

1 Wednesday, 9 September 2026 2 (10.06 am) 3 THE CHAIR: Good morning, please be seated. 4 Yes, good morning, Mr Dawson. 5 MR DAWSON: Good morning, sir. The first witness this 6 morning is Nicky Connor. 7 THE CHAIR: Thank you. 8 MS NICKY CONNOR (sworn) 9 Questions by COUNSEL TO THE INQUIRY 10 MR DAWSON: Good morning. You are Nicky Connor? 11 A. I am Nicky Connor. 12 Q. There are microphones in front of you. Hopefully 13 someone has explained this to you but if you could speak 14 broadly into the microphones they will pick up your 15 voice for the transcript. Thank you very much indeed. 16 As I've said to you already if you need to take any 17 breaks or anything like that during the course of the 18 day then feel free to ask. I'm sure the Chair will be 19 amenable to that. You contributed to a witness 20 statement which was provided to the Inquiry dated 21 8 June 2026; is that correct? 22 A. Correct. 23 Q. Could we have a look, please, at page 1 of NHST-04944. 24 Is that the front page of the witness statement that you 25 contributed to? Page 1	1 of subsections where you address, or the board 2 addresses, or Dr Cotton addresses, a number of different 3 types of documents which fall within that ambit and 4 explain what of those types of documents are still 5 available to the board, is that right? 6 A. Correct. 7 Q. And there is a subsection in the statement where the 8 type of document that is being addressed is theatre 9 logbooks, is that right? 10 A. Yes. 11 Q. And is that the section of the statement which you 12 contributed? 13 A. That is. 14 Q. Thank you. Sir, just for the sake of clarity I think it 15 might be worth pointing out, both for the witness and 16 for people more generally, that it's our normal practice 17 as I set out yesterday to publish statements at the end 18 of the day when witnesses have given evidence that day 19 related to that statement. So for example yesterday we 20 would have published Liz Smith's statement after her 21 testimony. Because of the way that Ms Connor has 22 explained the statement was provided, it's our intention 23 to lead evidence all of the contributors to the 24 statement at various different times over the next 25 few weeks but not to publish the whole statement until Page 3
1 A. It is. 2 Q. It says that the statement was given by Dr James Cotton, 3 who is he? 4 A. Dr James Cotton is the executive medical director and 5 carries executive lead responsibility for the Inquiry. 6 Q. Thank you. My understanding is that the statement has 7 been signed by him? 8 A. Yes. 9 Q. And that there were various contributors to the 10 statement based on the fact that it covered a wide 11 variety of different subjects, is that right? 12 A. Yes, that's correct. 13 Q. And that the contribution to the statement that you made 14 focused on, if you put it this way, a particular 15 subsection of a particular section. The section dealt 16 with the documents relevant to the Inquiry's ambit which 17 had been asked for which were in the possession of 18 NHS Tayside? 19 A. Correct. 20 Q. And as a subset of that we had asked you, or the board, 21 to explain to us whether there are documents that fell 22 within that category that had at some point been 23 destroyed, is that right? 24 A. Correct. 25 Q. And that section of the statement is split into a number Page 2	1 the last has given their evidence. That's currently 2 scheduled to be on the last day of the sessions so 3 therefore in order to try to make clear publicly what it 4 is we're talking about in the absence of the statement 5 being published at the end of the day, we will take 6 witnesses through relevant passages and that will have 7 the result of those passages being replicated in the 8 transcript of the proceedings such that people who take 9 an interest can look at that at the end of the day. 10 THE CHAIR: Yes. Thank you. 11 MR DAWSON: Is that understood, Ms Connor? 12 A. Yes. 13 Q. So obviously aspects of this statement are contributions 14 by you. It won't be published in the normal way but 15 I'll take you to some of those passages and they will be 16 recorded in the evidence that's being given by you 17 during the course of today. Can I just ask you a few 18 questions about your background. If we can go to 19 paragraph 2.1, please, of the statement. Thank you very 20 much. It says there: 21 "I am Nicky Connor, RGN, Bachelor of Nursing, MSc in 22 Primary Care. I am Chief Executive of NHS Tayside, 23 a position I have held since July 2024, and an executive 24 member of the NHS Tayside Board. I qualified from the 25 University of Dundee in 1997. I was Chief Page 4

1 Officer/Director of Health and Social Care in Fife from 2 2019 to 2024 and I have previously held senior nursing 3 leadership roles in NHS Fife. As Chief Executive I also 4 hold the role of Accountable Officer for NHS Tayside." 5 You go on to say: 6 "I do not and have never practised clinically within 7 the Neurosurgical Department at Ninewells Hospital. 8 I am also NHS Tayside's Accountable Officer, and this 9 includes the Neurosurgery Department. I worked at 10 Ninewells Hospital while a student nurse between 1994 to 11 1997, before commencing a role as a registered nurse 12 in February 1997." 13 So, Ms Connor, you come from a nursing background? 14 A. I do. 15 Q. And what senior nursing roles did you hold in NHS Fife 16 before arriving at NHS Tayside as chief executive 17 in July 2024? 18 A. Thank you, I was lead nurse then I became associate 19 director of nursing. So one of the senior nursing team 20 reporting directly to the executive nurse director. 21 Q. Right and was that from when you qualified from Dundee 22 University in 1997? 23 A. No, when I qualified in 1997 I worked in Ninewells 24 Hospital within the medical department. I then moved to 25 Fife. I worked within Victoria Hospital in coronary Page 5	1 director of Health and Social Care, can you tell us 2 a little bit more about what that role entailed? 3 A. I can, thank you. That role is part of integration in 4 line with the legislation where I was the 5 most senior officer to Fife Integration Joint Board of 6 which there is only one within Fife but I also carried 7 operational responsibility for delivery of all of the 8 services that were delegated to the Health and Social 9 Care Partnership. So that included health services, 10 community hospitals, mental health, learning 11 disabilities, but also included community services 12 whether that be nursing, allied health professions. It 13 also included services such as adult social work and 14 adult social care. 15 Q. Okay, thank you. And does that then, in terms of the 16 hierarchy which I know can be complicated, sit as 17 a senior management role underneath the chief 18 executive of NHS Fife, is that right? 19 A. In that role -- it's a complex role, it covers both the 20 services delegated from the local authority and also 21 from the NHS. So I was a direct report to both the 22 chief executive of the local authority so that would be 23 Fife council and the chief executive of NHS Fife. 24 Q. Thank you and you're now the chief executive of 25 NHS Tayside? Page 7
1 care and cardiology. I moved out into the community and 2 worked as a community nurse and then a specialist nurse 3 and then I undertook leadership roles. My most recent 4 role though prior to coming to Tayside was as chief 5 officer and director of Health and Social Care which is 6 not a nursing role within Fife. 7 Q. And all of those apart from the Ninewells training was 8 within NHS Fife? 9 A. Yes, that's right. 10 THE CHAIR: I'm sorry to interrupt, Mr Dawson. Although 11 these proceedings are actually being transcribed, some 12 of us particularly old-fashioned people like me are 13 actually noting what you have to say. I know it's very 14 easy and tempting when giving evidence to speak quickly 15 but can you just slow down a bit for my benefit if not 16 for anyone else's, thank you. 17 A. Absolutely. Thank you. 18 MR DAWSON: Thank you very much. And you say that you 19 worked at Ninewells between 1994 and 1997 as part of 20 your training? 21 A. I was a student nurse for the University of Dundee. 22 Q. And did you have any experience of the neurosurgical 23 department or of Mr Eljamel at that period? 24 A. No. 25 Q. The role that you held at NHS Fife as chief officer and Page 6	1 A. I am. 2 Q. Can you tell us something about the main 3 responsibilities that you have in that role? 4 A. Of course. So I carry, as chief executive, the overall 5 responsibility for the leadership, the management and 6 the performance of NHS Tayside ensuring that we are 7 delivering safe, effective, person-centred healthcare 8 for the population of the entirety of Tayside. In 9 addition I'm also the accountable officer. 10 Q. Okay, I'll go on to that in a second. Just in terms of 11 what you said there about the geographical spread, 12 something that came up yesterday and I think is 13 reflected in other parts of the statement answered by 14 your colleagues, obviously we're predominantly 15 interested in this Inquiry in the neurosurgical services 16 that were offered by NHS Tayside and some other bodies 17 and its predecessors from 1995 to around 2015. And we 18 understand that the position is that the primary 19 service, if you like, that's offered by NHS Tayside 20 relates to three local council areas in that area but 21 that acute services, including neurosurgery, are offered 22 more broadly than that; is that correct? 23 A. So it might be helpful just to describe, my 24 responsibilities are discharged through my executive 25 team. Within that executive team there are groupings of Page 8

1 staff that form part of my team. So I have got 2 professional leadership and that's the executive nurse 3 director, executive medical director and director of 4 public health. I then also have business enabling which 5 is the director of workforce. 6 THE CHAIR: Sorry, who is that? I didn't catch what you 7 just said. 8 A. Business enabling, so those that enable the business and 9 that is both the director of workforce and the director 10 of finance. I also then have a key set of roles which 11 are operational leaders and that includes chief 12 officers. One for Angus, one for Perth and Kinross, one 13 for Dundee and one for acute services and together they 14 make up my team. 15 In terms of the delivery of how services are 16 delegated, there are some services that are delegated to 17 these chief officers that work within health and social 18 care purely for the locality that they serve but they 19 also sometimes take leadership across the whole of 20 Tayside. None of them have leadership for neurosurgical 21 services, that is delivered within the acute services. 22 MR DAWSON: I see. So you have identified there I think 23 that there was a geographical component to certain 24 elements of those jobs. I think for chief officers 25 I think they are the three local council areas that Page 9	1 Q. -- were you trying to convey that there are aspects of 2 the delivery of services, more specifically that you 3 wouldn't know about or be responsible for, that they 4 would be better to ask effectively? 5 A. No, no, it depends on the level of detail -- 6 Q. Of course. 7 A. -- that would be sought. However, the point that I was 8 trying to make, apologies, was that as well as leading 9 for a geographical area there are some services that 10 they deliver for the whole of Tayside. So I gave you 11 an example, psychological services is delegated to 12 Dundee but it is delivered for the whole of Tayside. So 13 I did not want it to be interpreted that they will be 14 delivered purely for the geographical area and that's in 15 line with the integration scheme that is published. 16 Q. Right, thank you. You say that you also hold a role as 17 accountable officer for NHS Tayside, is that something 18 that derives from your position as chief executive or is 19 it something separate? 20 A. It's chief executive and accountable officer and that is 21 part of being appointed by ministerial appointment into 22 the board and it carries that accountability with it. 23 So through being accountable officer I'm accountable to 24 the board and ultimately to Scottish Government and that 25 covers the stewardship of public resources, financial Page 11
1 I mentioned, is that right? 2 A. They are. 3 Q. So that's Perth and Kinross, Angus and Dundee; is that 4 right? 5 A. Yes. 6 Q. And then separate to that there is a chief officer for 7 acute services, yes? 8 A. Yes. 9 Q. And neurosurgery is delivered within acute services? 10 A. It is. 11 Q. And that neurosurgical services, insofar as provided by 12 NHS Tayside, goes beyond those three geographical areas 13 into a broader area; is that correct? 14 A. So we may well accept patients at times from outwith 15 Tayside, is that what you mean, sorry, or do you ...? 16 Q. Yes. 17 A. We may at times and that covers a whole range of 18 specialties by which that may sometimes happen 19 particularly where we have boundaries with Northeast 20 Fife and particularly where we would work with other 21 health boards to support the delivery of healthcare 22 across boundaries. 23 Q. When you were telling us a moment ago about the various 24 different executives that work under you -- 25 A. Yes. Page 10	1 standards, governance, risk management and compliance 2 with statutory organisations, legislation, as well as 3 the use of public funds. 4 Q. I see so -- is it fair to say that you're ultimately 5 responsible to Scottish Government for everything that 6 happens below you in NHS Tayside? 7 A. I am accountable into the board and the board has 8 accountabilities that feed up into Scottish Government 9 but I also have direct responsibilities to the 10 director general. 11 Q. I see, but just to address my question, are you then 12 accountable and responsible for everything that happens 13 below you in NHS Tayside? 14 A. I am accountable. I think responsibility is a different 15 thing. I discharge responsibilities through my 16 executive team but ultimate accountability sits with me 17 as the accountable officer. 18 Q. So if something's gone wrong in NHS Tayside the 19 government can hold you accountable? 20 A. Yes. 21 Q. How do you account to the Scottish Government? 22 A. There are a range of ways that that happens. It happens 23 through the annual public meetings that take place in 24 terms of the annual performance meetings, it happens 25 through inquiries, submitting letters and there's also Page 12

1 a regular meeting that happens with the director general 2 with all accountable officers across Scotland so it 3 would depend on the topic or the subject that was done. 4 Q. So you mentioned there -- just for the sake of clarity 5 for everyone and so that I'm getting it right in my own 6 mind -- the director general you mentioned there is the 7 director general for Health and Social Care? 8 A. Yes. 9 Q. And that is a senior civil service position within the 10 government; is that correct? 11 A. Yes, yes. 12 Q. And that sits within the directorate of Health and 13 Social Care? 14 A. Yes. 15 Q. Which is the directorate through which the Scottish 16 Government discharges its responsibilities for 17 healthcare under the devolution settlement? 18 A. Yes, and I may at times also have direct communication 19 with ministers. 20 Q. Thank you. I'm glad I have that right, thank you very 21 much. I understand that the director general also holds 22 the position as the head of NHS in Scotland, is that 23 right? 24 A. My understanding, yes, chief executive of NHS Scotland. 25 Q. Chief executive, that's right, yes. I was interested to Page 13	1 Q. Thank you. Just one more question on that, just in 2 terms of the structures. Is it the case that all chief 3 executives across the country or boards come from 4 a clinical background or is there variation in that? 5 A. There's variation. 6 Q. Right. Is it deemed important that you do or in fact 7 deemed preferable that you don't? 8 A. I don't know that there would be a view on that. 9 I certainly find it helpful to have that background 10 because I have a strong understanding but I don't think 11 it's imperative. It's not part of the job description, 12 not a requirement of the role. 13 Q. Right, so it's a management function effectively, a very 14 senior management function? 15 A. Yes, it's not a clinical function. 16 Q. Not a clinical function and you have, as I think you've 17 described to us already in the details, other executives 18 who sit below you responsible for clinical aspects of 19 the board's delivery of its services? 20 A. That's correct. 21 Q. Thank you. Understood. In your experience as a senior 22 leader and ultimate accountable officer, in what 23 circumstances you would expect a chief executive of 24 an NHS board to become involved in handling issues 25 relating to the practice of a consultant like Page 15
1 know how that works as regards the interface between the 2 overall chief executive, if you like, who I think is 3 also the director general and then the chief executive 4 of the territorial health boards of which you are one? 5 A. So as I said earlier, there is a coming together on 6 a fairly regular basis where the director general meets 7 with all accountable officers across Scotland and that 8 is discharged what is called through the NHS Scotland 9 executive group. Beyond that I think it's very clear 10 that for each individual board the accountabilities sit 11 with the accountable officer. 12 Q. Right, understood, thank you. You say that you're 13 accountable to the government and to the board. Are you 14 accountable to anybody else? 15 A. I'm accountable to the people of Tayside and I am 16 accountable to staff. 17 Q. And how do you account to them? 18 A. Transparency, openness, sharing. We have public board 19 meetings. We are able to show fully the matters that 20 are being considered at board level. In terms of staff 21 I do regular visits out and about, meeting with people, 22 speaking to people, listening to people. 23 Q. Okay, that's an important part of delivering healthcare 24 in the NHS, isn't it? 25 A. Vital. Page 14	1 Mr Eljamel? 2 A. So I guess in an organisation there's lots of layers, if 3 I could call it that, where there are -- and if I can 4 speak specifically to acute services within NHS Tayside, 5 there will be the front line teams. They sit within 6 what are called clinical care groups that have leaders 7 there. They sit within a wider directorate and then 8 they report into overall acute services and then it 9 comes into the wider element of the organisation. So 10 I would expect for anybody that we are managing matters 11 as locally as possible until they're escalating, they 12 will go through due process and we have policies in 13 place that clarify levels of escalation if there are 14 matters of conduct or capability. Particularly I think 15 there is a role as chief executive where my team needs 16 support or where there is sitting is reputational risks 17 for the organisation. 18 Q. So I'm a patient that has an issue with myself or 19 a family member and I want to try to work out what 20 happened or possibly seek redress for some harm that's 21 been caused to me or my relative and you are accountable 22 to the public. Can I come to you? 23 A. I regularly receive emails and correspondence and 24 communications from the members of the public. What 25 I would do with that on receiving that is it would be Page 16

