach you and say: I have problem with my surgeon, can you do something about that? And if they did, what you would do would be to send them somewhere else; is that right?

A. Yes, that's right.

Q. I'm trying to understand -- I'm not criticising, I'm just trying to understand the function?

A. Yes, that's right.

Q. Do you get people approaching you like that?

A. I can't remember any in my time. We may have had, in the team, the occasional approach but it's not something that's come to me.

Q. I was thinking it's quite a daunting building to walk up and knock on the door?

A. Well, it's all email now. But no, I have not dealt with any personally. I can't recall it being something we talked about.

Q. In a sort of straight sense, I suppose, that's not a part of your function?

A. That's right.

Q. And although you might well helpfully signpost people to other places whose function does cover those areas, that's not a part of your function?

A. Exactly. Exactly right.

Q. Okay, one of the aspects of the statement that I was interested in exploring with you is a concept that one sees in the literature around this area quite a lot actually and it features in your statement as well which is the concept of a surgeon being "in good standing". And I think if I could summarise what I understand this to mean from your instalment is that there has perhaps been an evolution as to what this means and that at one stage it meant effectively that the individual had paid their subs to the college, is that right?

A. Yes, that's right.

Q. And that at some later stage the bar was heightened, albeit only slightly, that it also meant that -- you were required to have done that but also to have -- to not have any outstanding disciplinary complaints against you by other bodies, is that right?

A. Yes, not to be -- not to have those outstanding matters relating to your regulator, yes.

Q. I took it -- there's a useful section at the end of your statement where you tell us about some things that might improve or there might be changes contemplated in the

future as regards the role of the college. I think there that you contemplate there might be room for discussion or a debate about whether the college could play a more proactive role in that sort of area. Could I have your reflections or thoughts on that?

A. So this has been a very live discussion over the last couple of years and as you'll have seen from the material we've provided we've thought a lot about our disciplinary process which probably I think it would be fair to say was not right for the current era, the one that we have at the moment and which we're in the process of reforming. That's where the concept of "in good standing" came up and you're absolutely right, when you got down to it, it reflected whether you had paid your subs or not. And where we've looked to change that is to add in another element which allows us to take more effective action against people who have been suspended or raised by their regulator.

I think there is still difficult situations that arise where there are -- somebody is in trouble with their regulator, shall we say, where there may be an investigation going on, there may be conditions put in place. From the outside, which we are, it is very hard to understand what's going on. It's hard to understand how serious those issues might be and where

they've derived from and whether they should rightly affect somebody's standing as a surgeon or not. You can have conditions placed upon you by the GMC because of mistakes that have occurred which you have owned up to as a surgeon and where effectively the conditions are for an extra element of training to take place, perhaps for certain procedures to be supervised by somebody else before -- almost like a retraining process, before you get to a point where you can sign somebody back off with that particular procedure.

That's very different from some of the other situations which might lead to regulatory action. And I think the view from within the college is always that mistakes can happen. It's candour and probity which are absolutely key. And the biggest problems, from our clinicians' point of view, and I'm sure this is reflective of the surgical leadership across the UK, is it's issues around probity, issues around lack of candour which are most problematic and where the colleges would feel, I think -- certainly, this college would feel it would want to take firm action. But it's sometimes hard -- well, at the moment in the system as it is it can be hard to identify those until such point as there's been a thorough examination and then a decision has been reached but that can take

a considerable period of time.
Q. Okay, that's very helpful.
A. During which time, of course that person would remain as a member potentially, if they've continued paying their money.
Q. So just to understand the context, as far as any potential sanction that the college might be able to impose do I understand it to be that the sanction would involve removal of the gifts that had been bestowed upon that individual by the college? So you can have a fellowship removed, you can have a membership removed, but you can't be struck off the GMC register by the college, that sort of thing?
A. That's exactly it. So -- that's exactly it, yes.
Q. So insofar as the college were looking at matters of candour or probity, as you said, which is something that interests them, that would be in the limited context of deciding whether that person was fit to continue to hold the title of fellow or member of the college?
A. Yes, there are other -- obviously there are other aspects of college membership where people can get involved as examiners, for example, which is germane to this Inquiry or involved in various standard-setting activity where the college might take a view in certain circumstances that somebody should be removed from that

but it would need not affect their overall membership and fellowship. I think if we look at the fellowship it is, I think, a signal to the public that this person is of a certain status and if you are -- if your surgeon has that certificate on the wall, that should give you some confidence about their calibre and that's, I think, where we feel most -- you mentioned about earlier around public confidence, I mean that's where we are most troubled by these sorts of cases because people should expect that and sometimes it may not go -- it may go wrong.
Q. Yes. So you're indicating there that there are a wider variety of sanctions because there are a wider variety of gifts that can be taken away, if you like?
A. Yes -- yes, I'm not sure I'd use the word "gifts" but there's roles that people take on which may not be appropriate in certain circumstances if there are investigations going on by the regulator.
Q. I mean in the sense of it being in your gift rather than a Christmas present.
A. Exactly, yes.
Q. So as far as those systems are concerned, you've mentioned a fellowship. So membership is basically part of the suite of different things you need to have in order to be a surgeon, is that right? Passing the

membership exam?
A. So the membership exam is your entry, your gateway to higher surgical training, is when you choose your specialty. And the fellowship is when -- is your gateway to independent practice as a consultant. So it's a pathway that people take. So, some people do stop at the membership for various reasons but effectively it's -- you think of it as a pathway to that point where you have independent practice as a consultant.
Q. Right, so to touch on fellowship then, it is, is it -- you mention that you would in order to be a surgeon you'd have to have the membership and various other things you would need to satisfy along with the technical skills as well as passing the exam. As far as fellowship is concerned, how does that work? You mentioned what it is a gateway to, but to what extent is that something which automatically entities you to something else or is that part of a suite of different qualities someone is to demonstrate?
A. It's what I said before that to become a consultant which is to be appointed to the specialist register by the GMC, you need to have -- the standard way is to have what's called a CCT which is sign-off essentially -- it's a certificate of the completion of training. So

you've completed a regulated training course which itself has been signed off by the GMC, and you have passed the fellowship exam from one of the -- the intercollegiate fellowship exam, overseen by the joint committee and intercollegiate examinations. So you need those two things.
The membership, you simply take the exam and you've got the membership route. And it's commonly -- it's an international exam. It's principally used in the UK to give people entry to the higher surgical training where they choose a specialty to specialise in and then they work towards that fellowship exam.
Q. And you mentioned examiners a moment ago. What's the important role played by them?
A. So examiners oversee the exams. So the exams are -- there is question-writing activity to create the exams and then there's the delivery of the exams in various areas. So the exams normally fall into two parts, a written -- it's not exactly -- well, it's a form of multiple choice exam, where people are given different -- it's tougher than what you might imagine for a multiple choice exam because many of the answers are plausible and you have choose the most likely or the best outcome from a range of plausible scenarios. And then you have -- I mentioned before what we call the

OSCE exams where you go around a number of stations and you're confronted with a number of scenarios and you're assessed on your diagnostic skills, your communication skills, your ability to deal and manage a problem quickly.

The examiners' role principally is to write questions and also to be the people who run those OSCE exams. So somebody has to be -- somebody will quiz the candidate during that, about what they're going to do and score them. And we also have an assessor process to assess the quality of the examiners.

THE CHAIR: Does that involve role-play or does it involve scenarios being put to a candidate?

A. So it involves scenarios. There is a proposal at the moment -- actors have been used and there's a proposal to bring them in, in some specialties. They lend themselves to some specialties and not others, but it's principally -- but it's rare to use actors these days.

MR DAWSON: Another aspect of the function of the college that you helped us with was something that had arisen in a different context and so I'll try to deal with the context first and then the specific thing. There are other Royal Colleges in the United Kingdom, is that right?

A. Yes, there are four in total.

Q. What are the others?

A. So there's ourselves, the Royal College of Surgeons of England, there's the Royal College of Surgeons Physicians and Surgeons of Glasgow and then the Royal College of Surgeons in Ireland, so not in the United Kingdom, but part of our British Isles system.

Q. I see and there are, no doubt, some ancient, historical reasons as to why these different organisations have come into being that way. It seems slightly lopsided that there are two in Scotland, but is there an explanation for that of which you're aware?

A. Well, you probably wouldn't design the system as it is now if you were starting from scratch, that's fair to say. It's historic reasons, so the Edinburgh College started as an incorporation of surgeons and barbers in 1505, it's like a Guild setup, essentially. And then with the evolution of the medical practice particularly centred around Edinburgh, we gradually took on a leadership role regionally, nationally and internationally.