1 acknowledged and it would be passed on to a dedicated 2 team we have around our patient experience team who 3 would support an investigation into those matters. 4 Q. Because the way that you've described the service there, 5 which is no doubt very familiar to you, the acute 6 services and the different levels and layers, it does 7 sound slightly impenetrable for a member of the public 8 to try to work out how they access the accountability of 9 a board like NHS Tayside? 10 A. Regularly I will receive communications from patients 11 and we would seek to support the connections, the 12 signposting and the direction for people to help them 13 navigate that. I do recognise that an organisation of 14 14,000 people and the complexity that I described 15 earlier regarding both integration and acute services 16 can be challenging. That would not be unique to 17 Tayside, that would be the position of all boards across 18 Scotland. 19 Q. Thank you. 20 THE CHAIR: Well, do you agree with Mr Dawson's proposition 21 which was that it might, to the outsider, seem somewhat 22 impenetrable the arrangements he described? 23 A. I think there can be challenges in terms of how people 24 know to access the service. I think that becomes what's 25 really important in terms of the information that we Page 17	1 then? 2 A. Yes. 3 Q. You mentioned the formation internally of "huddles", 4 I have noticed that expression in other places. Could 5 you explain to the Chair what those are or were? 6 A. Yeah, so there was a mechanism in place which was called 7 the huddle that was led by the executive medical 8 director to make sure that we were bringing together all 9 of the key information. What began as a huddle has 10 progressed in terms of governance and evolved on to 11 becoming the oversight group. 12 Q. So what is a huddle then in this context? 13 A. It's where the key information comes together with the 14 key group of people that require to be involved and know 15 and they're able to share that with each other and have 16 a central mechanism, is what that started with in terms 17 of the Inquiry. 18 Q. Because I think we've encountered this already but we'll 19 certainly encounter this as we're going on today that 20 one of the main purposes of this Inquiry or one of its 21 main objectives is to try to address the issue of 22 communication -- 23 A. Yeah. 24 Q. -- in healthcare and certainly the Inquiry's impression 25 from what it's seen so far is that that is a real Page 19
1 have publicly available. So we've got a website that is 2 publicly available, we have got social media where we would 3 share information. We have got clear policies as well 4 that are able to support the signposting of people. So 5 we seek to be able to make that as accessible as 6 possible, but I would recognise at times it can be 7 challenging for people to know where to start. 8 MR DAWSON: I understand that you first joined NHS Tayside 9 as its chief executive in July 2024? 10 A. I did. 11 Q. What information was provided to you about the Eljamel 12 situation, if I can put that way, when you joined? 13 A. So at that time I was advised that we were looking at 14 that being a public inquiry, that that was a direction 15 that was being taken forward. I was advised that we 16 were establishing huddles, and that we had mechanisms in 17 place in terms of supporting a level of readiness in 18 relation to that. I was also made aware of some of the 19 previous key reports such as the due diligence report 20 and other previous work that had been undertaken on the 21 build-up to the Inquiry. 22 Q. So the Inquiry was announced by the Cabinet Secretary 23 in September 2023. 24 A. Yes. 25 Q. So it was already up and running, it was a thing by Page 18	1 issue in lots of different ways but it definitely 2 appears to manifest itself in the sense that -- and 3 I recognise that lawyers fall into this trap often 4 yesterday as well -- that the healthcare providing 5 organisations have their own language for things that 6 can often be difficult and can be perhaps sometimes 7 a barrier to accountability and communication. So 8 I just want to be clear as to what these things are as 9 we go along and exactly what you mean about things. 10 Because there may have been occasions on which, I think 11 perhaps reasonably, aspects of the language that's used 12 have been misunderstood because there is really almost 13 a different language used at times. So this is where we 14 come across this for the first time. So would it be 15 fair to say that a huddle is where something arises that 16 needs NHS Tayside's attention and a group are put 17 together to try quickly to assimilate all of the 18 relevant information and work on a plan; would that be 19 fair? 20 A. So I accept your point around how language is used and 21 "huddles" can mean different things in different 22 context. 23 Q. I see. 24 A. In the context of this it was the bringing together of 25 key people in terms of the central co-ordination of the Page 20

1 Inquiry. The executive medical director, 2 Dr James Cotton, who has chaired that will be best 3 placed to tell you the detail of how that worked, but it 4 evolved from being a huddle into being known as the 5 oversight group to formalise that governance more. 6 Q. Understood. So it became a more formal group later but 7 initially it was a huddle. Had that been set up 8 before you joined in July 2024? 9 A. I would -- that feels like a long time ago so I would 10 require you to clarify that with Dr Cotton. 11 Q. Okay, thank you. And my understanding is that -- we'll 12 come back to the due diligence review in a moment, but 13 my understanding is that one of the things that was done 14 when the due diligence review was carried out, which was 15 completed in August 2023 I think, was that all of the 16 information that was thought relevant to the Eljamel 17 affair, if you can put it broadly, was put together in 18 something called an information log; is that correct? 19 A. Yes. So my understanding is that was the establishment 20 of the key element of the team, so the patient liaison 21 team that was put in place and elements of that included 22 both the support for patients but also evolved into 23 including key information logs being gathered. 24 Q. Yes, because you mentioned a moment ago I think that the 25 time you joined key information was being put together Page 21	1 affair? 2 A. So, it's very serious and that this warrants a public 3 inquiry. I also know that there had been ongoing 4 concerns from patients and understand there had also 5 been concerns regarding both the time bar issue as well, 6 so that was another element that I was made aware of. 7 I understood that Mr Eljamel is not here and that this 8 Inquiry was going to be looking into the full findings 9 of this. 10 Q. And I'm imagining that when you come along as chief 11 executive that you get a lot of information given to you 12 but if one of the things that you're told is that 13 a public inquiry has been announced only a few months 14 before into an important component of the service that 15 you deliver, affecting nobody knows how many but 16 potentially hundreds maybe even thousands of patients 17 that that would become something of a top priority, is 18 that fair? 19 A. Absolutely, yes. 20 Q. And did it? 21 A. Yes. Yes. 22 Q. And the priority that it was accorded was through the 23 process that you discussed of the huddles being formed, 24 them doing their work and eventual that moving into 25 a more formal group? Page 23
1 in 2024. I'm trying to understand why that was 2 necessary when the due diligence process had put 3 together the key information as I understood it? 4 A. So apologies if I misunderstood your question, 5 I understood it to be what was I being made aware of and 6 I gave examples of the type of information I was being 7 made aware of. As to when the log was populated with 8 what I'm unclear but the log also remains 9 a contemporaneous information and the logbooks would be 10 an example of how we continue to build that log. 11 Q. Okay. 12 THE CHAIR: Sorry, I'm not sure I follow what you mean by 13 that. 14 A. So there would have been a level of information that was 15 gathered together in terms of that but actually if we 16 had information relevant to the Inquiry -- and the most 17 recent submission would have been the outcome of the 18 AAB report -- we would continue to make sure that that 19 was registered, rather than it being a completed thing 20 entirely at a moment in time, I think it's important 21 that that's kept up to date. 22 THE CHAIR: All right, thank you. 23 MR DAWSON: I'll address some of those aspects with 24 Dr Cotton when he comes along. What were you told when 25 you joined NHS Tayside about the history of the Eljamel Page 22	1 A. I think my involvement was more active than that. 2 I would regularly be meeting with Dr Cotton. Also there 3 was -- the board had an active role there as well. 4 Q. Did you meet with any of the patients of Mr Eljamel 5 around that time? 6 A. Not immediately on starting, no. 7 Q. Were you aware of them being keen to meet with you? 8 A. I was aware that there was ongoing discussions and I was 9 aware, I guess at that time, that there was work ongoing 10 in relation to the time bar specifically. 11 Q. I'm going to ask you some questions in due course, 12 Ms Connor, about the board's position about various 13 aspects of what I'm calling "the Eljamel affair" so as 14 not to exclude any particular aspect of it but I'm keen 15 to understand whether, in formulating the board's 16 position on the matters that the Inquiry was to look at, 17 which inevitably must have happened and you've explained 18 how, that whether you were a part of formulating the 19 position if you like or whether the position was 20 effectively a fait accompli given what had been found in 21 the due diligence report the year before? 22 A. Apologies, could you clarify. I'm not sure what you're 23 asking. 24 Q. I'm asking whether you were a part of forming 25 NHS Tayside's position in relation to the matters which Page 24

1 would be covered by the public inquiry announced before 2 the year that you were appointed as chief executive? 3 A. The matters -- so there's elements to that as well. So 4 the matters of that, I mean that had been announced 5 before I took up post, is the position. However -- 6 Q. That's correct. 7 A. -- as we said earlier, I have been involved in the 8 submission that has been given to the Inquiry in terms 9 of the evidence base. 10 Q. So you have been involved in writing some paragraphs 11 about the destruction of logbooks -- 12 A. Yes. 13 Q. -- which happened later? 14 A. Yes, yes. 15 Q. But have you been involved beyond that? 16 A. I will have read the entire submission before that was 17 submitted. In terms though of deciding what the scope 18 of the matters were, that was prior to me taking up 19 post. 20 Q. When you say -- I think we're going to run into some 21 difficulties of language. 22 A. Sorry, I don't understand you, apologies. 23 Q. Just let me ask the question. When you say that the 24 scope of matters was decided within NHS Tayside before 25 you read the submission, what do you mean by "the scope Page 25	1 A. The answer to that would be a mix of things. I know 2 that the recent position for example that we took in 3 relation to the time bar I was involved in formulating. 4 I know that the submission in relation to logbooks I was 5 actively involved. There's other elements that will 6 have come from either before I took up place or key 7 members of the team. 8 Q. Did you sign off the opening statement that was made at 9 this Inquiry? 10 A. I was part of signing off that, yes. 11 Q. So when you say you were part of signing that off the 12 answer is "yes"? 13 A. Yes. 14 Q. Could I have a look, please, at section 2.3 of the 15 statement which was NHST-04944, zooming in on 2.3, if we 16 could. This is just reading on from where we were. 17 This is the section, I think, where you have written 18 a few paragraphs just introducing yourself and then 19 everybody else is introduced and you see Dr Cotton comes 20 in, but just to complete that passage, you said: 21 "I have contributed to the responses in this witness 22 statement request that relates to the loss of the theatre 23 logbooks at Ninewells Hospital as I have commissioned 24 internal and external investigations relating to this 25 matter in Part E ..." Page 27
1 of matters"? 2 A. I don't think I have understood your original question. 3 Can we please go back to that? 4 Q. My original question was to do with the extent to which 5 you have been involved in formulating NHS Tayside's 6 position on the matters that this Inquiry addresses or 7 whether that has been done by others or was decided 8 effectively in terms of the conclusions of the 2023 due 9 diligence report? 10 A. I'm really sorry but I'm still not understanding. 11 Apologies. 12 Q. You look very confused, Ms Connor. I hope my question 13 is relatively clear. I'm just trying to work out -- the 14 board has presented to this Inquiry a multitude of 15 different positions about various matters that fall 16 within its remit. That is because the recognised legal 17 representatives have been asked to do so and they have 18 compiled, no doubt on the senior team's instructions, 19 the board's position. 20 A. Yes. 21 Q. I'm keen to try to explore with you a clear 22 understanding of what those positions are today so 23 I'm asking you whether you were involved in formulating 24 those positions or whether those were formulated by 25 other people? Page 26	1 Then you highlight the questions you answered. Were 2 the theatre logbooks lost? 3 A. The theatre logbooks were destroyed. 4 Q. Why did you use the word "loss" there then? 5 A. I think the word "loss" would have -- there is a loss. 6 I think there is a range of matters of how things become 7 a loss. 8 Q. But they were destroyed? 9 A. They were destroyed. 10 Q. And they were destroyed despite the fact that a "do not 11 destroy" notice covering them had been issued by the 12 Chair of this Inquiry? 13 A. Yes. 14 Q. To describe this situation as a loss could be deemed to 15 be misleading, could it not, Ms Connor? 16 A. It certainly was not intended to be misleading. 17 Q. Thank you. And given your ultimate accountability, 18 you're ultimately accountable for their loss, aren't 19 you? 20 A. Yes. 21 Q. Because you made the distinction earlier, are you 22 responsible for it? 23 A. So through this -- I discharge my responsibilities 24 through my team but the findings of the independent 25 inquiry have clearly found that there were failings Page 28

1 across the organisation of which I also carry 2 responsibilities as well as accountability. 3 Q. Okay, thank you. Could I just, on a slightly different 4 topic, ask you about a recent event because it's of 5 interest to the Inquiry. I understand it was announced 6 in parliament last Tuesday that NHS Tayside is to be 7 disbanded; is that correct? 8 A. So I appreciate that was announced. That's not 9 necessarily my understanding. My understanding is that 10 we are moving to national reform, that they have 11 announced there will be two boards. 12 Q. Yes. 13 A. Beyond that I am unclear on what the next steps are. 14 Q. Thank you. It is a bit unclear and I just wondered if 15 you could help us a little bit more. I'll just explain 16 a little more about what our primary interest in that 17 is, which is: are there going to be moves that you're 18 aware of in the medium term that will mean that the 19 responsibilities we've talked about and the people 20 involved will change or, as far as you're aware, will 21 the people that we have been corresponding with about 22 the Inquiry continue to be those who have we've been 23 corresponding with up till now? 24 A. I don't know that I know enough about what's going to 25 happen next to be able to honestly answer that question Page 29	1 review? 2 A. I read the -- apologies, I read the due diligence 3 review. 4 Q. Shortly after the due diligence review was published, 5 the then Cabinet Secretary, as we've already touched on, 6 on 7 September 2023 announced that there would be 7 a public inquiry into the Eljamel affair, is that your 8 understanding? 9 A. Yes. 10 Q. It was made quite clear in his address to parliament and 11 also in the evidence we heard yesterday from Ms Smith 12 that the findings of the due diligence report had been 13 instrumental in him making a decision there should be 14 a public inquiry, was that your understanding? 15 A. Yes. 16 Q. Was it communicated to you, and has it been communicated 17 to you, what the gaps or deficiencies of the due 18 diligence review were thought to be such that a public 19 inquiry would be appropriate? 20 A. At the time of taking up post, I am -- I can't recall 21 that level of detail. 22 Q. And subsequently have you learned more about that? 23 A. Well, there was definitely -- there was definitely 24 concerns regarding, I guess, honesty in terms of the 25 probity that had been shared. There was definitely Page 31
1 because I don't know what the timescale for any change 2 will be and I don't actually know what that change will 3 involve. 4 Q. Okay. That's because you don't have that information 5 yet? 6 A. I don't, no. 7 Q. Okay, I appreciate that, thank you. Could I ask to go 8 to another document now, please, it's ELJ-00538. This 9 is a copy of the opening statement that was delivered on 10 behalf of NHS Tayside which I think you said you were 11 part of signing off, yes? 12 A. Yes. 13 Q. One of the helpful sections in this relates to something 14 we've mentioned already which is the due diligence 15 review which took place in 2023. When you started with 16 NHS Tayside in 2024 what information were you given 17 about what that review had done? 18 A. So I was given -- and there's a copy I think within the 19 evidence pack regarding the findings. I was advised 20 about the outcome of the review and I was advised on 21 some of the next steps of which that included the 22 establishment of the PLRT team and included the 23 establishment of further work. 24 Q. And did you get a briefing or did you get information 25 about what the findings had been of the due diligence Page 30	1 concerns in relation to patients' experience and how -- 2 the handling of those matters over what had been quite 3 a considerable period of time. So the due diligence 4 review goes into consider areas such as complaints 5 handling, it gave consideration across a wide range of 6 issues and that was felt to have been perhaps -- well 7 not perhaps, felt to be insufficient. 8 Q. Right, thank you. But as to the -- that was the sort of 9 general observation, that's helpful. But was there 10 anything specific that you understood to have been 11 within that remit to be deficient such that a public 12 inquiry would be necessary or was it just your 13 understanding was that there was a general -- 14 A. A requirement for openness and transparency and ongoing 15 concerns in relation to the public and being able to 16 make sure that the reasons were understood fully. 17 Q. So does it follow from that then that your understanding 18 was that the due diligence review had been considered by 19 government not to have been open and transparent with 20 the public? 21 A. I didn't intend that it had been -- I didn't intend to 22 say that. What I believe is that there have been 23 concerns over a period of time regarding the openness 24 and transparency, not that it was the due diligence 25 review itself. Page 32

1 Q. But it was those concerns that the due diligence review 2 was designed to address, wasn't it? 3 A. Yes, and it's identified that there requires to be 4 a further wider review which I trust is why the public 5 inquiry was initiated. 6 Q. Could we have a look, please, at paragraph 20 of this 7 opening statement. Here your recognised legal 8 representatives, as signed off by you, helpfully tell us 9 some things about this process and they tell us within 10 a number of bullet points some of the areas that I think 11 you have identified were covered by it. It says, in the 12 first bullet point: 13 "The behaviour of individual doctors. 14 "Mr Eljamel was not open and honest with patients 15 and colleagues. Whilst such behaviours are rare within 16 the medical profession, there is a need to have systems 17 in place to detect and act on these if they occur. 18 Since Mr Eljamel practised in Tayside, NHS Tayside has 19 overhauled the governance and alert systems in place for 20 professional governance." 21 In what ways and over what period does NHS Tayside 22 accept that Mr Eljamel was not open and honest with 23 patients during his career in the board? 24 A. So I would need to go back to -- I don't have the level 25 of depth around that but it covers the period -- because Page 33	1 over what period NHS Tayside accepts that Mr Eljamel was 2 not open and honest with patients? 3 A. The key finding of the due diligence review was that 4 there were concerns regarding openness and honesty. 5 There was also the Royal College of Surgeons report that 6 also supports that. So that -- there is the period of 7 time over his tenure and there's specific examples that 8 have been explored during that period of time where 9 concerns have been raised and concerns raised by 10 colleagues. 11 Q. You say there was "a period of time over his tenure", 12 does that mean the whole tenure or does that mean 13 certain parts of it? 14 A. I'm unable just now to narrow that down. 15 Q. In what ways and over what period does NHS Tayside 16 accept that Mr Eljamel was not open and honest with 17 his colleagues? 18 A. We accept that there has been a finding over his tenure 19 that requires to be part of what is understood through 20 this -- through this Inquiry, including you hearing from 21 people that were involved in the due diligence review 22 and people who were in post over this tenure here. 23 Q. You can't tell me the answer to that question either, 24 can you? 25 A. He was in post for the period of time, there are Page 35
1 here he left the organisation in 2014, so it covers 2 within that period there are specific examples but 3 I don't have that level of depth from recollection. 4 Q. I'm not asking for a specific examples, I'm asking 5 a deliberately quite general question about in what 6 broad ways and over what period does NHS Tayside accept 7 that Mr Eljamel was not open and honest with patients 8 during his career while working in NHS Tayside? 9 A. The duration in which he worked at Tayside is clear. In 10 terms of the acceptance of that, I'm unable -- 11 I'm unable to clarify. 12 Q. Just to be clear so everyone understands what 13 I'm looking at here, this is a document which sets out 14 NHS Tayside's position -- 15 A. Yes. 16 Q. -- in relation to matters that are important to the 17 Inquiry. 18 A. Yes. 19 Q. Is that your understanding? 20 A. Yes. Yes. 21 Q. And this is a document which you signed off? 22 A. I was part of the sign off, yes, I signed off. 23 Q. Amongst others? 24 A. Yes. 25 Q. So you can't tell me, is that right, in what ways and Page 34	1 concerns regarding that. I'm unable to narrow that down 2 for you just now. 3 Q. But yet you signed on this being represented as being 4 the board's position at the opening statement hearing at 5 this Inquiry? 6 A. I did and I stand by that because it does say that the 7 finding -- one of the findings of the due diligence 8 report was that he was not open and honest. I don't 9 have in front of me the recollection to narrow that down 10 further. 11 Q. And this helpfully recognises that there's a need to 12 have systems in place to detect an act on individual 13 doctors like Mr Eljamel not being open and honest with 14 patients and colleagues. 15 A. Mm-hmm. 16 Q. I assume you accept that? 17 A. I do. 18 Q. And you also tell us that -- or the statement told us 19 that the systems in this regard have been overhauled 20 since. Could you tell me how the systems of what's 21 called "governance and alert systems" in place for 22 professional governance were overhauled in the aftermath 23 of the Eljamel affair? 24 A. Yeah, so I will be happy to give you a broad answer to 25 that and would suggest that the clinical professional Page 36