The English college followed after that, but I'm not an expert on why it was felt it needed to set up a college there. The Glasgow college I think is older than the English one and was the result of a falling out

between different surgeons, I understand. And so that's what you ended up with in the 16th century, 17th century. But I'm not an expert on the history of all of them, I'm afraid.

Q. Historic but with current resonance, perhaps?

A. Absolutely.

Q. So, as far as the functions of the different colleges are concerned, do I understand from your earlier evidence that in some way there is -- you get together in some way in order to try to make it clear what you're all doing? How does that work, there may be a system through which that operates?

A. So we compete for membership but we also collaborate across a wide range of fields in the interests of -- really in the interests of patient safety. So I think the main thing to mention is what's called the joint surgical colleges meeting which has been going for 30, 35 years, something like that, which brings together the four colleges and meets quarterly. The presidents, vice-presidents, chief execs and various other committee leads. It oversees a number of committees, so the joint committee on intercollegiate examinations runs the fellowship exam. There's something called ICBSE which runs the membership exam which is administered from RCS England, joint committee of surgical training which is

also administered from RCS England which is in charge of effectively the curriculum and the training pathway. So all matters to do with quality around all of those things ultimately come up through that structure and are decided at the joint -- at the JCSM.

Q. So the function of that is to try to co-ordinate the activities of the different colleges but to make sure that the standards in each are similar or equally good?

A. It's more than that because things like all -- well, the joint committee on intercollegiate exams, that's the fellowship exam and the JCST, the curriculum and pathway organisation, they are entirely joint. So there is no separate fellowship exam around the different colleges, there is no separate curriculum development going around the different colleges. So those are examples where there has been -- it's more than simply co-ordination, it's collaboration to the exclusion of independent college entities. In other areas, there is more collaborative activity which tries to bring together college functions but in those crucial areas it's more than that.

Q. What about in the issuing of standards that you talked about earlier, do they tend to be joint or are those issued by different colleges in certain areas?

A. So I think through the curriculum, the curriculum is

dealt with as an intercollegiate matter. Standards and other areas, it's not necessarily co-ordinated, different colleges will focus on different areas and put out different standards depending on what their fellows are interested in at the time or what they think are most significant.

Q. Yes, dependent on their experience or their interest, what they're talking about, to generate the sorts of standards you talked about earlier?

A. Yes.

Q. The particular aspect of this that we're interested in is to do with the mechanism which we are aware of, having existed in our sphere of an invited review, whereby it was possible, certainly we know in 2013, for NHS Tayside to approach the Royal College of Surgeons of England to undertake what they call an invited review about concerns that had been raised about his practice. Is that something which, at that time, they could approached the Royal College of Surgeons Edinburgh to do?

A. Probably not because my understanding is that we, RCS Edinburgh, only started to develop the invited review concept in 2013 and before that time we didn't do them. There was something RCS England had started 20, 30 years ago and I think people in our college had looked at that

you were talking about standards and the sorts of thing that the college would be interested in you mentioned candour and probity. Candour is obviously an area this Inquiry is particularly interested in and hence your evidence about the more recent innovations and initiatives in that area of the college are of interest. But what did you mean by "probity"?

A. I think probity is truthfulness in terms of not misrepresenting yourself, not saying, for example in this field claiming you can perform operations that are perhaps outside your scope of practice, claiming you can do things that you can't. That would be an example. I think there's -- yeah, that would be the main thing. I would think about candour is obviously more about what you reveal and what you say and being truthful and there's obviously an overlap there but I think there's an element of probity in terms of being honest to yourself and a degree of integrity there in terms of what you can and can't do, maybe an element of self-insight as well.

Q. Thank you, that's helpful. So those would be the sorts of areas that would be most of interest to the college if it were to be exercising its -- if I could call it, its limited disciplinary function, am I getting that correct?

and thought that's an area we should get into and some work began around 2013, as I understand it, to pilot invited reviews but we wouldn't -- in 2013, I think I'm right in saying we wouldn't have ever done one before, so it would've been -- it's unsurprising that NHS Tayside would go to RCS England for that because they had an established service. They could have approached us and asked for it to be done, but we wouldn't have had the protocols and the methodology which clearly had been developed through RCS England.