1 leads who will be -- you will also be meeting with will 2 be better placed to give the detail but there has been 3 significant work done and significant evolution of 4 clinical governance arrangements -- 5 THE CHAIR: Would you mind just slowing down? 6 A. Apologies. There have been significant evolution of 7 what are called clinical governance arrangements over 8 the past kind of couple of decades of what's been done. 9 Within NHS Tayside there's a really clear clinical 10 governance framework, it has really clear professional 11 responsibilities. So in addition to the executive 12 medical and executive nurse director they have also got 13 teams in place. We have got a committee within 14 NHS Tayside board that specifically deals with clinical 15 governance, the medical director has put in place very 16 specific groups and that includes the responsible 17 officer's oversight assurance group, which is a ROAG 18 group, where if there are concerns about doctors, 19 there's a mechanism for the medical director to be 20 directly reviewing those individual cases. 21 We also have mechanisms in place regarding 22 whistleblowing and we encourage speak-up within the 23 organisation. So to make it encouraged that people can 24 come forward, to make sure that we are then listening 25 and learning from those and if there are concerns Page 37	1 A. They did not -- these concerns did not come through in 2 as structured a governance mechanism as we have in place 3 just now. Governance has absolutely been strengthened 4 since the due diligence review. 5 Q. So what you're telling me is the systems you have now 6 didn't exist then? 7 A. Yes. 8 Q. The systems we have now are stronger than they were 9 then? 10 A. Yes. 11 Q. Were the systems in place at the time too weak? 12 A. The system -- I mean, we'd have to speak to the 13 individuals that were there at the time who will be 14 better placed than me to talk to the systems that were 15 in place because I don't have that knowledge. My 16 reflection -- 17 Q. Sorry, Ms Connor, I'd perhaps just clarify one thing. 18 I'm not asking you what people thought at the time, 19 I'm asking you what the position of NHS Tayside is now 20 and you're the chief executive? 21 A. So my position is that the mechanisms we have in place 22 now are much stronger than they were before. Had those 23 been in place, it may have enabled an earlier 24 identification of concerns and management of concerns at 25 that time. Page 39
1 regarding that practice, that's able to be considered 2 by the relevant professional leads. 3 MR DAWSON: Thank you. We will get into some of the details 4 of aspects of that including the ROAG, the responsible 5 officer group, with Dr Cotton in due course. Given that 6 these changes were instituted you say since Mr Eljamel 7 practised, is the position that the board accepts -- because 8 again this is about what you accept and what you don't 9 accept -- that these systems with regard to clinical 10 oversight, clinical governance and professional 11 governance were defective at the time when Mr Eljamel 12 was in post? 13 A. So I refer back to what I said a little bit ago around 14 how clinical governance arrangements, not just within 15 Tayside but across healthcare in Scotland, have evolved 16 significantly over that period of time. Were the 17 mechanisms that we have in place now in place at that 18 time? No, they were not. And some of the findings of 19 the due diligence review around some of those mechanisms 20 generated that. So I think there has been 21 a strengthening of mechanisms that were put in place. 22 Whether they were defective at the time in comparison to 23 what other boards would have had in place, I feel less 24 clear about. 25 Q. You can't tell me whether they were defective? Page 38	1 Q. Do you accept, Ms Connor, that when we're standing here 2 asking questions of you in a public inquiry, that things 3 have got quite serious? 4 A. Absolutely. 5 Q. Do you think that one of the reasons why things might 6 have got this serious is because the many, many patients 7 who allege that they were harmed by Mr Eljamel and let 8 down by NHS Tayside's systems haven't been able to get 9 a straight answer as to what NHS Tayside accepts went 10 wrong and what they do not accept went wrong? 11 A. Yes. So I accept there have been failings in terms of 12 the -- this ability for this to have been identified and 13 to have been addressed but I was not the chief executive 14 who had accountability at that time. 15 Q. But I'm asking you -- you are the successor, if you 16 like, of the chief executive at the time. 17 A. No, there's been multiple chief executives. 18 Q. But you are responsible for the board -- 19 A. I am. 20 Q. -- that is the successor of what happened at that time; 21 is that not correct? 22 A. Yes. 23 Q. So I'm asking you just now whether the board now accepts 24 these things; do you understand that? 25 A. I do understand that. Page 40

1 Q. So is it your position, is the current board's position 2 that the systems of clinical governance in place at the 3 time were too weak? 4 A. I think -- yes, but I do not think that was necessarily 5 unique to NHS Tayside. 6 Q. The statement goes on -- we can do this all day, 7 Ms Connor, because I'm looking for straight answers here 8 and a lot of the questions I'm asking you are designed 9 to try and get straight answers. Now that's important, 10 as you fairly accepted for patients but it's also very 11 important for this Inquiry because what we are seeking 12 to do is we are seeking to clarify with some degree of 13 precision, which our lawyers have tried to introduce 14 into our proceedings which is a good starting point, as 15 to what it is the board accepts and what you do not. 16 What lawyers call that is narrowing the ambit of the 17 dispute. If you accept that things went wrong then the 18 Chair may well be able to make a finding that in that 19 area the board accepts it went wrong. And of course we 20 will look at as you said the various measures that 21 appear to have been taken subsequently, such as the 22 responsible officer group which we will find out about 23 in due course, but it's very important that we 24 understand what is accepted and what is not because 25 otherwise this Inquiry will range over enormous areas Page 41	1 complaints come in, if there's also concerns, if -- all 2 of that would be triangulated to give consideration to 3 a range of signs. In terms of our opening statement -- 4 and apologies, I wasn't meaning to be evasive to what 5 you were asking -- I recognise in our opening statement, 6 both in terms of the behaviour of individual doctors and 7 the monitoring signals of poor practice and harm, we 8 are accepting they were not as they should have been. 9 Q. Thank you. The reason I asked that question is I think 10 this is just the way that the English works. I think 11 what is meant here -- and please correct me if 12 I'm wrong -- is not the signs that were not joined up 13 but the systems of detection of poor practice that were 14 not joined up, or "triangulated" as you put it, is that 15 right? 16 A. Yes, I accept that. 17 Q. I think what you're trying to say is there might have 18 been in place different systems which sought, as their 19 ultimate aim, to detect poor practice and I suppose 20 their overall ultimate aim to enhance good patient 21 experience and care, but one of the problems was that 22 those different systems of detection weren't working 23 well enough together to be able to achieve their 24 ultimate aim; is that what we're seeing here? 25 A. I accept that. Page 43
1 that it need not. If we can start from a point of 2 clarity, we can make the Inquiry useful for everyone. 3 A. Okay. 4 Q. If this level of what was described yesterday as 5 "obfuscation" -- not my word, but Liz Smith's word -- is 6 to continue then the Inquiry will be significantly 7 frustrated in achieving its aims. So what I'm trying to 8 do is to try to get that clarity and I'm hopefully 9 fairly doing that because I'm using material which you 10 yourself have provided to us; do you understand? 11 A. Yes, I do. 12 Q. Thank you. The document goes on to say: 13 "Monitoring signals of poor practice or harm. 14 "Whilst there were multiple ways in which signs of 15 poor practice could appear, the way in which some of 16 those signs were joined up was lacking, and feedback 17 from trainees was not always seen by line managers. 18 Since Mr Eljamel practiced in NHS Tayside, joining up of 19 potential alerts is achieved through an Executive 20 Director-led Safety Oversight Group which responds to 21 emerging potential issues." 22 This says that signs were not joined up. I wonder 23 if you can help me by understanding what that means? 24 A. In terms of -- so how we would consider that just now 25 would be around different elements of -- so if Page 42	1 Q. Thank you. Now, this would tend to suggest that what 2 systems there were did detect poor practice and it was 3 only the fact that those signs of poor practice which 4 had been detected were not triangulated, to use your 5 word, that was the problem. So what is your 6 understanding of what poor practice, on the part of 7 Mr Eljamel, these systems detected? 8 A. So it would be around elements of concerns raised, 9 whether that be from colleagues, whether that be from 10 patient complaints, whether that -- so both of those 11 elements would come together. So we would hear what 12 people experienced and there would be incidents 13 reported, there would be a range of mechanisms by which 14 concerns would be in place. So that would be the 15 mechanisms that we would have. 16 Q. I see that, but what I'm asking you is really a question 17 of fact which is: what is it that those systems detected 18 about his poor practice? Which signs were not joined up 19 in the overall system? 20 A. I think that was the pulling together of the fact there 21 had been complaints and there had been concerns from 22 colleagues, there had been feedback from trainees within 23 the system working there, pulling all of those together, 24 which I called earlier "triangulation", would have been 25 able to more easily identify that there had been Page 44

1 concerns. 2 Q. So, you are focusing there on, I think, the aspect of 3 the system of detection that deals with opportunities 4 for professional colleagues to raise concerns, both at 5 a higher level and at a lower level, is that right? 6 A. As well as complaints and concerns from patients. 7 Q. Yes, okay, so that would be a different part of the 8 system. 9 A. Yes. 10 Q. And those two parts needed to be triangulated with each 11 other? 12 A. Yes. 13 Q. I don't know, can you triangulate two things? I'm not 14 sure, but there needs to be triangulation of all of the 15 parts of the system. So I'm just trying to get to the 16 bottom of what it is the board accepts. If it's done 17 an analysis which says the problem here was that there 18 was no joined up operation, which appears to be what 19 you're saying, it tends to suggest that it would have 20 made a difference if the system had been more joined up; 21 is that fair? 22 A. Yes. Yes. 23 Q. So I'm trying to work out if the system had been joined 24 up, what information, what signs that had been detected 25 would have been pulled together such that there might Page 45	1 frankly going right back the very near the beginning of 2 his career. Now, what I'm trying to get to here is 3 there appears to be some acceptance here which is a helpful 4 starting point, I appreciate that, but I think what we 5 need is some indication as to the time period over which 6 that acceptance applies because do you accept -- does 7 the board accept that these signs existed and should 8 have been triangulated from the beginning of his career 9 or was it at a much later stage? 10 A. In terms of the due diligence review I do not believe 11 that that has differentiated any specific timeframe, so 12 accepting over the period. 13 Q. Over the period of his whole employment? 14 A. I don't have that level of detail to be specific. 15 I don't have that, that is where the medical director 16 may be able to provide further information, but I am 17 accepting -- 18 Q. But your understanding was -- sorry. 19 A. Apologies, I'm accepting the findings of the due 20 diligence review. 21 Q. And your understanding of it is that it doesn't 22 differentiate? I.e, it recognises that there were 23 concerns and information about concerns throughout his 24 employment, is that right? 25 A. Yes. Yes. Page 47
1 have been a different outcome? 2 A. I think that is something that James Cotton, in terms of 3 medical director who is close to this work, will be able 4 to elaborate on. 5 Q. So you don't know the answer to that question, do you? 6 A. There is complaints. There is concerns from staff. 7 There would have been other matters from colleagues that 8 would have all come together. They would have been amongst 9 the key signs. 10 Q. What were the concerns that were raised by staff? 11 A. There was concerns around the -- I guess some of that 12 feedback that came in. I don't have the level of depth 13 on this. 14 Q. Because, you see, this is quite important for us because 15 what we're trying to work out here is whether it is the 16 case -- and we heard quite a lot of evidence about this 17 from Liz Smith yesterday who spoke on behalf of a wide 18 variety of patients -- their concerns relate to the 19 question as to whether there was information available 20 which should have been acted on at an earlier stage 21 because there are patients who allege -- and it's 22 an allegation at this stage -- that the treatment they 23 received from Mr Eljamel was sub-standard in various 24 different ways, operative treatment, pre-operative, the 25 way he communicated with them, over a number of years, Page 46	1 Q. Thank you. You mention there an executive 2 director-led safety oversight group, that was one of the 3 things that's happened since to try to deal with these 4 issues? 5 A. Yes. 6 Q. Is that broadly -- we'll get the detail from others, but 7 again is that different from the responsible officer 8 group that you were talking about earlier? 9 A. It is and it's evolved further since then but 10 essentially that would be led by the clinical -- 11 executive medical director with the other executive 12 nurse director being part of that and that is 13 a mechanism by which is evolved on to be called 14 a clinical governance oversight group but at the time it 15 was a safety group that gave oversight of matters 16 regarding clinical governance and patient safety across 17 the organisation. 18 Q. And again, its function therefore -- this is a group 19 that's come in since the Eljamel tenure period, yes? 20 A. Yes, yes. 21 Q. And its function focuses on that very specific 22 issue which has been addressed here which is the 23 triangulation of the different services, is that right? 24 A. It covers a range of things. It covers all things 25 clinical governance and patient safety but one of the Page 48

1 things that that would enable, and it does enable, is 2 the consideration of what all of these things look like 3 together. What we also have in terms of how reports are 4 presented is called an SBAR report, but what accompanies 5 that is supplementary information -- 6 THE CHAIR: Sorry, an SBAR report meaning? 7 A. SBAR, situation, background, assessment and 8 recommendation. 9 THE CHAIR: Hang on. Situation? 10 A. Situation. So, in a nutshell what is it we're 11 exploring. Then background, what is the background to 12 that. The assessment of whatever the matter is in 13 question and then what does it recommend. 14 But what it has, in addition to that, is it asks for 15 key information regarding what that means for quality, 16 what it means for workforce, what it means for finance, 17 what it means for equality. So it brings a requirement 18 to bring that key information forward. I think that 19 also supports when people see information to support the 20 triangulation. But the very nature of having this key 21 group and having that oversight across the whole of the 22 organisation means that when things are coming forward, 23 even if it comes forward at different times, there is 24 the ability, that organisational memory, the records 25 that are held of these being formally minuted and they Page 49	1 up everything you say. It can be tricky, I understand, 2 but if you can try that I'd very much appreciate it. 3 So we were in the opening statement and were at 4 page 6 now. It's ELJ-00538, at page 6 please, Rory. So 5 this section of the opening statement relates to the 6 subject of guidance to ensure consistency in governance 7 processes and it says, in the first sentence: 8 "There was variability in the organisational 9 response to signs of poor practice within the system." 10 Can you help us with what evidence there is of that? 11 A. So we -- I fully accept the findings that have been 12 presented here in relation to the due diligence review 13 and finding that variability in terms of response. 14 Q. Do you know what time period this relates to? 15 A. My understanding is it's over his tenure. 16 Q. Over his whole tenure from 1995? 17 A. That would need to be -- that would need to be clarified 18 but my understanding is there's been concerns identified 19 from early on in practice that came forward. 20 Q. Thank you, and then it goes on to say that some 21 complaints did not lead to formal investigation using 22 governance processes. So again just to clarify because 23 we talked earlier about there potentially being two 24 streams through which broadly complaints could come. 25 One through a complaints system that might be designed, Page 51
1 also then report now through to the executive group that 2 I chair and they report on as an executive medical 3 director and executive nurse director assurance report 4 into the committees of the board. So that takes what 5 was described in the opening statement even further in 6 terms of ensuring that we have stronger governance in 7 place. 8 MR DAWSON: Sir, that would be an appropriate moment for 9 a break. 10 THE CHAIR: Yes, thank you. 15 minutes. 11 MR DAWSON: Thank you. 12 THE CHAIR: Right, everybody, we'll have a break for 13 15 minutes. I can't see the clock but that will take us 14 to a little after 11.20. Thank you. 15 (11.08 am) 16 (A short break) 17 (11.25 am) 18 THE CHAIR: Thank you. Please have a seat. Thank you, 19 Ms Connor. 20 MR DAWSON: Ms Connor, I mentioned at the beginning speaking 21 into these microphones. It can be quite tricky but if 22 you can try your best. I think you can sense when your 23 voice is picked up by it or not. But if you can be 24 careful because there are people listening and some are 25 on a hearing loop so just to make sure they're picking Page 50	1 say, for patients or patient relatives and you talked as 2 well about another aspect of this where concerns or 3 complaints could be raised by colleagues. Do you know 4 which aspect that relates to? 5 A. Yes. My understanding is that some complaints not 6 leading to formal investigation relates to patient 7 complaints and level of supervision etc takes the 8 complaints regarding colleagues further on. 9 Q. Right. So the particular aspect of this that's 10 highlighted as a failing, which appears to be accepted, 11 is that when complaints were made in some cases that 12 didn't lead to the formal investigative processes that 13 were in place being triggered; is that right? 14 A. I think that relates to both patient complaints but 15 also, as it's described further on in that paragraph, 16 the professional governance concerns being raised. So 17 I think it relates to both when it's raised by staff as 18 well as when it's been raised by patients. 19 Q. Right and it also says there that there was a variation 20 in response times in that area. Again, is that across 21 the board or is that related to a particular time 22 period? 23 A. I think it's across the board. 24 Q. It then goes to say that: 25 "Once multiple signs of poor practice were Page 52

1 considered together in 2013, decision-making related to 2 Mr Eljamel practice was delegated too far down the 3 organisation." 4 So the first thing about that is that sort of chimes 5 with something you were saying earlier about the 6 triangulation. Was it then the case that -- does this 7 identify that in 2013 there was a triangulation that 8 meant that action was taken? Is that what "the signs of 9 poor practice being considered together in 2013" means? 10 A. I think it looks like it's suggesting that it doesn't 11 have the appropriate level of seniority of oversight to 12 have been able to have a look at those different 13 concerns that came together but, yes, there were 14 multiple signs in 2013. 15 Q. But the first half seems to be a factual statement, 16 we'll get onto the second half in a second, but the first 17 half seems it identifies that in 2013 something 18 happened. 19 A. I accept that. 20 Q. And I'm just trying to understand is that related to the 21 evidence you gave earlier about the triangulation of the 22 systems? Because it sounds like it is, the multiple 23 signs of poor practice picked up by these various 24 systems do appear to have been triangulated because we 25 know in 2013 that something did happen; is that right? Page 53	1 that's what I meant when I said did something happened? 2 A. Yes. 3 Q. And is it that decision-making that's been talked about 4 here when it was delegated too far down the 5 organisation? There should have been executive involvement 6 in those decisions being reached? 7 A. I think there is -- yeah, I would require to refresh -- 8 I would require to refresh myself regarding who took 9 that decision in terms of the commission to the Royal 10 College. 11 Q. So there's also the question of the supervision which is 12 something that we're interested in. 13 A. Yes. 14 Q. I'm wondering -- tell me if you can help me with this -- 15 that what it means here is that the supervision and the 16 level of the supervision that was entered into was 17 delegated too far down the organisation? 18 A. Yes, that's what it suggests to me too. 19 Q. Yes, and I think you were saying there that the problem 20 with that was that you would expect there to be 21 executive level involvement in something that serious 22 and it appears that there wasn't? 23 A. Yes. 24 Q. And the -- 25 A. So I was just going to say I would require to Page 55
1 A. Yes, yes. 2 Q. And the position I think was that there had been 3 a failure in the triangulation of those services over 4 the whole tenure of his career before that point? 5 A. I think there's been a failure, yes. 6 Q. Because that's one thing we do know is that in 2013 7 something was done, there was a step taken. The Royal 8 College of Surgeons invited review happened, but it 9 also says that even at that time, "decision-making 10 related to Mr Eljamel's practice was delegated too far 11 down the organisation". Can you help us with that 12 understanding, where that should have been dealt with, 13 where in fact it was dealt with and why that was 14 an issue? 15 A. Yeah, so what I would expect is that there would have 16 been executive oversight if there is concern regarding 17 our consultant's practice as to -- in terms of the 18 delegation, I think that goes back to what I said 19 earlier about the different spans and layers that there 20 are within an organisation and that meant it didn't have 21 the appropriate executive oversight, which is a gap. 22 Q. Right. So we know that in 2013 what happened was that 23 Mr Eljamel was placed under a period of clinical 24 supervision and that an invited review was instigated 25 with the Royal College of Surgeons of England. So Page 54	1 familiar -- I would require to be familiarised regarding 2 the chronology that was there because I'm unable to say 3 exactly who commissioned the further review just now, 4 I'm not able to say that. So I wouldn't want to suggest 5 there was not, but my understanding, absolutely, in our 6 opening statement is that we are accepting that there was 7 failings in terms of the level of supervision and 8 oversight and the pulling together. 9 THE CHAIR: Could I just ask one point which may be a very 10 obvious one to you, not necessarily to everyone. When 11 you speak of "executive oversight" in this context, what 12 do you actually mean by that and what practical 13 difference do you, in your own mind, anticipate that 14 that would have? 15 A. So for me just now that would be back to what we spoke 16 about being that ROAG earlier, where the executive 17 medical director would be leading, understanding those 18 concerns and being able to both triangulate and inform 19 the next steps. That's something we knew was not in 20 place at that time. 21 Q. Then we go on to read that the board's position is that 22 restrictions placed on Mr Eljamel's practice in 2013, 23 which we just touched on: 24 "... were not adequate and decision-making was not 25 sufficiently well documented. The level of supervision Page 56

1 decided upon was not proportionate to the concerns being 2 raised at the time and once implemented was not 3 monitored effectively. During the period of 4 Mr Eljamel's employment, there was an absence of 5 an advanced process of professional governance from 6 concerns being raised to their being acted upon, and in 7 ensuring clear documentation of decisions made." 8 It goes on to say that there is now a process in 9 place through the ROAG group that we have touched on. 10 So there's a number of different aspects to this. In 11 what way does the board accept that the restrictions 12 placed on Mr Eljamel's practice in 2013 were not 13 adequate? 14 A. The restrictions -- so I completely accept that they 15 were not adequate, I take that position as the board and 16 I think that Dr Cotton will be best placed to talk 17 through the professional observation of that. 18 Q. Okay, but there should have been a higher level of 19 restriction placed on what he was allowed to do and what 20 he wasn't allowed to do? 21 A. Yes, yes. 22 Q. And also another aspect of this, which we'll come back 23 to because it's a very important theme, is the 24 decision-making was not sufficiently well-documented. 25 So does that relate to the decision-making around the Page 57	1 Q. And what do you know of the concerns that were raised at 2 that time, so in 2013 when these decisions were being 3 taken, to understand the level to which the supervision 4 needed to be proportionate? 5 A. Again, I would take advice from the executive medical 6 director in relation to supervision being placed on 7 doctors. 8 Q. Okay, and what appears to be a more general statement 9 follows, which is: 10 "During the period of Mr Eljamel's employment, there 11 was an absence of an advanced process of professional 12 governance from concerns being raised to their being 13 acted upon." 14 Now that would tend to suggest that the absence of 15 an advanced process existed throughout the period of his 16 employment; is that correct? I think you've already 17 accepted that? 18 A. Yes. 19 Q. And there was also, over that period, an absence it 20 would appear of ensuring that clear documentation was 21 put in place of decisions made? 22 A. Yes. 23 Q. Could I just pause on the documentation point because 24 this is an area of some difficulty, as I know you 25 understand. It is important that clear records are kept Page 59
1 level of restrictions? 2 A. Yes. 3 Q. Rather than it being a more wide-ranging comment? 4 I think in that context it does relate to restrictions? 5 A. In that context it relates to that, yes. 6 Q. So you accept that the restrictions placed on 7 Mr Eljamel's practice in 2013 were not adequate and they 8 weren't strong enough, yes? 9 A. Yes. 10 Q. But when this was being looked at in 2023, which I think 11 informs your position now, your position is that the 12 decision-making around that was not sufficiently 13 documented? 14 A. Yes. 15 Q. So how do you know restrictions placed on his practice 16 in 2013 were not adequate? 17 A. In terms of fully accepting the findings in relation to 18 the due diligence review and the advice and assessment 19 that I have been given. 20 Q. Okay. So it also says that the level of supervision 21 decided upon was not proportionate to concerns. Now, 22 again, that would tend to suggest that there would -- 23 there should have been a higher level of supervision put 24 in place, yes? 25 A. Yes. Page 58	1 within a health board, isn't that right? 2 A. Yes. 3 Q. And that doesn't just -- that applies to patient medical 4 records, doesn't it? 5 A. Yes. 6 Q. But it also applies, as I think this context relates to, 7 to what one might describe as administrative records? 8 A. Yes. 9 Q. Because there are lots of reasons for that but they 10 relate, to an extent, to the accountability that you 11 talked about earlier, doesn't it? 12 A. Yes. 13 Q. Because it's important, where decisions are made, that 14 there is clarity at the time around what decision was 15 taken? 16 A. Yes. 17 Q. But also around why decisions were taken, yes? 18 A. Yes. 19 Q. So that ultimately any of the bodies to whom you are 20 responsible, which I think you said were the board and 21 the government and the public in your area, if they 22 wanted to know what decisions had been made and how, and 23 by whom, this documentation should exist to enable them 24 to find that out? 25 A. Yes. Page 60

1 Q. And so if a patient group were attempting to try to find 2 out what had happened that might have had a bearing on 3 what they perceived to be a bad clinical outcome for 4 them, they should be able to come to a health board and 5 be given documentation that tells them the answer to 6 that? 7 A. Yes. 8 Q. And they shouldn't have to engage the support of 9 a member of parliament to help them to do that? 10 A. Agreed. 11 Q. They shouldn't have to resort to statutory systems of 12 document recovery that effectively will force the board 13 to give them the information they need? 14 A. Yeah, so there would be different mechanisms by which 15 different types of information can be requested, whether 16 that be subject access requests or Freedom of 17 Information requests. They are processes that are 18 standardised that are in place which actually gives 19 exactly what you're talking about, it gives a really 20 clear: when was this asked for, what happened and what 21 response was given back. So I guess there are levels of 22 process that are in place that would be followed but 23 I would expect us to be following the processes and 24 I would be expecting us to give patients information 25 that they require regarding themselves. Page 61	1 been failings identified over a period of time that were 2 not acted on and I -- and those failings have caused 3 distress. I've had engagement directly with patients 4 and understand the level of trauma that this has caused 5 for people. So that apology covers the fact that we 6 accept the full findings that we've outlined within this 7 opening statement. 8 Q. So obviously there's an apology and there's sincerity 9 around that with regard to what the outcomes have been 10 for patients, the distress and their various 11 consequences. But I think does the apology attempt to 12 try to say that this was something for which NHS Tayside 13 was partially responsible -- 14 A. Yes. 15 Q. -- because it failed to have in place sufficient 16 measures to safeguard their well-being? 17 A. Absolutely accept that there was failings within 18 NHS Tayside over this period. 19 Q. And those failings are the sorts of things that we've 20 discussed including the absence of a proper, 21 professional and clinical governance system, yes? 22 A. Yes. 23 Q. Over the entirety of Mr Eljamel's employment? 24 A. Yes. 25 Q. And a failure to triangulate different systems of Page 63
1 Q. And to be able to give them that information, I accept 2 whatever the appropriate level of request is -- 3 A. Yeah. 4 Q. -- then that would have to exist and be clear and in 5 writing? 6 A. Yes. Yes. 7 Q. Could we go, please, to paragraph 61 of this document 8 which is at page 17. It says here that: 9 "NHS Tayside remains sincerely sorry for the 10 distress experienced by parents of Mr Eljamel. It is 11 acknowledged that NHS Tayside failed to put in place 12 sufficient measures to safeguard patients once concerns 13 were raised about Mr Eljamel and this placed the safety 14 and wellbeing of patients at risk." 15 In this regard it's important, isn't it, when boards 16 or public authorities give apologies that they are 17 meant; is that correct? 18 A. 100%, yeah. 19 Q. And that they are clear as to what they cover? 20 A. Yes. 21 Q. Can you tell us what it is that you were trying to 22 convey when this apology was no doubt instructed to be 23 put forward to the Inquiry? 24 A. Yeah, so it probably covers a range of the bullet points 25 that we've already just discussed there, that there have Page 62	1 detection of poor practice, again over his whole 2 employment? 3 A. Yes. 4 Q. Thank you. One of the things that one sees frequently 5 within the documentation, the policy documentation that 6 has been provided by NHS Tayside, is the assertion that 7 it is a learning organisation. What is meant by that? 8 A. So being a learning organisation we recognise that 9 whilst things should not happen, things do happen. And 10 what we would -- I would expect is that we adequately 11 investigate those things, we take the learning from 12 those and we make sure that they're embedded to seek to 13 ensure that that does not happen again. 14 Q. Is that just an assertion or does that actually happen? 15 A. That is absolutely what we would be seeking to deliver. 16 It's a core -- fundamental, I believe, to how NHS 17 organisations and boards should be operating that when 18 something has happened we take learning from it and we 19 embed it. 20 Q. So it's an aspiration? 21 A. No, I believe it is how we seek to practice. Whether we 22 always get that fully correct, there are times when 23 things happen again and they should not, but there are 24 also times when we're able to take action and fully 25 embed those. So I don't think it is fully just Page 64

1 an aspiration but I think there are -- and there 2 continues to be, in any learning organisation, further 3 strengthening that can continue to be delivered to make 4 sure that things do not repeat themselves. 5 Q. So just to take an example. One could go on any of 6 these areas but you talked about the failures, the 7 documentation suggests there were failures in relation to 8 properly documenting the decisions that were made at 9 a governance level relating to Mr Eljamel. I think 10 that's accepted? 11 A. Yes. 12 Q. And that there were various reviews, including the due 13 diligence review which were undertaken which sought to 14 try, in part, to learn from that and make things better? 15 A. Yes. 16 Q. And the ultimate objective of that would be to be able, 17 as you've said, to provide clear written documentation 18 of what had been going on to patients or others that had 19 a right to know? 20 A. Yes. 21 Q. Is it the case, Ms Connor, that the recent history even 22 under your tenure of failings relating to documents 23 indicate that it's learned absolutely nothing from that? 24 A. Would you like -- I would welcome just understanding 25 clarity of what it is you mean? Page 65	1 contrary to its aspiration, not learned in this regard? 2 A. There's an absolute commitment from NHS Tayside board to 3 ensure that we have very strong information governance 4 systems in place. Patients and the public should 5 absolutely expect from us that we are keeping their 6 information safe and that we're able to provide that 7 information. As such, the board has placed such gravity 8 on it that it's set in as a corporate objective for this 9 year and there has been a review of wider learning that 10 this means for information governance within the 11 organisation. A further action plan that has been put 12 in place -- I don't know whether this will be covered 13 later or you want me to expand now, but I will bring 14 a learning organisation means that you are continuing to 15 seek to learn and when things go wrong continue to learn 16 those, be open about them, be transparent about them and 17 seek to make the improvements and embed that. 18 Q. Okay, thank you. Could I just go to page 6 of the 19 document, please. There's another important aspect of 20 the opening statement that I'd like to ask you about 21 which very much impinges upon areas that we're 22 interested in. Down at the bottom, the last paragraph, 23 "communication with patients". It says there that -- 24 this is again, going back to -- 25 going back to the section where there's an explanation Page 67
1 Q. You need me to explain to you what failures there have 2 been -- 3 A. No, no, I'm just asking is there a specific failing that 4 you are -- 5 Q. Well, I'm kind of assuming that you're aware of the 6 failings. If we were to go through them it may take 7 some time but there have been, for example, multiple 8 data breaches. 9 A. Yes. 10 Q. You're here today to talk about the destruction of 11 logbooks relating to these very patients. 12 A. Yes. 13 Q. There have been innumerable reports of patients 14 being unable to access medical records or other 15 administrative records relating to them. I could go on. 16 A. No, no. Thank you for clarifying. 17 Q. All of these, I think, have arisen largely over your 18 tenure and I'm just trying to link together the 19 acceptance here which is understood about there being 20 failings relating to the creation and retention of 21 documentation which was not available at the time of the 22 2023 review and indeed seems to be accepted wasn't 23 properly created at the time relating to decisions that 24 were made. Does the fact that these problems persist in 25 such frequency suggest that the board has in fact, Page 66	1 being given as to the outcome of the 2023 due diligence 2 report and what the NHS Tayside accepts of that. It 3 says: 4 "Communication with patients affected by 5 Mr Eljamel's practice. 6 "The communication with patients throughout the 7 process was of variable quality, fragmented, and 8 generally poor. There had been no central coordination 9 to ensure a truly person-centred approach. Where 10 concerns were raised by patients, the issue was managed 11 through a small subset of the Acute Management Team. 12 There was a lack of visibility within NHS Tayside, no 13 governance routes to assure and scrutinise and no 14 indications of reporting of improvement through action 15 plans." (As read) 16 Now, I was just interested to understand that where 17 it says the communication was poor "throughout this 18 process", again, as I've asked you before, what time 19 period does that relate to? 20 A. I think it relates to the full tenure. 21 Q. Full tenure of Mr Eljamel? 22 A. Yes. 23 Q. As we said before. So just as well because again, 24 communication is a very important theme in this Inquiry 25 and it is important to understand which aspect of Page 68