Q. But you now have such a mechanism?

A. Yes, so we've done, I believe, five over the last few years and we've got to a point of developing a suite of protocols, methodology, which are just about to be signed off by our council. So if an organisation came to us today we would agree and go ahead because we have some experience, we have some trained people. We have some protocols on though they haven't been formally signed off. That wouldn't have been the case in 2013.

Q. When you say "organisations", what organisations or other groups or individuals would be able to seek the instigation of an invited review?

A. NHS Trusts and health boards.

Q. Okay, you mentioned earlier in your evidence just a particular thing I wanted to pick up on which was when

A. I think we get a range of cases. Some are probity cases in terms of people not -- surgeons not being truthful about certain situations. Some are straightforward, they've been erased by the GMC for all sorts of things, some are to do with sexual harassment, behaviour in the workplace, that's also not unusual, sadly.

Q. The reason I'm interested in that in particular is that, as I understand it in the statement in the sections where you talk about the college's involvement with Mr Eljamel, I think the position is that you say that the college received no reports of any adverse events concerning Mr Eljamel. Is that right?

A. I believe so, yes.

Q. Obviously we're working here, Mr Egan, on the basis of you having conducted a search amongst the archives, if you like, to try to answer our questions; is that right?

A. A very extensive search, yes.

Q. Well, we appreciate that. But obviously you're trying to tell me what that research has revealed, rather than being someone who was there at the time obviously?

A. Exactly, yeah.

Q. And I was interested to know, it seemed -- we understood from the statement that, in fact, information about issues with Mr Eljamel's practice had perhaps reached you through the media; is that correct?

A. As I understand it, that was the first point in time at which any issues around Mr Eljamel were known within the college. There was a media story I think in The Herald, I think it's in the pack. That, as I understand it, was the first time and led to some internal correspondence about him.

Q. Do I take it therefore that, that being the first intimation there hadn't been any prior intimation by NHS Tayside to the college as far as you could ascertain?

A. As far as we know, no. And from my experience as chief exec, I would be surprised to receive something from a health board or a Trust along those lines, I don't recall that occurring.

Q. Why would you be surprised by that?

A. Because it hasn't happened and issues arise all the time and also I suppose because there is an employee/employer relationship which I imagine the employer would not necessarily think automatically to inform a college, they wouldn't necessarily know which college one of their clinicians was associated with. So I think what I'm indicating is it didn't surprise me to see that NHS Tayside appears not to have informed the college.

Q. You hadn't received any prior intimation from any of the other Royal Colleges either I don't think?

A. No. As far as I'm aware, no.

Q. In particular the Royal College of Surgeons of England?

A. Indeed.

Q. Nor the GMC?

A. Well, as far as I can see from the press cutting -- well, certainly we found no evidence that the GMC contacted us before that press reporting and the reason that press report -- that individual was subject to conditions but wasn't suspended or erased and it's the suspension or erasure of surgeons which we would tend to find out from the GMC, not other matters.

Q. And before -- well, I suppose it's possible that conditions correlate to matters of candour or probity that are of general interest to you?

A. Or not, yes, exactly. It's what I alluded to earlier, there are a range of reasons why conditions might be put in place.

Q. Absolutely, but you also weren't told before that time about Mr Eljamel himself, as I understand it?

A. As I understand it, no. From what I can see, the only correspondence around that time was his decision to retire from practice and therefore give up his membership at the college, but from what I've seen in the information that's before you, it was presented in those very limited terms with no explanation.

Q. Okay, thank you. So he was a member of the college?

A. He was a fellow, yes.

Q. And he was a fellow of the college?

A. Yes, he was a fellow of the college.

Q. And he was an examiner in the college as well?

A. So, he was a JCIE examiner, so for the intercollegiate body and then around the end of that period he had applied to become an MRCS examiner for the membership exam and he had that status around about until the time he left.

Q. And I think he had applied for other positions as well, is that right?

A. He appears to have applied for council, he appears to have applied to become a regional surgical ambassador, or advisor I think it would have been at the time.

Q. The council is the sort of governing body, is that right?

A. Yes, at the time it would have been the trustees of the organisation as well as the professional lead body.

Q. So do I take it that -- is the council -- who makes up the council, is it various surgeons or is it a mixture?

A. Yes, essentially.

Q. So it's presumably very eminent surgeons?

A. Yes.

Q. And the president will be a particularly eminent surgeon

usually, I imagine?