1 communication we're talking about because when you deal 2 with a complex organisation like the one you lead there 3 are lots of different communications streams and 4 I'm sure you'd understand, you'd accept that they're all 5 very important. So are we talking here about the 6 communication by Mr Eljamel himself or are we talking 7 about a corporate level communication, if I could put it 8 that way? 9 A. I think that -- I think there has been failings in 10 corporate level communication. I also think other parts 11 of the document that we've discussed today covers 12 concerns about Mr Eljamel's failings and communications, 13 so I think they're both. But here, I think we are 14 talking about the organisational response to 15 communication. 16 Q. Right, but it is -- based on what you've said I think do 17 you accept that Mr Eljamel's communication was of 18 variable quality, fragmented and generally poor? 19 A. Yes. I accept the concerns that we covered earlier 20 regarding that, yeah. 21 Q. And as to the corporate response, if you like and the 22 corporate responsibility, does this statement mean 23 that -- does it cover communication by the board of what 24 it knew about Mr Eljamel's poor practice? 25 A. I think it covers -- it covers the response -- so by the Page 69	1 A. Yes. 2 Q. I'm interested to know whether this acceptance of poor 3 communication relates to an acceptance that the board 4 did not adequately communicate to patients about what it 5 knew of Mr Eljamel's poor practice? 6 A. Yes. 7 Q. Yes, that might be a feature of the lack of 8 triangulation perhaps, is that right? 9 A. I think that could be a feature of triangulation but it 10 also could be a feature of escalation. 11 Q. I see, yes. It -- the fact is that that information 12 communication was not communicated adequately? 13 A. Yes. 14 Q. But you are then trying to help us with the reason as to 15 perhaps why that happened, which I think this is saying 16 here is because communication with patients about 17 Mr Eljamel happened in this small subset of an acute 18 team? 19 A. Yes, and some of the key actions that were therefore 20 taken was the establishment of the patient liaison 21 response team to make sure that we were able to -- so 22 one of the outcomes there was to recognise a gap in 23 terms of people's concerns, that ability to recognise 24 when more than one person has raised a concern and to 25 draw all of that together, which I think also feeds into Page 71
1 board, yes, it covers the response that we have given 2 being able to ensure that we are engaging with patients 3 and that they're being heard at the most appropriate 4 level in the organisation and that feeds into the 5 triangulation I think again earlier. 6 Q. Let me just try to tease this out because it is quite 7 complicated. I'm just trying to understand which 8 aspects of the communication you're accepting were of 9 varying quality, fragmented and generally poor. We've 10 covered Mr Eljamel, his communication with patients. 11 What you're talking about there is the communication in 12 response to complaints being raised, so for example 13 whether they were handled properly, whether people knew 14 what stage they were at. Is it being accepted that 15 aspect is fragmented and poor? 16 A. Yes, yes. 17 Q. There's a slightly different aspect of communication 18 that I'm trying to speculate as to whether that might be 19 included within this which is you mentioned earlier that 20 there was a poor triangulation of information that was 21 available within different systems about poor practice 22 on Mr Eljamel's part and I think you've said that that 23 existed throughout his career? 24 A. Mm-hmm. 25 Q. Is that correct? Page 70	1 the triangulation. 2 Q. Yes, thank you. And just on that patient liaison 3 response team, that was something I was going to ask you 4 about more generally but you've touched on it a few 5 times. I was just quite keen to note, it's described in 6 the statement, we don't need to go to the passage, it 7 says: 8 "Patients with long-running concerns have a single 9 point of contact to build improved relationships and 10 understanding of concerns to achieve a more consistent 11 and person-centred approach." (As read) 12 This is one of the mechanisms that the board has 13 instituted, as I understand it, to try to deal with the 14 problems it accepted existed before, is that right? 15 A. Yes. Yes. 16 Q. We weren't really aware of the precise workings of that 17 team, though I had heard of it so I was interested to 18 explore with you, is that a response team that just 19 exists for the Eljamel patients or does it exist for any 20 patient? 21 A. No, they have absolutely supported people beyond 22 Eljamel. It was established with this key purpose in 23 mind but what we have in place is a complaints process 24 which will work for a number of people and we can either 25 deal with the complaints informally or we can deal with Page 72

1 them formally but then there are a level of concern by 2 which we have a team that is able to support, 3 particularly if things will be over a period of time, to 4 make sure there is continuity into the organisation, 5 taking a trauma-informed approach with people. 6 Q. So I could see how that would definitely apply to the 7 Eljamel patients -- 8 A. Yes. 9 Q. -- who are in an identified group, if you like. Indeed 10 perhaps a number of different groups group themselves 11 together. So they all come together and say: we are the 12 Eljamel patients, we would like to speak to a single 13 point of contact, and they now have that; is that right? 14 A. Yes. 15 Q. But as to other patients who may also benefit from this 16 single point of contact because of the difficulties 17 in accessing information that they need elsewhere, who can 18 access it? Can any patient in NHS Tayside access it, or 19 is it only for particular groups like the Eljamel group, 20 for example? 21 A. Yes. So we would go through our normal complaint 22 processes in terms of informal and formal complaints. 23 I am aware there are other patients beyond Eljamel that 24 have also sought and received support from this team. 25 Q. Okay. Thank you. I think there are perhaps details of Page 73	1 statement a range of those failings. We've also 2 covered, I think in the discussion that we've had here 3 just now, that that extends beyond those individual 4 failings. It also covers in relation to communication. 5 There is also recognising the impact of this on people 6 and the distress, as you say, and the trauma that people 7 have experienced we're deeply sorry for. I also 8 recognise, and we covered it within our opening 9 statement, that that is not purely a historic thing and 10 I am personally sorry for the impact of the logbooks on 11 patients, recognising that should not have happened and 12 recognising that it did. 13 Q. And I assume also, given what you've accepted earlier, 14 that the apology would cover the accepted failings of 15 the systems within NHS Tayside to pick up poor practice 16 on behalf of Mr Eljamel over the entirety of his career? 17 A. Yes. 18 Q. Thank you. Another area that I'd like to cover with you 19 relates to an aspect again that comes up, the starting 20 point I think is -- it says at paragraph 4, where it 21 says: 22 "NHS Tayside knows that it failed to react 23 appropriately and acted at an adequate pace when there 24 were concerns raised at Mr Eljamel's clinical practice." 25 (As read) Page 75
1 how that works in other places that we can pick up with 2 other people but that's very helpful general context. 3 Could I go, in this document now, to page 1, 4 paragraph 2. This is again the same document but just 5 earlier, the opening paragraphs. It says here that: 6 "NHS Tayside recognises the importance of this 7 Inquiry for many patients of Mr Eljamel and their 8 families. It understands that the Inquiry will be 9 a difficult time for many people. NHS Tayside wishes to 10 extend its sincerest apologies to all patients who have 11 suffered because of the treatment they received from 12 Mr Eljamel." 13 One of the things that frankly -- well, this 14 Inquiry, but to be perfectly honest with you, Ms Connor, 15 this moment offers is an opportunity, is an opportunity for 16 clarity around what it is that NHS Tayside apologises 17 for. You've accepted that apologies need to be sincere 18 and they need to be meant and need to be clear what they 19 cover. So rather than probing the particular wording 20 here I wonder, in light of the testimony that you've 21 given about things that are accepted by NHS Tayside, 22 whether you might like to explain what it is that the 23 board would like to apologise for? 24 A. Yes. So the board fully accepts that there have been 25 failings. Fully, we have covered within the opening Page 74	1 I think we've covered that: 2 "Again, in this regard, it let down its patients. 3 NHS Tayside understands that patient trust and 4 confidence has been eroded because of the actions of 5 Mr Eljamel and its own failures to ensure its systems of 6 oversight and supervision of Mr Eljamel were adequate." 7 (As read) 8 The aspect of that that I'd just like to pick up by 9 extension to what we've just discussed already is the 10 importance of recognising -- and I ask whether you 11 recognise this -- that it's not only the failings of 12 Mr Eljamel and the systems at the time, if I can put it 13 that way, but the possibility that further failings can, 14 in light of that context, have a significant compounding 15 and exacerbating effect on the outcome? 16 A. Yes. 17 Q. Do you recognise that? 18 A. I do, I accept that. 19 Q. And is it accepted therefore that the failings that have 20 gone on and are ongoing, which you've accepted on behalf 21 of NHS Tayside, have compounded and exacerbated distress 22 and poor outcomes for patients? 23 A. I accept that. I have met directly with patients and 24 they have explained to me directly the impact of trauma 25 including the most recent logbook incident and there is Page 76

1 no doubt in my mind that that has eroded trust and had 2 a significant impact on patients for which I am deeply 3 sorry. 4 Q. And the other aspect, which I think you mentioned there 5 but is certainly mentioned in the statement which is 6 important I think is the fact that this sequence of 7 events, leading even up to today, has eroded the trust of 8 patients in NHS Tayside. Do you accept that? 9 A. I accept that. 10 Q. It's important, not just as a lofty principle but for 11 real practical reasons for many of these patients, that 12 their trust in NHS Tayside is maintained? 13 A. Yes. 14 Q. And would you accept that it's particularly important 15 because a lot of them continue to rely on NHS Tayside 16 and its services for care because they suffer from 17 various physical and psychological problems in 18 connection with which they're entitled to expect to 19 receive care? 20 A. Absolutely and I would want -- I absolutely do accept 21 that and I would want to build confidence with patients. 22 Part of that I hope began in terms of the discussions 23 we've had directly, both with a group of patients but 24 I have also had subsequent individual conversations with 25 patients and seek genuinely to be accessible and open Page 77	1 that right? 2 A. Yes. 3 Q. But what causes a particular issue with relation to 4 these logbooks is really two things which are related. 5 One is that they have been destroyed in contravention of 6 an order not to destroy them by the Inquiry; is that 7 accepted that that happened? 8 A. Yes. That is accepted, yes. 9 Q. Secondly, the reason that is connected is it has eroded 10 significantly any lingering trust that patients have in 11 NHS Tayside because a major part of the trust that they 12 retained related to the ability of this Inquiry to get 13 to the bottom of what had happened which is something 14 that has been, perhaps to an extent, undermined by this 15 action? 16 A. Yes. 17 Q. And therefore this is, I think -- would you accept this 18 is something that the NHS Tayside board has taken 19 extremely seriously? 20 A. Absolutely. 21 Q. And you have instigated a number of processes to try to 22 find out what happened? 23 A. Yes. 24 Q. But also to try to work out how things might work better 25 in the future? Page 79
1 and willing to have conversations. 2 Q. That's appreciated. Thank you for clarifying that. 3 Because where trust has been eroded -- in a general 4 sense but in the specific circumstances of these 5 patients as I've outlined, where trust has been eroded 6 it must be rebuilt? 7 A. Yes. 8 Q. And do you consider this process and your attendance 9 here today to be part of that process? 10 A. Yes. 11 Q. Thank you. You have come along also today and helped 12 clarify that you provided some helpful evidence in the 13 board's written statement about the way in which the 14 board has handled the situation of the destruction of 15 the logbooks. I'd like to ask you some questions about 16 that. You've provided quite a lot of information about 17 what has happened. 18 A. Yes. 19 Q. But also what has been done to try to deal with what has 20 happened, which has been helpful. 21 A. Yes. 22 Q. The starting point I'd like to take to this is that 23 a health board is entitled to operate its own systems of 24 document destruction or handling in accordance with 25 broader government guidance and its own policies, is Page 78	1 A. Yes. 2 Q. And those processes I think have been motivated both by 3 a desire to provide an explanation to the Inquiry? 4 A. Also our patients, absolutely. 5 Q. That would have been my next question. 6 A. Yes. 7 Q. But to the Inquiry? 8 A. Yes, absolutely. 9 Q. And to patients? 10 A. Yes. 11 Q. And ultimately to try to restore trust? 12 A. Yes. 13 Q. And faith that such things won't happen again in the 14 future? 15 A. Yes. 16 Q. You have instigated a lot of processes, as I've said and 17 we'll look at some of them in more detail in a moment, 18 but would it be fair to say that you haven't really 19 involved the Inquiry in the processes that you've 20 instigated? 21 A. In terms of the -- the Inquiry were notified of this 22 ahead of -- or as a part of the opening submissions. In 23 terms of the sharing with the Inquiry -- 24 Q. There's a point that's actually in your favour. In fact 25 we were notified about it before that through your Page 80

1 recognised legal representatives. 2 A. Yeah, yeah. 3 Q. But the public announcement I understand was through 4 your instruction. 5 A. Yeah. 6 Q. So to be fair, you did actually tell us before that but 7 carry on, sorry. 8 A. No. But also in terms of when the independent review 9 has published that has been -- that was shared with the 10 Inquiry pretty much as soon as it had gone through the 11 board processes. So in terms of making sure that the 12 Inquiry was aware, both of that investigation outcomes 13 and those next steps, that has been shared with the 14 Inquiry. 15 Q. But you would have understood, would you not, that the 16 Inquiry itself would be undertaking an investigation of 17 what had happened? 18 A. Yes, but the board and myself as accountable officer 19 required also, from the point of view of board's 20 governance, to ensure that we were fully able to review 21 and understand and take forward that learning and to 22 offer that helpfully to the Inquiry. 23 Q. And did you tell us that you were going to do that? 24 A. You were notified, as you said, through the Inquiry that 25 this had happened. I think we've been really clear Page 81	1 agencies. Would that be a fair characterisation or not? 2 A. No, I mean I think that if we look at the incident in 3 relation to the logbook that the first stage was 4 fact-finding. It was entirely reasonable that there was 5 an internal investigation into that. I did not accept 6 the findings of that investigation and then that has led 7 on to a wider, more independent investigation. 8 I think -- I felt that was really important for 9 a range of reasons. One, being able to be of entirely 10 objective with it. But two, going back to what you said 11 earlier around a trust and confidence within NHS Tayside 12 and my hope was that by having an independent review of 13 this we would be able to evidence that we were not 14 marking our own homework, so to speak. We had somebody 15 else able to have a look at this and that those findings 16 would be generated independently. 17 Q. But you did initially conduct an internal review? 18 A. Yes, yes I -- I consider that appropriate, yes. 19 Q. And in fact the independent report finds several 20 failings in the internal review? 21 A. Yes, and that's why we did not accept the full findings 22 of the internal review and it extended to a wider 23 independent review. 24 Q. But you accept that the Chair of the Inquiry is fully 25 entitled to undertake an investigation into this himself? Page 83
1 since this became more publicly available at that time 2 that we were going to undertake a full investigation 3 into that. 4 Q. Did you tell us you were going to instruct 5 an independent review? 6 A. I don't know if I -- I don't know if we communicated 7 directly with the Inquiry on that specific matter but 8 that was something that we were very clear of publicly. 9 Apologies if we should have notified the Inquiry 10 directly of that. 11 Q. Because it might be suggested, it might be suggested, 12 that by undertaking your own reviews you sought to usurp 13 the Chair of the Inquiry's right to reach conclusions 14 about what had happened himself? 15 A. Absolutely not. I consider that this independent 16 Inquiry will be helpful to understand the board's 17 findings of which the Inquiry will identify their own 18 position on having considered everything at the hearing 19 totality. 20 Q. That was not the intention -- 21 A. Absolutely not. 22 Q. Because there is something of a pattern emerging from 23 the evidence that this Inquiry has heard that when 24 something goes wrong the instinct of NHS Tayside is to 25 try to investigate it itself and not involve external Page 82	1 A. Absolutely, yes. 2 Q. And he will make findings, if he wishes to do so, on 3 what happened? 4 A. Yes. 5 Q. And who is responsible? 6 A. Absolutely. 7 Q. Thank you. When you provided material to us related to 8 this, were you keen that the names of individuals who 9 had been involved internally would not become public? 10 A. We applied the same principles that we would with data 11 information regarding junior staff. The reason for that 12 is that I am, as accountable officer, accepting that 13 this was systemic and the independent review found no 14 individual failing of individual people. So I was keen 15 that our frontline, junior staff were not included but 16 all of our staff at a more senior level are included. 17 Q. So you wanted -- your starting point was that the 18 internal investigation had found that no individual had 19 been in any way to blame for anything that had gone 20 wrong? 21 A. No, apologies if that's what I have said. What I meant 22 was in terms of the independent review, which is what -- 23 is that what we're talking about just now -- 24 Q. No, the internal review. 25 A. Apologies, I thought you said independent review. Page 84

1 Please ask that question again. I answered it from the 2 point of view of independent. 3 Q. The starting point for your approach to your request 4 that names would not be made public of individuals was 5 I think, on the basis of your evidence, your assumption 6 that the finding of your internal review was correct 7 that no individual was in any way to blame? 8 A. Yeah, the outcome absolutely of the internal review 9 found there was no conduct or capability or further actions 10 for any named individual. 11 Q. And I think what you told us that is one of the reasons 12 why you suggested that there would be no need for 13 individual's names to be part of the publication of any 14 of the material that the Inquiry was looking at? 15 A. Yes. 16 Q. But of course the Inquiry could take a different view, 17 couldn't it? 18 A. Yes, it could. 19 Q. So the Inquiry does need to look at the individuals' 20 actions and try to work out whether they may not be 21 wholly to blame, because I know you accept some 22 responsibility, but they may be partly to blame? 23 A. I entirely accept that the Inquiry would seek so do 24 that. I guess there was something about our staff, some 25 of whom are very junior and working in the front line Page 85	1 "Through work led by NHS Tayside's Health Records 2 and Theatres Departments, it has been determined that 3 much of the information normally detailed in theatre 4 logbooks is also normally contained in operation notes 5 within patient records. It is understood, therefore, 6 that much of the information lost when the theatre 7 logbooks were destroyed should be available within 8 operation notes. However, not all relevant patient 9 records remain in existence." 10 So I think the issue that people may have with that 11 statement is the word "normally". Because in the 12 particular circumstances of the Eljamel patients they 13 have been told -- many of them, I understand, have been told 14 by NHS Tayside that some or all of their medical 15 records, including operation notes no longer exist? 16 A. Yes. 17 Q. So whether it might normally be the case isn't really 18 relevant, is it? 19 A. No, I accept -- I absolutely accept that for patients 20 some information here will have been lost and that is 21 not acceptable. 22 Q. Yes, and in fact it might go further than that because 23 it might in fact be the case that parts of these 24 logbooks which would have been crucial in those 25 circumstances in ascertaining information about the Page 87
1 and we are recognising that -- we're accepting 2 accountability for this, but I entirely accept the 3 Inquiry's right to be able to decide. 4 Q. Okay. What are theatre logbooks? 5 A. Theatre logbooks are a record that carries key 6 information regarding operations that occur in 7 a theatre. 8 Q. You've provided us in this statement and other 9 documentation with a sort of list, if you like, of 10 various information that might be contained within 11 a theatre logbook. Could we go to paragraph 114.35 of 12 NHST-04944. Sorry, a slight technological hitch. 13 (Pause). So this is part of the -- to go back to this 14 from the beginning, it's part of the NHS Tayside's 15 statement and this is amongst the paragraphs that you 16 wrote, yes? 17 A. Yes. 18 Q. So it's one of the sections where you're explaining 19 documents that may be limited in what you have and this 20 is the logbook section, yes? 21 A. Yes. 22 Q. So you're telling us there the sorts of -- the operation 23 details that were captured within the logbook and you 24 give us a list. And then the next paragraph please, 25 Rory. It says: Page 86	1 nature and the circumstances of their operations, which 2 for many of them is precisely the reason why they're 3 here; is that accepted? 4 A. Yes. Yes. Yes. 5 THE CHAIR: Sorry, Mr Dawson, could I just clarify then what 6 exactly was the point of this paragraph? 7 A. So at the time -- there's a further piece of work that 8 I would be very happy to provide to the Inquiry which 9 I believe the Inquiry has been notified is ongoing is 10 notes reconciliation. So what we're able to say here is 11 give the broad response to how that's going to be but 12 recognising, in terms of the relevant records not being 13 in existence, that would be through destruction in line 14 with our retention guidance. But what we have done is 15 a piece of work to do notes reconciliation. 16 So phase one of that was to identify the logbooks 17 that we hold and assess what patient procedures are 18 documented in there and the phase two is to assess the 19 possibility of reconciliation with the information that 20 may have been in the logbooks from the other records 21 that we hold for patients. So the piece of work that we 22 are trying to do is to -- well, not trying to do, the 23 piece of work that we are doing that we will provide to 24 the Inquiry once complete has been able to identify 25 who -- and we'll be able to provide this information to Page 88