A. Especially when they become president, yes.

Q. And how do applications to the council work, the elections, or how are you accepted as a council member?

A. So elections happen every year amongst the fellowship and membership, the number of vacancies varies from year to year. People put themselves forward and there's a vote. These days it's administered by independent election service and there is a vote and the result is announced. We never -- I never see the actual figures, but we see who has been elected to the council and by implication, we know who wasn't elected to the council.

Q. Yes, and would -- if there were any disciplinary proceedings, if I could put in a limited sense, would it be the council that would be responsible for conducting those? So effectively a peer-on-peer system, if you like, is that right?

A. In respect of the college fellowship and membership, yes. Obviously not in respect of action the GMC takes.

Q. No.

A. But there is a process overseen by the council and ultimately council is the decision-maker as to who is a fellow or a member and who isn't.

Q. So that could mean admission to those positions but also could mean those brought to an end for some reason?

A. Yes, exactly.
Q. I think, just for clarity, is it the college laws that there's a kind of guidebook -- the rules, effectively, is it?
A. So the laws which are agreed by a council but signed off by the Privy Council are the overall legal framework and beneath that sits a set of regulations which council itself can amend from time to time, so there's a balance between the two.
Q. Okay, thank you. Could I ask just to have the statement put up, please, that you helpfully provided, you have a lot of information about different stages of Mr Eljamel's involvement with the college, but if we look at page 43, please, at paragraph 18.1. This is helpfully summarised in the chronology that you have provided and there are some aspects of this that I would be interested to ask you some more questions about arising from your research. In particular, in 1986, it states that Mr Eljamel was awarded a fellowship of the Royal College of Surgeons in Ireland and that the qualification later enabled his application for fellowship within your college without examination. Is that correct?
A. Yes.
Q. How did it come to be that fellowship which you've

described was bestowed upon Mr Eljamel without examination?
A. So historically the main route to fellowship of the college is to take the college's fellowship exam, but obviously at some point in the quite distant past, it was recognised that there were surgeons out there who hadn't taken the college's exam but had achieved equivalent status in terms of their knowledge and experience and a route was created to enable them to apply for and gain entry to the college. That's developed over time and there's a number of routes but essentially the one we're concerned about here is called a sister college route. So that is where fellowship of one of the other three British Isles colleges would enable somebody to enter the Edinburgh college without taking the Edinburgh exam because they've already taken a fellowship exam which has been held to be of equivalent status.
Looking at Mr Eljamel's CV what I noticed about it as well was that he took -- he was awarded the fellowship of the Irish college in 1986 which was shortly before the joint intercollegiate fellowship arrangements came into play and he then took -- seems to have taken, from his CV, the intercollegiate examination in neurosurgery in 1992. So a candidate taking that

exam in 1992 could have joined any of the four colleges. It was an identical qualification at that point.
So that another factor, I think, in understanding why he would have taken that sister college route. It's just that when -- for whatever reason when he took these exams, he took them with the Irish college rather than the Edinburgh college.
Q. Right, but what was the exam you say he took in 1992?
A. So in 1986, the colleges would have all had their individual different fellowship exams, not necessarily at the same standard or covering the same things. An intercollegiate systems was set up in the late 80s, overseen by the joint committee on intercollegiate examinations which established a common fellowship exam in each specialty. And from his CV he, in 1992, took that intercollegiate compassion in neurosurgery. So that would have -- a new candidate for the fellowship coming in in 1992 taking that exam and joining the Edinburgh college would have taken the same exam. So if they passed that exam it would have been identical, but they would have elected to join the Edinburgh college, for whatever reason he joined the Irish college.
But the point I'm making is at that point when he took that intercollegiate exam in 1992 it was a fully intercollegiate exam. So the sister college

application -- my feeling reading the paperwork is he was working in Scotland, wanted to get involved with a college and the Edinburgh college was a more obvious one to get involved in than the Irish college and so he sought a route in through that sister college rule.
Q. So, is what you're trying to illustrate that the time when he was given the fellowship, I think in August 2002, he wasn't -- he didn't just have as part of his background the fact that he was already a fellow of the Irish college since 1986 but he had also passed the joint intercollegiate exam which, in 1992, would have entitled him to get into the Edinburgh college anyway?
A. Or the English college or the Glasgow college. That's my reading of his CV when I looked at it.
Q. So that is an important factor of the analysis but presumably when someone is given a fellowship it's not just a question of looking at whether they've passed exams or their membership somewhere else, is there some other aspect of the entrance system which would perhaps consider their practice, their probity, their candour and this sort of thing?
A. So the position then evidenced in this -- in these papers is he would have required someone to nominate him and a certain number of signatures from fellows of the

college and that was common -- it still is common practice for people who have -- who are seeking to join the fellowship without having taken the Edinburgh college's -- taken the intercollegiate examination and immediately connected to the Edinburgh college. So that is, I think, intended as an extra element in the application process to indicate that somebody is a good fit for the Edinburgh fellowship.

Q. Understood, thank you. I think you give us details in the statement of the numerous people, I think from the Tayside area, who did that, who put Mr Eljamel's name forward?

A. I believe so.

Q. So just back to the statement. It was actually on 28 February 2003 that Mr Eljamel was formally elected as a fellow of the college. And it says that between May 2003 and February 2013 Mr Eljamel served as an examiner for the membership and it also says, for certain examinations, is that -- can you explain which examinations it was for?

A. So, if you don't mind, if I could just have a look at the rest of this section?

Q. Of course.

A. Yes, so I'm slightly thrown by the way we formatted it, May 2003 to February 2013. So, it would seem from the

records that he started off as ophthalmology examiner in both the membership exam and the fellowship exam. So -- yes, so that was his first experience of being an examiner. At the same time, I think it was slightly later, he was also an intercollegiate specialty examiner in neurosurgery, but ophthalmology, yes, was perhaps his first one.

Q. Is that ordinary or is that normal that someone would be an examiner in a different specialty than their own?

A. Well, that's what I asked when I read this. It would be odd now, certainly. Ophthalmology is a little bit of a special case because of changes in governance around ophthalmology. Today, all we run at the moment in ophthalmology is a fellowship which is offered internationally and the examiners must be from that specialty. It would appear that, at this point in time, that wasn't strictly adhered to and I can see, from some of the material that's in the pack, that because he practised in an area that was related to ophthalmology it offered a route to being an examiner. But it is -- so my understanding from what I have learnt is it wasn't unusual in his case but it's certainly not something we would do now.

Q. I was wondering whether it's possible that -- our understanding is that he had quite a broad practice, if

you like, in a number of different areas and whether neurosurgeons can operate in the area where ophthalmological procedures are more common and perhaps because he had that in his CV that that might have qualified him, or could it be a mistake, for example?

A. No. I don't think it was a mistake. I think those are questions that you might need to look elsewhere to answer because I am not -- you're right to identify that as unusual. I don't think it's specific to him. And it's not something we would do now. But what the rationale was for it at that point in time, I wouldn't know.

Q. And that carried on over the period that's mentioned there between May 2003 and February 2013?

A. So it would appear.

Q. Yes, and there's an end date recorded in 2014 but there's no record of why that came to an end at that time?

A. Examiner terms are normally ten years so it's not necessarily the case you would read something into that.

Q. It's just because by 2014 he had been suspended.

A. Indeed.

Q. Would it automatically be the case that -- I suppose, if you found out he was suspended, that that would come to an end?

A. If we found out. Certainly today, if we found out then -- if we found out somebody was -- if I had read the article that we've seen in the pack around Eljamel today and -- I would immediately want to know who this person was and what role they had in the college and if they were an examiner, then we would put the wheels in motion immediately to take them off active membership of any kind of examiner panel, pending a final outcome. But of course you've alluded to the fact that the college may not have known. Practice may have been different at that point.

Q. Right, because if you go over the page, there's the examiner for the JCIE intercollegiate specialty, as you've said, but that does appear to run over a ten-year period which would be more normal?

A. That's right.

Q. And you've mentioned there, something we've come across before, that in 2007 and 2009 he unsuccessfully applied for election to the council and to join the specialty advisory board in neurosurgery. Is there any record that tells us why he was unsuccessful?

A. No, so council is a voting process. So like any voting process it's not usually possible to tell why an outcome has arisen. With this specialty advisory board, it would normally be the case that people would apply to

join and they would be asked -- usual practice now, which I have no reason to think would have been significantly different then, would be to supply a CV, a letter to explain why you want the role, a couple of references, and then there would be an interview process of some sort which would be conducted, in most cases, by senior council members, office bearers. So it may be there were a number of applicants and they were better people. There's no record that I can point to to give any further explanation for that.