1 patients as well -- who have got all of their procedures 2 documented, who have got some but not all of the 3 information present and where is there no data. And 4 we'll be able to provide that level of granularity which 5 I believe will be helpful to both patients but also 6 helpful to the Inquiry. 7 MR DAWSON: I was going to come to that reconciliation 8 exercise later about which we heard relatively recently 9 but just while we're on the subject, I'm struggling 10 slightly with its concept. Because if you have no 11 operation record in your medical records and if the 12 theatre log has been destroyed, how can we know what 13 detail has been lost by the former as opposed to the 14 latter? 15 A. Yeah, so what we had is a list of roughly -- of 16 procedures of roughly 3,800 procedures from operation 17 notes. What we were able to do is go through all of 18 that information and be able to say, for the logbooks 19 that we do still have, what information is within there. 20 For the logbooks that we don't, be able to have a look 21 at what's contained within the records and for that list 22 that you just showed me, what of that information do we 23 have but in some other means. 24 Q. So that might show, as I understand it, you might be 25 able to say: let's look at one of the logbooks we do Page 89	1 A. I hope for some patients we're able -- 2 Q. Yes, that would be a good news story, wouldn't it, that 3 we don't appear to have lost anything? What 4 I'm focusing more is on the type of patient that I have 5 described, who don't have the record to compare with. 6 What would you say to them about what has been lost, not 7 in the generality but in the specifics of their case? 8 A. I would be saying: I'm sorry and we don't know 9 precisely -- 10 Q. Because there's a very particular case that I can put to 11 you because we heard evidence about it yesterday and 12 that's -- evidence was given by Ms Liz Smith on behalf 13 of a patient called Mr Pat Kelly and what she told us 14 this was an area which had concerned him for many years 15 and there were particular aspects of his records which he 16 had, for particular reasons, an interest in which you had 17 never been able to find. And those particular pieces of 18 information related to concerns that he had a basis for 19 developing over the years about what precisely had 20 happened in his surgery and what he wanted to know was 21 principally, amongst many other things I'm sure, was 22 Mr Eljamel actually at his surgery, and who else was at 23 the surgery? Now, there were a number of reasons for 24 that. It was to do with the fact that he suspected that 25 Mr Eljamel may not, in fact, have carried out the Page 91
1 have. In that, we can see it has this sort of 2 information. It tells you about the operation and some 3 of the things that you've listed in the statement. And 4 then you could look at the notes and you could say: oh 5 look, all of that stuff is already in the note so it 6 didn't look anything has been lost. That might be 7 a hypothetical situation that might occur, yes? 8 A. So I guess the motivation for that was to not accept 9 a broad position that we may or may not have it, to 10 recognise how important this is for our patients in 11 terms of their story and to make sure that we had gone 12 through and be able to provide the information that we 13 do have to patients. 14 Q. Okay, could we just go back to the question. 15 I understand the motivation behind what you're doing, 16 I'm just wondering whether it's actually going to help. 17 That's what I'm trying to get to. 18 A. Okay. 19 Q. So I'm hypothesising with you a situation, a situation 20 where you look at the other entries in the logbooks that 21 we do have and you say: this contains this sort of 22 information and then you go to the medical records and 23 go: oh, good news, all that sort of information is 24 already there, so that's good, we haven't lost anything. 25 Could that be a hypothetical case that could happen? Page 90	1 surgery at all and he also suspected that someone else 2 may have done it but he didn't know who that was and he 3 was also interested who might be a witness what 4 happened. They all seem to me to be reasonable 5 questions but as I understand it the reason why he was 6 interested in these matters is because none of those 7 pieces of information are in his medical records. 8 So if I could take that example, if that's easy 9 enough to follow, if there were a theatre log relating 10 to a patient like Mr Kelly the theatre log would contain 11 the information he wanted, wouldn't it? 12 A. Yes, if it had been entered, yes. 13 Q. Yes, because that's the sort of information -- I mean, 14 I have looked at the logs that you've provided and 15 I think one thing that it always does is it tells you 16 who was the surgeon that did the surgery and alongside 17 that, who else was present. So that's precisely the 18 information that Mr Kelly, and as I understand it 19 numerous other patients, want to get. And the reason 20 they want to get it, if they had been able to get it 21 through their own medical records, frankly we might not 22 be here but the reality is that that's exactly the sort 23 of information that Mr Kelly would have about his 24 particular case in his theatre log, yes? 25 A. Yes. Page 92

1 Q. But he is not going to get now because that theatre log 2 has been destroyed? 3 A. Yes. 4 Q. And given the broad context, which I am assured by my 5 colleagues is the position, that that sort of situation 6 applies to a number of patients, this is an absolutely 7 disastrous consequence for the legitimate desire of 8 these patients to get to the bottom of what happened to 9 them? 10 A. I absolutely accept that. I accept how serious this is 11 and the gravity of this impact for individuals. 12 Q. Another aspect, the aspiration here I think is that the 13 exercise that you've instructed, the reconciliation 14 exercise, will go some way towards dealing with the 15 current situation and working out, well, we haven't 16 perhaps lost as much information as we thought. But 17 what we will always have lost is a particular type of 18 evidence. My understanding, and tell me if your 19 understanding is different, is a theatre log is compiled 20 contemporaneously to the operation? 21 A. Yes. 22 Q. It's compiled, I think by necessity, by people who 23 aren't scrubbed up and part of the operation? 24 A. Yeah, there'll be a team that's there that all have 25 different roles in the room, yes. Page 93	1 practice that takes place within a theatre, after 2 a theatre, but that is something that one of our 3 clinical leads will be able to answer. 4 Q. Would you be prepared to accept -- 5 A. Absolutely. 6 Q. -- as a hypothesis that that does happen? It doesn't 7 seem out of the ordinary? 8 A. I am prepared to accept the different -- yes. 9 Q. So if that was a standard -- on the hypothesis that is 10 a standard practice -- 11 THE CHAIR: It might be thought to be implicit in the name 12 itself, "a logbook" is something you would log as 13 a contemporaneous record. 14 MR DAWSON: Well, what I'm trying to get at, sir, is 15 something slightly different from that. What 16 I'm suggesting is it is probable, if not certain, that 17 the note in the log will have been prepared at 18 a different time to the note put in the patient records? 19 A. Yes. 20 Q. It will have been prepared more contemporaneously to the 21 operation than the note that will necessarily be written 22 at a certain remove because people will have to come out 23 of the theatre and go and write it up, yes? 24 A. Yes. 25 Q. And it is likely, at least on the hypothesis I have Page 95
1 Q. Absolutely, but there will be a surgeon who will 2 obviously be scrubbed up, as they say, so in the sterile 3 field? 4 A. Yes. 5 Q. There will be other perhaps junior surgeons, there might 6 be a scrub nurse, all of whom are participating in the 7 surgery, yes? 8 A. Yes. 9 Q. And somebody else would be noting down the salient 10 features that go into the theatre log, yes? 11 A. Yes. 12 Q. There aren't really necessarily any clear rules, 13 I think, around who ultimately puts the information 14 about the surgery into the surgical note or the patient 15 notes. It could be a variety of different people, is 16 that right? 17 A. I am unclear of that level of detail of what happened in 18 a theatre, but I would imagine it can be. 19 Q. So if that is the case, so for example I would imagine 20 in many cases the surgeon himself will write a note 21 after it or he might delegate it to a junior to say: 22 could you write up the notes of that surgery for me. 23 And whoever has put it in would sign it; is that the 24 usual practice? 25 A. I am not close enough to know exactly the clinical Page 94	1 presented, highly likely that a different person will 2 have compiled the theatre log note to the note which is 3 contained within the medical record? 4 A. I accept that as a hypothesis. I am not close enough to 5 know who signs it off. 6 Q. Is it not logical that if it's being prepared 7 contemporaneously to the surgery it can't be prepared by 8 the surgeon? 9 A. Yes, I am accepting that. 10 Q. So therefore even -- in any case it appears that we must 11 have lost a contemporaneous source of evidence that 12 would have been useful? 13 A. Yes. 14 Q. A potentially corroboratory source of evidence from 15 a different individual that would have been useful? 16 A. Yes. 17 Q. And in some cases the only evidence of what happened in 18 their surgery? 19 A. Yes. 20 Q. Thank you. There's one other aspect of this which 21 I feel I have to draw to your attention which is related 22 to the Independent Clinical Review. At the time when 23 the occasions you discussed at the opening statement 24 hearing at which the public airing of this issue was 25 addressed, we received correspondence from Page 96

1 Professor Wigmore who is in charge, as you know, of the 2 Independent Clinical Review, setting out his concerns 3 about the consequences. And he actually told us 4 a little bit about what theatre logs are because they're 5 not in any way particular to Tayside or particular to 6 neurosurgery, they're very commonly used; is that your 7 understanding? 8 A. Yes. 9 Q. What he has brought to my attention, which I think is 10 important to raise with you, is that he considers the 11 absence of this material may be a significant detriment 12 to the ambitions of his process in being able to answer 13 the legitimate clinical questions being posed by 14 patients. Were you aware of that? 15 A. I'm certainly aware that if we are unable to provide the 16 information, that patients would have known as their 17 only source in there and unable to provide that, that 18 has an absolutely detrimental impact for patients and 19 I can accept that has an absolute impact on the 20 Independent Clinical Review. 21 Q. Because, to be perfectly frank, it has been very much at 22 the forefront of the Inquiry's and Professor Wigmore's 23 mind from the start of the conception of the two 24 processes that we knew from the start that there were 25 missing records. Page 97	1 not to jump straight to the public inquiry because 2 I think she didn't think that would be very realistic 3 but to go through various levels and process using the 4 different mechanisms then ultimately she was persuaded, 5 in around the middle of 2022, that it was time to put her 6 support behind a public inquiry. 7 But she explained that throughout all of that 8 process the absence of documents had been an integral 9 part of why people, and many people, kept coming back to 10 ask her questions which she thought she should take 11 forward because it was the absence of when things had 12 gone wrong clinically, when people asked for 13 an explanation, the absence of documents was what had 14 triggered their suspicion that something must be going 15 on that people weren't prepared to tell them. Do you 16 understand that concept? 17 A. I do. 18 Q. And do you understand that to be the background as to 19 how we got to that point? 20 A. I understand there to be absolute concerns regarding, as 21 you've outlined throughout this questioning, around 22 people being able to understand access and that 23 transparency. 24 Q. I think sometimes it might be thought that document 25 management is the sort of administrative exercise that Page 99
1 A. Yeah. 2 Q. And that it was important as much evidence as could be 3 assembled reasonably to solve the important question of 4 what actually happened should be put together. That is 5 why, for example, it was very important that patients be 6 able to put in an applicant statement detailing what 7 their perspective on things was. But in this area this 8 is precisely the sort of thing where patients like 9 Mr Kelly don't know what happened, do you understand 10 that? 11 A. I do. 12 Q. And therefore the loss of this evidence to both 13 processes, in cases like Mr Kelly's and as I understand 14 it many others, is extremely serious? 15 A. I absolutely accept the seriousness. My sincere apology 16 to the Inquiry and to the Independent Clinical Review as 17 well as the apology that I provide to patients. 18 Q. We heard yesterday in Ms Smith's evidence, in a section 19 where she was detailing the various stages that had been 20 gone through in getting to the point of trying to find 21 answers then build it up through different levels and 22 eventually getting to a public inquiry, that the absence 23 of documents was an enormous part of why the campaign 24 for a public inquiry carried on the way that it did and 25 she explained that she had tried to persuade campaigners Page 98	1 doesn't play a very important, substantive role in any 2 organisation. Is that the position of an NHS Tayside? 3 A. No. 4 Q. Is that the reason why things like the destruction of 5 the logbooks happened? 6 A. The independent review found there was a range of 7 failings that took place of which I own and accept. 8 What we have in place is there is obviously the national 9 code of practice regarding records management. That's 10 not just a "good to have". There are statutory duties 11 we hold as an organisation that we take very seriously 12 and we have policies in place for delivery. Being able 13 to ensure that every one of those policies are 14 implemented across the organisation would be 15 a challenge. So gaps in application, I guess, of policy 16 and of that national practice can absolutely result in 17 issues such as the logbooks going missing. 18 Q. But I think this is really the nub of it which is that 19 might well happen in an organisation of that scale but 20 surely it shouldn't happen in relation to this sort of 21 situation -- 22 A. Absolutely should not have happened. 23 Q. -- when document management issues, significant document 24 management issues, were at the very core of why the 25 public inquiry was announced in the first place? Page 100

1 A. Yes. 2 Q. So is it not self-evident that from day one of you 3 arriving at NHS Tayside it should have been your highest 4 priority to make sure that, in order to deal with what 5 you accepted were the serious matters being addressed by 6 this Inquiry, you made absolutely sure that special 7 measures were taken to ensure that no Eljamel-related 8 document could be destroyed under your watch? 9 A. Yes. 10 Q. I understand that the patient groups or certain groups 11 of patients have called upon you to resign? 12 A. Yes. 13 Q. What is your position on that? 14 A. My position on that is that I am not intending to resign 15 as a result of this. When this was brought to my 16 attention I took both immediate -- and I have taken 17 sustained actions to ensure that this was taken forward, 18 that it was delivered and we have now got an absolutely 19 robust framework in place for the delivery of this going 20 forward which we are sharing across for further learning 21 across other areas in Scotland. But I absolutely accept 22 the accountability for this. 23 Q. You're accountable for this then? 24 A. I am accepting, as the accountable officer for the 25 organisation, the accountability that I hold to ensure Page 101	1 for lunch. Can I just mention something that I will 2 generally do over the lunch break for a witness still 3 giving evidence, and I'm sure you understand the reasons 4 for it, but to keep matters regular we ask that you 5 don't discuss your evidence over the lunch break and 6 we'll resume again at 1.15. 7 (12.31 pm) 8 (The short adjournment) 9 (1.21 pm) 10 THE CHAIR: Please have a seat. Thank you. Just before we 11 resume can I just say something briefly. I recognise, 12 of course, the strength of feeling generated by evidence 13 of the kind that we are hearing but it is very important 14 that the conditions are such that we hear the witness's 15 best evidence and indeed that as a matter of fairness 16 the evidence of all witnesses are listened to with 17 consideration. 18 So can I ask for your help with that as I now invite 19 Ms Connor to come back into the hearing suite. 20 Thank you, Ms Connor, just a reminder that you're 21 still under oath and Mr Dawson will have some more 22 questions for you. 23 MR DAWSON: I just noticed that somebody wasn't here but not 24 essential for our interaction. So, I'd just like to ask 25 you some questions. We were on the topic of the Page 103
1 that the systems, processes, policies and structures are 2 in place and embedded. I was not responsible for the 3 individual actions that took place nor was I directly 4 involved in the destruction of the logbooks but that 5 does not negate the responsibility that I hold and 6 discharge through my team to ensure that the logbooks 7 were and other records are kept safe. 8 Q. So you're nominally accountable but you're not actually 9 accountable? 10 A. I am accountable as the accountable officer for 11 NHS Tayside. 12 Q. Thank you. Sir, I have a number of other questions for 13 Ms Connor relating to the logbook issue. It may be, 14 however, that the details of what I feel I would need to 15 go into would be assisted if we broke early for a lunch 16 break which may have an overall benefit as some of the 17 answers that have been given already will cover, 18 I think, some of the areas that I intended to cover in 19 some more detail. So if that would be an appropriate 20 moment, in light of those considerations, we might 21 perhaps break for lunch now? 22 THE CHAIR: Break for the usual 45 minutes would take us to 23 1.15, if that would -- 24 MR DAWSON: That would be very helpful. Thank you, sir. 25 THE CHAIR: Thank you. Ms Connor, we're going to break now Page 102	1 logbooks in a general sense and you have sent us a lot 2 of documentation about all of this and it's very helpful 3 to help understand but I think it's important that we go 4 through some element of the detail of it with which 5 I know you're familiar just to give a clarification for 6 people who are listening as to what appears to have gone 7 on and the actions that have been taken by the board as 8 a result. 9 Could I start, please, by looking at a document 10 NHST-01485. 11 Could we go to the last page, please, which is 12 page 4. Now quite often when we get documents from 13 organisations there are chains of emails and they've 14 been quite hard to follow through but they tend to work 15 like this where you start from the back and have to work 16 through to the front. This was some documentation that 17 was sent in, in connection with the NHS Tayside 18 statement and it appears to be an email which you can 19 see there between Pamela Johnston and I think it's 20 an Alison Dailly and it is dated 24 April 2023. 21 What it says is: 22 "Dear all, could you please provide assurance that 23 all medical notes of patients who have had contact with 24 Professor Eljamel have been retained and have not been 25 destroyed or had sections of said notes removed? Page 104