Q. Understood. The specialty advisory board in neurosurgery, to try to fit that into the various structures we've discussed, what would that have been doing?

A. So I think that what's we would now call a surgical specialty board. So it sits under council, it's made up of neurosurgeons and its role is to advise council on matters relating to that sub-specialty. So they would discuss educational resource, that the college would make availability for that specialty, it might discuss journals that the library should take around neurosurgery, it might have issues around curriculum development that it wishes to communicate through to the joint committee on surgical training. There's a whole range of things to do with that specialty that the

specialty board would potentially get involved in.

Q. Thank you, and in June 2010, a bit further down, it says he expressed an interest in becoming a regional surgical advisor and was sent an application form. Do we know whether he got that position, I think perhaps not?

A. We don't think he did from the evidence we've seen.

Q. Yes, so hence the application form and then it sort of runs dry, I think is what you said elsewhere?

A. It would be a similar process, I think, to the process that I have described, culminating, one would expect, in an interview senior members of the college.

Q. Yes, if he went through with it, presumably?

A. If it got to that point.

Q. Yes, and a regional surgical advisor, would that be someone providing advice from a particular part of Scotland or how would that work?

A. It's a UK-wide network of surgeons who are the college's eyes and ears across the country in terms of local issues that might need to come to the attention of council but also helping to set up events for local members of the college. So it's a mix of helping the college understand what it's like on the ground and what the issues might be that college -- the council should be pertinent of and should take forward, but also helping to maintain a college presence and to recruit in

the -- out around the country. So it's not just in Scotland.

Q. Right, I see. And that was a surgical advisor rather than -- specifically on neurosurgery, but that's different from the specialty advisory board because the board is advising the council whereas this is feeding in about local issues, if you like?

A. Exactly, so it's not specific to any particular specialty.

Q. Understood. And the application in 2012 where he applied to become an intercollegiate MRCS examiner through ICBSE, how did that process work?

A. My view would be that he's coming to the end of his tenure as a JCIE examiner, presumably enjoys being an examiner. It wouldn't be unusual to then apply to be an examiner for the membership exam. So again, he would apply with a couple of references through the college. College council would consider and approve those and then it would go to -- ICBSE is a committee based in the Royal College of Surgeons of England which looks after the membership exam.

The membership exam is different to the fellowship exam. Whereas the fellowship exam is completely intercollegiate, the membership exam has an intercollegiate core, so the exam is the same for all

of the colleges but the colleges run them separately because they are a key recruiting ground and it also runs internationally in a way that the fellowship exam doesn't. So the ICBSE would receive a recommendation to appoint somebody as an examiner from college council and would endorse that and they would then become an ICBSE examiner. But all of their work would be through the college because it would be to be an examiner for college membership exams.

Q. How does that relate to what we were talking about earlier to do with the ophthalmology side? That's a membership exam?

A. Yes. So ophthalmology -- the whole governance of ophthalmology changed, I believe, during this period there was --

Q. Rather specifically on the ophthalmology, is that the same exam we're talking about or is it different? Because one looks like it's an exam to become a member in a specialty, whereas this seems to be a more general, intercollegiate exam?

A. So I believe it was to bring somebody into the specialty but I'm not -- there's a limit of my knowledge is those ophthalmology exams because they changed so much and the Royal College of Ophthalmology came on the scene at some point. Normally colleges run membership exams, not

ophthalmology, so I would need to come back to elucidate that further.

Q. Right, but does it appear, because the entry in 2013 suggests he attended a mandatory examiner training course, he was appointed to that position?

A. Yes, it would appear so.

Q. Right, and you say, in 2014 -- we've discussed this to an extent already -- that:

"[The Royal College] first became aware of concerns about Mr Eljamel's professional practice through a public article in the Herald newspaper. The article reported that Mr Eljamel had been suspended from Ninewells Hospital following operating error under investigation by the GMC ..."

And that was RCSE-00092. And that:

"This article was circulated internally to senior staff, including the then Chief Executive Officer, Director of Membership and Marketing, Executive Officer, Honorary Secretary, and Membership Manager [RCSE-00011 and RCSE-00091].

"Following this, an internal email exchange took place between the Membership Manager and the Honorary Secretary, who had responsibility for fellowship matters [RCSE-00011 and RCSE-00091]. There is no record of any disciplinary hearing being initiated under the college

laws."

So I think it's the case that no disciplinary action was ever taken in connection with Mr Eljamel; is that right?

A. That's right.

Q. And I understand from the statement, and perhaps what I have just read there, that's because the college really didn't know very much about what was going on, if anything, about Mr Eljamel before they read that article?

A. Exactly.

Q. And on 22 May, 2014, the president -- the then president of the Royal College wrote to Mr Eljamel offering pastoral support following his suspension. Can we have that one up, please, it's RCSE-00090. So if we just go down to the original letter, it says:

"Dear Professor Eljamel.

"I was so sorry to hear about the trouble that is afflicting you at the moment. I know that this must be a very difficult time for you. As President of your College, I would be happy to talk to you if you felt that would be a help. I am not sure that there is anything I can do other than to listen to you and to empathise with you in a very difficult situation. If you feel that would be helpful I would be very happy to

meet with you.

"Once again, my sympathies for you in a very difficult situation."

That was from the then president and then, if we scroll up to the top, please, we can see a short reply, which says:

"Dear Ian.

"Many thanks for the email that means a lot to me. Many thanks for thinking of me.

"Regards."

Do you know, or can you deduce from your experience, whether that is an email that would be sent out to all members in those circumstances or is that a particular missive that was sent for reasons that were, no doubt, personal to the president?

A. I don't know. I don't know. There is -- it's certainly a live debate now in the college around what support can and should be provided to surgeons who are subject to disciplinary proceedings and there's a recognition that these proceedings need to occur and are very important but, at the same time, there are people at the heart of it whose welfare also needs to be thought of. And that's principally I think the role of the employer but as a membership organisation there is a role for the college to signpost a support, that's our current

approach would be to signpost a support.

My feeling would be that this email reflects the same sense at the time of providing a support during a difficult period. But I couldn't -- I wouldn't know whether this was something that was routinely done or whether there were some special reason on this occasion why it was done.

Q. Of course. That was the reason I was asking the question. Really I was trying to tap in whether the college has a pastoral role in these types of situation because I suppose, in essence, an employer might be in a similar situation to the extent that they might be imposing restrictions on someone and doing that for a good reason but also have obligations to support the individual in question. There's a sort of dichotomy in the role, but you don't know the particular circumstances in which this was written?

A. I don't, no.

Q. Thank you very much. Those are all the questions I have for now. At this stage what I normally do with witnesses is to ask if there is anything in particular you would like to say about anything we've discussed or any other aspect of the evidence of the college?

A. Well, I think I would go back to some of the questions you asked earlier around patient care. I think --

I can't remember whether I said it clearly or not, but I think a key role in the college is to protect the public. It's so that when you are as a member of the public and you are subject to surgery it's a very difficult process. You have no control over the situation. You are subject to actions which in normal life would be considered an assault, a serious assault, and you have to believe and have evidence and faith and confidence that the surgeon is properly trained and is doing their very best to achieve the best outcomes. I think from the college's point of view and the reason why we have been so keen to take part in this process and to offer this evidence is in order to learn lessons around what's happened here and to play our part in further enforcing the system as a whole to ensure that these things don't happen in future.

So I think it's important to just explain we have a slightly different role to many of the other participants. We're not an employer, we're not the regulator, we didn't know what was happening, as we've established in these papers, but we certainly from a future perspective, in terms of what we want to do going forward, we want to be part of a solution which tackles these problems effectively for the future.

MR DAWSON: Thank you for that, Mr Egan, and we share those

ambitions and so thank you for that. There will now be a short break to allow core participants the opportunity to come up with some more questions but it won't be long, maybe ten minutes.

THE CHAIR: That's fine. If you slip next door and we will resume again when we're ready to do so.

(4.11 pm)

(A short break)

(4.22 pm)

MR DAWSON: Sir, there are in fact no further questions for Mr Egan. Thank you. Thank you, Mr Egan.

THE CHAIR: Thank you very much.

Mr Egan in fact there are no further questions for you. That means that that concludes your evidence. Can I thank you for coming in and giving evidence today and putting all the work into the presentation that you have given overall. We are very grateful and you are free to go. Thank you.

Right, any matters that we need to address before --

MR DAWSON: No further matters today, sir.

THE CHAIR: Thank you everybody. We'll finish now. We seem to have lost the secretariat but I'll just go anyway.

Thank you for your help.

(4.23 pm)

(The hearing concluded)

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