1 Dr Johnston also requires assurance that these medical 2 notes will continue to be held on retention until 3 further notice due to the ongoing investigations 4 pertaining to Professor Eljamel." (As read) 5 Now, I think this is not a document that was 6 produced either in connection with the sections that you 7 have completed nor was it a document -- it's a document 8 which pre-dates your involvement, I think within 9 NHS Tayside but I just wanted to point to it as part of 10 the picture because it's dated April 2023 and it 11 appears, as I understand it, to be someone from the 12 medical director's office, in fact the medical director 13 herself I think it may be, Dr Johnston, asking for the 14 care to be taken in the retention of medical records 15 because of ongoing investigations. Does that appear to 16 be a correct context to -- 17 A. I don't have that in front of me but, yes, I recognise 18 what you're talking about and yes it does. 19 Q. Thank you. The reason I wanted to bring that up was 20 whether that reference to medical records would not -- 21 or records of patients would normally within Tayside be 22 thought to include things like theatre logbooks or 23 whether that would be a term of art that would mean 24 something different? 25 A. I think, in fact in terms of the independent review what Page 105	1 theatre log, correct? 2 A. Yes. 3 Q. But the theatre log contains multiple entries relating 4 to multiple patients, yes? 5 A. Yes. 6 Q. And they are, I think from the documentation we've seen, 7 stored, importantly, separately from what one might 8 describe as an individual patient's records? 9 A. Yes. 10 Q. And in fact, rather than being stored in I presume the 11 medical records department or something like that, they 12 are stored within the office to the neurosurgical 13 theatre; is that correct? 14 A. That's where they were stored, yes. 15 Q. Thank you for that. Could I then just take you through 16 some aspects of the statement which you did write which 17 helps us with the chronology as to what actually 18 happened. The statement, please, at paragraph 114.26. 19 So just because we're not publishing this, I'm just 20 going to read out aspects of this but really just to get 21 the chronology. In that paragraph it says that: 22 "On 28 August 2025, a verbal request was received 23 into NHS Tayside Health Records Department from 24 Police Scotland Operation Stringent (the police 25 investigation to Mr Eljamel), to seize theatre logbooks Page 107
1 was found was there confusion regarding terminology 2 and confusion regarding responsibilities in relation to 3 that. Without a patient record some interpreted to be 4 the record that related to only that individual, whereas 5 a logbook contains information across a range of people. 6 However, we look back to both policy and the code of 7 practice for Scotland it contains information that would 8 make it relevant and I think -- and that's absolutely 9 a point of reflection. 10 Q. Yes, okay. Understood. But in receipt of this do 11 I take from what you're saying this would be understood 12 to mean the patient's medical records, the sort of thing 13 I'm picturing in a folder but may now exist in 14 electronic form and that would exclude logbooks; is that 15 correct? 16 A. Again, another finding from the review was that there 17 was the health records and there was the responsibility 18 that was held regarding logbooks which was held within 19 theatres. So again that clear responsibility and who 20 hold that responsibility for all information was one of 21 the findings and one of the things we needed to address. 22 Q. Yes, this is important not just for this issue but the 23 Inquiry's wider consideration of document management 24 because as we've ascertained there was information 25 related to patients and their operations within the Page 106	1 containing information regarding the surgical practice 2 of Mr Eljamel dating from May 1995 to November 2014. 3 This was followed up by Police Scotland with a formal 4 request in writing from Operation Stringent on 5 24 September 2025 ..." 6 And we've given that document reference number 7 NHST-04671. 8 So what happened at that time was a request came in, 9 in connection with the police investigation about the 10 recovery of records. Is that right? 11 A. Yes. 12 Q. And one thing I just wanted to ask you about that, is 13 there any, as far as you're aware significance to be 14 attached to the fact that is dated from May 1995 because 15 my understanding is that Mr Eljamel started working 16 in October 1995? 17 A. I'm unable to answer that, sorry. 18 Q. Yes, it's the police who have asked for that so it may 19 be that that's matter for them to answer? 20 A. Yes, apologies. 21 Q. Thank you, not at all. And effectively this triggered, 22 as I understand it, an identification that there were 23 a number of logbooks which were over eight years old 24 held in the theatre suite pertaining to the theatre in 25 which Mr Eljamel would usually operate, is that correct? Page 108

1 That's the next paragraph 114.27; is that right? 2 A. Yes. 3 Q. So what's the significance of the eight years? 4 A. The retention policy period for -- 5 Q. So what we're looking at here is -- I mean obviously at 6 this time when the request was received anything of this 7 nature would be more than eight years old because 8 Mr Eljamel stopped working in December 2013, is that 9 right? 10 A. But the logbooks themselves may not be over eight years 11 old because the logbook itself is not pertaining just to 12 Mr Eljamel. 13 Q. Right, but it would have been necessary for the logbook 14 to have continued up until 2018, which was eight years 15 before the request, for it still to be have been 16 retained? 17 A. Yes. So the logbooks were identified, went back to the 18 1960s and they should have been retained at that time 19 for that period of time, yeah. 20 Q. So the logbooks as I understand it, because we have seen 21 some, they cover various different time periods. It 22 depends how many operations are covered in the period. 23 Sometimes there's an awful lot of operations and they 24 cover a relatively short period, sometimes the same 25 number of pages, if you like, can cover a longer period Page 109	1 A. Yes. 2 Q. Okay, thank you. Can I just ask whether you can help me 3 with a particular point of detail brought to our 4 attention by Professor Wigmore. He informed us that 5 it's normal for surgeons to carry out operations within 6 particular theatres where they are routine operations 7 but that it can often be the case that in emergency 8 situations they can carry out surgeries in whatever 9 theatre happens to be available in the emergency 10 situation. Is that a practice which you recognise as 11 being one that would have been adopted in Mr Eljamel's 12 time, as far as you understand it, or from your 13 understanding of surgical practice now? 14 A. So what you describe to me makes sense but I think it 15 would be the medical director who will be able to 16 explain more how -- 17 Q. The reason I asked the question, Ms Connor, is nothing 18 particularly sinister, it is just that that fact raises 19 the possibility that there could be documents like 20 theatre logs held in similar situations relating to 21 other theatres. Would it be something the board would 22 be prepared to do to investigate whether these theatre 23 logs might contain entries relating to Mr Eljamel in 24 other places other than the office associated to the 25 theatre which he regularly used? Page 111
1 because there are less operations, is that right? 2 A. Yes. 3 Q. But in effect it was identified that there were logbooks 4 relating to this request by the police? 5 A. Yes. 6 Q. At paragraph 114.28, it says: 7 "On attempting to locate these following the verbal 8 request from Police Scotland on 28 August 2025, it was 9 discovered these logbooks had been removed from their 10 location on 28 July 2025 and added to the confidential 11 waste stream to be destroyed." 12 So in trying to comply with the police request it 13 turned out that in fact some of the logbooks had been 14 destroyed on 28 July 2025? 15 A. Yes. 16 Q. As I understand it, I think you've already clarified for 17 us, that these were held within, is it, an office which 18 is the office for the theatre where Mr Eljamel typically 19 did his operations historically? 20 A. The senior charge nurse's office adjacent to the 21 theatre, yes. 22 Q. Right, so because of the fact, I think, that different 23 times of surgery would go on in that theatre, it's not 24 a neurosurgery office particularly but it's an office 25 associated with the theatre itself? Page 110	1 A. One of the actions that I put in place was to address 2 just that and we've called it "forensic walkabouts" but 3 there's been a review in terms of the entirety of acute 4 services and across corporate services and across our 5 Health and Social Care partnerships to identify if there 6 is any further information that could be relevant to 7 this Inquiry or Mr Eljamel. 8 Q. Can you undertake that those searches will include those 9 sorts of places in light of the suggestion I have made 10 to you -- 11 A. Yes. 12 Q. -- that he might have operated in different places? 13 A. It's used in every department within acute services. 14 Q. So that will cover every theatre? 15 A. Yes and beyond. 16 Q. That's very helpful, thank you, but to be fair it does 17 seem natural that that's the place you would go because 18 that would be the place, if there were such records in 19 the theatre in which he tended to operate in his routine 20 surgery, that would be the most likely place to find it? 21 A. Yes. 22 Q. So is that the thinking here? 23 A. Yes. Yes, that was the routine theatre that was used 24 and as a result of the forensic walkabout there was no 25 further information found within the organisation. Page 112

1 Q. Given the fact that the location of these ultimately 2 destroyed documents was in an office which served 3 a theatre in which he did most, if not all, of his 4 operations, how difficult would it have been for 5 NHS Tayside to issue a bespoke instruction to that 6 office to seek to secure Eljamel-related documents? 7 A. That could and should have been done. 8 Q. Because of the association of that office with his work? 9 A. Yes. I think absolutely. On reflection there should 10 have been more bespoke communications that took place to 11 the areas that were of highest risk within the 12 organisation. 13 Q. Because you said earlier, and this seems to be a fair 14 comment, that these sorts of things sometimes go wrong 15 across a large organisation? 16 A. Yes. 17 Q. But we're talking about here is a situation in which 18 precisely the sort of place where you might have found 19 Eljamel-related documents has been the place where they 20 were and from which they were destroyed? 21 A. Yes, and the actions that were taken at the time were 22 multiple. It was to a discussion with my executive team 23 with an ask for them to discharge responsibilities for 24 the areas of responsibility that they have. It was also 25 to send the communication across the whole organisation Page 113	1 the training for staff, it covers how senior management 2 assurance will come in place and it covers our wider 3 information governance around asset registers and 4 knowing the information we have held. This has all been 5 put together in terms of a very clear framework which 6 covers our governance structures, how it's activated, 7 communication and how it's monitored and assured. And 8 that has been approved in the past month by our 9 committee and board. 10 Q. Thank you for that. Am I correct in assuming that none 11 of that existed before? 12 A. These are a direct result of the recommendations, these 13 were found to be gaps and failings in our processes. 14 Q. Okay, thank you. And I think as you have accepted 15 already, the documents were destroyed in contravention 16 of the Inquiry's do not destroy notice. The document 17 reference for that is ELJ-00534. 18 A. Yes. 19 Q. And at paragraph 114.30, if we could scroll down 20 a little, in the statement. We're going back to the 21 statement, paragraph 114.30. Thank you very much. It 22 says: 23 "The destruction of some of the theatre logbooks was 24 despite a DND Notice in place from The Eljamel Inquiry 25 which had been received on around 11 October 2024. The Page 115
1 and it was also to make sure that we were focused on 2 that. The independent review found though that that was 3 not sufficient in terms of securing and providing the 4 level of assurance and protection to records that should 5 have been in place. 6 Q. The point I'm trying to get to, Ms Connor, is whether it 7 would be fair, despite the generality of those systems 8 and how they operate more generally, in these 9 circumstances that a bespoke approach could have been 10 taken to contact those who worked in the very places 11 where Eljamel-related records were most likely to be found? 12 A. Yes, I absolutely accept that. 13 Q. Is that part of the work that you intend to carry out 14 going forward? 15 A. Yes. So as a result of the independent review there 16 were 15 recommendations. We've accepted all of those 17 recommendations in full. What we now have put in place 18 is called a "do not destroy compliance framework". It 19 covers an end-to-end process in terms of delivery. It 20 means there will be the appointment of a single 21 executive lead. There will be a compliance group that 22 is brought together to do an exact assessment of what 23 should happen in the organisation when a DND is 24 received. That framework seeks to support both 25 communication and escalation arrangements. Its covers Page 114	1 DND Notice had been shared with all Executive Directors 2 on 18 October 2024 [document reference NHST-04506]. 3 An all-staff communication was sent out on 4 8 November 2024 to the organisation ..." 5 THE CHAIR: Sorry, we appear to have lost it. (Pause). 6 MR DAWSON: Thank you. I'll go back to the beginning of 7 that. 114.30 says: 8 ""The destruction of some of the theatre logbooks 9 was despite a DND Notice [do not destroy notice] in 10 place from The Eljamel Inquiry which had been received 11 on around 11 October 2024. The DND Notice had been 12 shared with all Executive Directors on 13 18 October 2024 [document reference NHST-04506]. 14 An all-staff communication was sent out on 15 8 November 2024 to the organisation regarding the Notice 16 with instructions to comply [NHST-01592]. Thereafter, 17 later in November and again in December 2024, the Notice 18 was reiterated to key employees of NHS Tayside who it 19 was thought may have relevant information ..." 20 And that's NHST-04495. This was the correspondence 21 I think you referred to earlier as to how it had been 22 sent around directors initially and then all staff that 23 this was a notice which had been received which required 24 to be complied with, is that right? 25 A. Yes. Page 116

1 Q. Was one of the findings of both of the internal and 2 external reports that effectively the people who were 3 involved in destroying this basically didn't read such 4 communications? 5 A. Yes. 6 Q. And is it part of the system which you intend to 7 implement that there will be a more targeted approach 8 because, to be fair to busy medical professionals if 9 they receive multiple emails of this nature a day, it 10 might be entirely predictable that they won't be able to 11 read them all? 12 A. Yes, I absolutely accept that. On taking up post, 13 I followed the established processes of bringing it to 14 my executive team with the expectation they would follow 15 that through within their areas and also in terms of 16 a wider staff communication. But it was indeed 17 a finding and it is absolutely within our DND compliance 18 framework which I'd be very happy to provide to the 19 Inquiry so that you have a copy to see everything that 20 that includes. 21 Q. Indeed, if we don't have that already, I think that 22 would be very helpful to see that in terms of trying to 23 understand what learning and what subsequent action has 24 been taken. 25 A. Yes. Page 117	1 equipment used. The information was recorded manually 2 in hard-copy books and held in the theatre suite for 3 ease of access and review. This process was superseded 4 by the introduction of the Opera theatre management 5 system brought in by phased implementation in 2012." (As 6 read) 7 So what happened in the aftermath of this was the 8 "do not destroy" notice was re-shared, yes? 9 A. Yes. 10 Q. And there was a high-level report commissioned by the 11 cap commissioned by the chief officer in acute services, 12 who is that? 13 A. That's Lynn Smith. 14 Q. Thank you, and that high-level report gave 15 information about the sorts of things that would be 16 included within theatre logbooks and therefore the types 17 of information that we discussed earlier that might be 18 lost? 19 A. It also raised concern that these had been lost and that 20 was considered by the oversight group. So it was 21 initially a fact-finding on finding out that this had 22 potentially happened at that time. It was the director 23 establishing fact. 24 Q. Just in case you know the answer, there's a mention 25 there of a system, the Opera theatre management system, Page 119
1 Q. And indeed, the process after that point is set out at 2 paragraph 114.32, where it says: 3 "The DND notice was immediately re-shared on 4 9 September 2025, NHST-01697, with all members of staff 5 across the organisation in a vital signs email 6 communication." (As read) 7 What is a vital signs email communication? 8 A. So there's regular staff bulletins issued. A vital 9 signs is a staff communication which is intended for all 10 staff to read and it also comes with a notification on 11 it asking that managers would print and display that 12 within their departments as well. 13 Q. And you say, at 114.33, that: 14 "A high-level report was initially commissioned by 15 the Chief Officer of Acute Services which outlined the 16 background and assessment of the circumstances of the 17 destruction of the logbooks and was provided to the 18 NHS Tayside Eljamel oversight group [which you mentioned 19 earlier] on 12 September 2025, NHST-04504, and discussed 20 by the Chief Executive Team (CET) on 15 September 2025, 21 NHST-04724." (As read) 22 And you go on to say: 23 "It was identified that the theatre logbooks 24 contained high-level information of the types of 25 operations performed, including staff in attendance and Page 118	1 is that an electronic system or something like this? 2 A. Yes, but again, I would ask that you ask the clinical 3 colleagues -- 4 Q. Yes, it's quite a point of detail. Thank you. 5 Paragraph 114.37, you go on to say that: 6 "Following a discussion on the circumstances of the 7 loss of the theatre logbooks led by the Senior 8 Information Risk Owner (SIRO), at CET on 9 15 December 2025, NHST-04724, initial actions were 10 agreed to mitigate further risk and it was agreed that 11 a full investigation should be commissioned to establish 12 more detailed facts of the incident. This was primarily 13 an investigation into people and their actions and 14 therefore it was agreed that the NHS Scotland workforce 15 policies investigation process was most appropriate 16 applying a just culture lens." (As read) 17 The investigation was commissioned by [you] on 18 18 September 2025, NHST-04697 to NHST-04740: 19 "It was completed on 30 October 2025." (As read) 20 So, you decided at that stage, after the initial 21 report, to commission a full report which took place 22 within certain existing investigative frameworks? 23 A. Yes. 24 Q. Thank you. And at paragraph 114.40, it says: 25 "The Operation Stringent theatre logbooks Page 120

1 investigation under NHS Scotland workforce policies 2 investigation processes ..." (As read) 3 Which I think is NHST-04507, so a report was done, 4 an internal report, which you've provided to the 5 Inquiry? 6 A. Yes, that is -- sorry, it didn't move on to 114. Yes, 7 that was the investigation, the internal investigation, 8 yes. 9 Q. The one that you had investigated? 10 A. Yes. 11 Q. I understand. And it says at paragraph 114.41: 12 "The investigation disclosed that an unknown number 13 of hard-copy theatre logbooks which would have contained 14 certain information relating to Mr Eljamel's surgeries 15 during the period 1995 to 2013 were destroyed on around 16 24 July 2025." (As read) 17 The aspect of that I just wanted to focus in on was 18 you mention there -- I think as I understand it the 19 process looked at a sort of deductive reasoning process 20 to try to work out: what logbooks do we have, therefore 21 what logbooks do we not have? Is that right? Is that 22 how the periods during which we don't have the logbooks 23 were identified? 24 A. Apologies, could you please ask that again? Sorry. 25 Q. Yes, I'm just trying to work out how it is that we know Page 121	1 destroyed? 2 A. Yes and assuming that that will cover the period that 3 Mr Eljamel practised. 4 Q. Yes, indeed, so we're not going back to 1960 we're just 5 starting in 1995? 6 A. Yes. 7 Q. And you've tried to estimate the number that you think 8 would have been used based on what we discussed earlier 9 about the length and number of surgeries and how many 10 you fit in a waste bag and that came to 40, we think? 11 A. Yes, I think that was based on how many waste bags there 12 were and how many you would be fitting within the waste 13 bag. 14 Q. How did it come to be that some of the theatre logbooks 15 were destroyed and some were not? 16 A. There was a freedom of information request earlier 17 within the year, a logbook was provided and as there is 18 time for people to respond, that was kept there. So 19 that's why it was known that there was theatre logbook 20 and there were some that were there. 21 Q. So some of the logbooks had effectively been removed 22 from the area to respond to a freedom of information 23 request, is that right? 24 A. There was a logbook -- that's how the team knew that 25 there was information available. As to how the others Page 123
1 what periods the logbooks cover that were destroyed? 2 A. That is down to understanding that the logbooks had 3 dated back to 1960 and it's down to knowing what 4 logbooks we had left based on the Opera system being 5 implement. 6 Q. Right, so does that mean that within the Opera system 7 there was some sort of record as to what logs were 8 there? 9 A. No, I don't think so. 10 Q. No, so again -- because at one stage in the 11 documentation I think it says that 40 logbooks were 12 lost? 13 A. Yeah. 14 Q. How do we know that? 15 A. That's the reason it says an unknown number. The 16 estimate of 40 was based off how many you would fit 17 within a confidential waste bag and how many 18 confidential waste bags we know were disposed. We do no 19 not know the number of logbooks that were destroyed. 20 Q. I see, but I think the assumption has been made when you 21 take 1995 as your starting point when Eljamel started 22 and 2013 as the end-point when he stopped operating in 23 Ninewells Hospital and you take the logbooks that we do 24 have, you've assumed that the ones in all the 25 other years and all the other periods have been Page 122	1 were there, I'm not actually sure. I don't know. 2 Q. I think you've produced to us a number of logbooks for 3 this period. 4 A. Okay. 5 Q. And I think the reality is that you've deduced, as 6 I've just pointed out there, that there are certain 7 periods for which the logbooks appear to have gone 8 missing but some remain? 9 A. Yes. 10 Q. And I was keen to try to work out -- because I have 11 looked at some, so they definitely exist -- I'm trying 12 to work out how it is that some did not get destroyed in 13 this effort in accordance with the policies to get rid 14 of them, but is that something somebody else will have 15 to help? 16 A. Yes, I don't know the answer to that. 17 Q. Okay, thank you. You go on -- we've discussed this to 18 a certain extent already, but you go on to say that the 19 logbooks were destroyed in accordance with certain 20 policies. When you talk about -- and indeed government 21 guidance that we've referred to already. In effect, 22 what -- does that mean that they were destroyed as if 23 they held no special status? 24 A. So, can you -- 25 Q. Yes, paragraph 114.44, it says there: Page 124

1 "The individuals involved believed they had carried 2 out the disposal and destruction of the logbooks in 3 accordance with NHS Tayside's Health Records Strategy 4 and Management Policy [NHST-01539], its Health Records 5 Operational Guidance & Service Operating Procedures 6 [NHST-01483], and Scottish Government guidance 7 [NHST-01484]. These indicate that documents such as the 8 theatre logbooks are required to be retained for 9 a minimum of eight years from the end of the year to 10 which they related, at which time they are eligible for 11 destruction." 12 So the assertion there is people thought that they 13 were simply applying the general policy? 14 A. Yes. 15 Q. But these were not documents -- 16 A. No. 17 Q. -- to which the general policy applied because they were 18 documents to which a do not destroy notice applied? 19 A. Yes, and I think that goes back to a feeling that has 20 been described regarding how the communication took 21 place regarding the DND, whether people understood it at 22 all levels in the organisation, whether we did 23 a targeted approach, but they did not know. 24 Q. The targeted approach may be one thing but perhaps 25 also the extent to which it was highlighted to them as Page 125	1 A. Yes. 2 Q. So these are the ones within the period that still 3 existed? 4 A. Yes. 5 Q. And you mentioned something about there being something, 6 a logbook falling within the freedom of information 7 request, but you can't help us as to why these ones 8 exist and the others don't? 9 A. No, my connection with what had been done is how did we 10 know there were logbooks in place. So we knew the 11 logbooks were there as part of a previous discussion 12 that had already taken place and that's -- when the 13 people went to have a look at what was in place and what 14 was not there, we recognised that things had gone 15 missing. 16 Q. So how did you know that the logbooks were there? 17 A. Because there's -- on the investigation the senior 18 charge nurse was able to confirm that they were kept 19 there. 20 Q. But there was no record of them as such? 21 A. No. 22 Q. Like an inventory or audit -- 23 A. No. So that's another gap that has been identified 24 through the independent review, that we did not have 25 information asset registers fully in place. That is now Page 127
1 being something of particular importance? 2 A. Yes. 3 Q. Because it's all very well to send emails to busy 4 medical professionals in a targeted way, ie picking the 5 ones you think it applies to most, but if it's amongst, 6 as we find out in the report, various other emails 7 perhaps it would be overlooked, the main message here is 8 that these documents don't fall within the policies? 9 A. Yes. 10 Q. And that is, from this paragraph, you've helpfully told 11 us they thought that they did? 12 A. Yes. 13 Q. If you look at paragraph 114.47, please. This is the 14 passage I was referring to earlier about what we still 15 do retain. It might be helpful for people to understand 16 this: 17 "NHS Tayside still holds hard copy logbooks for the 18 relevant theatre for the periods March 2000 19 to June 2007 ..., 7 May 2013 to 21 October 2013 ..., 20 21 October 2013 to 14 April 2014 ... and Theatre 21 Registers for 27 November 2006 and 20 November 2007 ... 22 These documents have been provided to Police Scotland in 23 accordance with its request." 24 A. Yes. 25 Q. I think they have also been provided to the Inquiry. Page 126	1 in place. 2 Q. And there's mention there of there being some theatre 3 registers for a period between 2006 and 2007. Can you 4 help us with what they are? 5 A. Again, I think I would value a clinical person being 6 asked to distinguish between that record. 7 Q. I'm not going to go through the detail of the 8 investigation because we've already touched on some of 9 the main conclusions and indeed, they're helpfully 10 highlighted in your commentary in the statement. One 11 aspect of it which I think is picked up in the 12 subsequent independent report is that the statement 13 contains -- this is NHST-04507 contains a number -- 14 sorry, the report contains a number of statements from 15 individuals who are, to some extent, involved in the 16 destruction to try to fact-find what they could tell us 17 about the circumstances of their destruction. 18 One aspect I think is of particular interest which 19 relates to there being passages in the report -- we can 20 go to them if you need to, but we can perhaps deal with 21 them in the generality -- where it was suggested that 22 the documents had been destroyed by individuals working 23 within that department, physically sent away for 24 destruction if you like, but that they had done so on 25 the advice, the specific advice that they had sought Page 128

1 from the medical records department. My understanding 2 is that, despite there being conflicting testimony about 3 that, that the report accepted that specific advice 4 about the destruction of these logbooks had been taken 5 from the medical records department. Is that your 6 understanding? 7 A. My understanding is specific advice was sought. Where 8 there is a mixed or a difference of opinion is whether 9 it was made clear the relevance of those logbooks. 10 Q. Right. Okay. By whom, to whom? 11 A. The individuals who sought the request to a member of 12 the health records team. 13 Q. But it does -- 14 THE CHAIR: Sorry, I'm being slow here. Mr Dawson, by that 15 should I understand you to mean there's a differing 16 recollection as to whether the medical records 17 department were told what these records were and with 18 whom there was a connection? 19 A. Yes, the individual, it wasn't -- the individuals phoned 20 and sought advice regarding finding these records and 21 what should they do with them, but it was not said nor 22 was it recognised that it was relevant to Mr Eljamel's 23 practice. 24 THE CHAIR: Thank you. 25 MR DAWSON: But they did seek specific advice about it? Page 129	1 within the office, yes? 2 A. Yes, it was. 3 Q. It was sought from the medical records department? 4 A. Yes. 5 Q. The medical records department appear to say that they 6 weren't entirely clear as to what the records were, is 7 that right? 8 A. Yes, they dealt with it as a general inquiry. 9 Q. Yes, but they knew that the request was coming from the 10 office next to Mr Eljamel's operating theatre? 11 A. I would accept again though, based on the communication 12 and the dissemination of that information, one of the 13 other learnings we have taken is if there is turnover of 14 staff, induction, how do you not do these once and make 15 sure this is fully embedded in the organisation. So 16 I'm accepting that as a system issue. 17 Q. Because what I'm trying to explore here is whether, in 18 circumstances where it would appear staff who work in 19 the office took the responsible course of seeking 20 advice, whether your earlier posited theory that you 21 can't disseminate information really to everybody really 22 applies because all you needed to do was make sure that 23 the medical records department knew that the Eljamel 24 documents were not to be treated in the generality of 25 the systems and that if responsible people, like those Page 131
1 A. They sought advice on the destruction of records that 2 they'd found. It wouldn't be normal to find records 3 dating back as far as they did. 4 Q. Yes, what I'm trying to highlight is that that might be 5 deemed to be a responsible thing for them to have done 6 when they were in a state of confusion or doubt what to 7 do with them? 8 A. Yes, absolutely I would expect that. 9 Q. And the precise place where you might expect to find 10 accurate information about what to do and the precise 11 individuals whom you might think would seek all the 12 information they need to be able to give accurate advice 13 about what those individuals should do with these 14 historic records is the medical records department, 15 isn't it? 16 A. Yes, but it was not made clear, the relevance of these 17 logbooks. I totally accept that there is learning and 18 reflection from that. 19 Q. I accept that you accept that there's learning and 20 reflection required. I'm just trying to establish, 21 effectively, the circumstances because as I think we're 22 at one to say that the testimony is slightly unclear on 23 this, but my understanding of the conclusions is 24 effectively that specific advice about the destruction 25 of these logbooks was sought by the people working Page 130	1 working at the office, contacted the medical records 2 department that they could disseminate that information 3 or take care to make sure that they had all of the 4 information they needed to know whether it applied? 5 A. What we are doing with the actions that we've put in 6 place around when a DND comes in and having a compliance 7 group and the response framework and the clear 8 communication and escalation framework means that that 9 will be addressed in terms of everybody who is relevant 10 being completely sighted on that and making sure we have 11 that in place going forward. 12 Q. Thank you. As we discussed on a few occasions already, 13 you subsequently commissioned, I think, an independent 14 report, is that right? 15 A. Yes. 16 Q. And why was that done? 17 A. I was not satisfied with the findings of the internal 18 review. On reading it, I was unable to see what the 19 system issues were. I felt it left -- what would the 20 word be -- inconsistencies and this is such a serious 21 matter that it required to have a further review. 22 Q. Can you -- because it was you who ordered the 23 independent report, is that right? 24 A. Yes. 25 Q. And can you help us with what particular aspects of the Page 132

1 internal report you were dissatisfied with? 2 A. Yeah, so the findings -- there was conflicting 3 statements in it which meant I could not understand 4 fully what was happening. There was something about the 5 scope and us being able to identify what is the learning 6 that we would be able to provide more broadly. 7 Q. Okay, and when did you commission the report, the 8 independent report? 9 A. That was discussed -- so I received -- I received the 10 draft of the internal investigation on 31 October. 11 I arranged a meeting with the director of people and 12 culture who was the person in agreement with me in 13 asking for that to be done, led to the commission, the 14 direct commission, so that's Elaine Watson led the 15 direct commission of that work. I was then arranging to 16 meet with the director of acute services and had 17 a meeting in the diary. They were subsequently -- had 18 started a period of sickness absence. Therefore it was 19 discussed later in November. The actual commission 20 going out was after that. 21 Q. And is it an accountancy firm that did the report? 22 A. It was -- yes. It was an audit firm, yes. 23 Q. Thank you. It's NHST-05239. Can we have a look at some 24 aspects of this, please. Could we go to page 23, 25 please. We're really going to need to zoom into this Page 133	1 about aspects of the clinical governance system relating 2 to Mr Eljamel having not been dealt with at the 3 appropriately senior level; would that be fair? 4 A. As I described earlier, on receipt of the DND I worked 5 on the established processes that were in place which 6 was to discharge through the executive team and to do 7 the wider communication across the organisation. What 8 the recommendations of this independent review has found 9 is that we did not have a named executive senior 10 responsible officer, which we do now have in place, that 11 we did not have a standard process for dealing with this 12 and to make sure, as we covered in our earlier 13 discussion around the targeted approach that was in 14 place, all of that has been covered by the DND 15 compliance framework that we now have in place. 16 Q. Thank you. I assume it was part of the commission you 17 gave that they should look at the internal investigation 18 itself? 19 A. Yes. 20 Q. In relation to the conclusions on that, could we go to 21 page -- paragraph 9.4.2, page 28, please. Again, it 22 says here -- this is to do with the analysis of the 23 internal investigation, its methodology, evidence and 24 conclusions. And one of the observations is: 25 "While we recognise the relevance of the individuals Page 135
1 because it's quite small. This is paragraph 8.5.11. So 2 this is in a section of the very detailed report which 3 is dealing with its various actions which I think it 4 should suggest this is the responsibility of the DND 5 notice which comes a bit earlier but in this particular 6 paragraph which is the last one in the section, it says: 7 "The reliance on assumptions, rather than structured 8 assurance, monitoring or leadership oversight meant that 9 the DND notice was not operationalised effectively, 10 despite its legal significance. This contributed 11 directly to the circumstances in which the theatre 12 logbooks were destroyed." 13 Now, it was that aspect of the lack of leadership 14 oversight that I was keen to explore with you. What did 15 you understand that to mean? 16 A. That goes back to the -- closing the loop, the assurance 17 loop, and making sure that what we have identified to be 18 put in place in terms of the communication was put into 19 operation. 20 Q. Okay, and who are the leaders that ought to have done 21 that? 22 A. That would be through myself and then through the 23 executive team and the directors. 24 Q. Right. I wondered whether that statement was 25 reminiscent of some of the concessions you made earlier Page 134	1 who were interviewed, we consider that the investigation 2 would have been strengthened by including more senior 3 staff whose oversight, decision-making authority and 4 organisational knowledge could have provided further 5 understanding of governance arrangements and 6 contributing factors. Specifically, the internal 7 investigation interviewees were limited to those 8 directly involved in the disposal of the logbooks who 9 were largely clinical staff focussed on delivering 10 patient care, without examining the role of executive 11 and management-level staff who held responsibility for 12 cascading the DND notice and ensuring that all relevant 13 teams understood and implemented it appropriately." 14 Again, that appears to be an observation made by 15 these independent assessors that there was a failure in 16 leadership? 17 A. There's two parts to that. One would be I appointed 18 an executive director to lead the internal investigation 19 into that and it goes back to the concern that I raised 20 earlier regarding not being able within the internal 21 review to find the systemic learning because it did not 22 go wide enough in terms of being able to understand 23 that. 24 Q. Okay, and is it the case that steps are being taken to 25 remedy that going forward? Page 136

1 A. All of this is included within – remedy what, sorry? 2 Apologies. 3 Q. Remedy the precise issue I have just highlighted, that 4 there was a lack of senior involvement and investigation 5 which could have provided further understanding of 6 governance arrangements and contributing factors? 7 A. Yes. So an independent review addressed one that in the 8 media. The moving forward, the DND compliance framework 9 will make sure there's named executive leads and 10 accountabilities are clear. 11 Q. Okay. Could I go to page 31, please, 9.7.2, which 12 I think gives some indication as to your position as 13 regards the internal report. Page 31. It says there -- 14 this is again about the internal investigation: 15 "The Chief Executive [that's you] told us that the 16 internal investigation report lacked critical detail. 17 [I think you told us that already]. They stated that 18 the report did not provide enough information to allow 19 the reader to fully understand the sequence of events or 20 form a complete picture how the failings interconnected. 21 Key elements were missing, making it difficult to 'join 22 the dots' and understand the systemic nature of the 23 issues." 24 That, I think, remains your position today? 25 A. It does. Page 137	1 Q. Why not? 2 A. Because I believe we've been completely transparent in 3 relation to both the purpose of the investigation which 4 was taken, the concerns that these logbooks have been 5 destroyed extremely seriously and making sure that we 6 were openly and fully sharing this. That's why it was 7 put on our public website, that's why there was a press 8 release, that's why we've shared the action plan. 9 What, I guess building on your wider point there 10 around NHS Tayside and the wider learning, I gave 11 reflection to what this meant in terms of wider learning 12 beyond just the logbooks and what that meant in terms of 13 information governance and took a range of actions. One 14 was around the strengthening the leadership and 15 accountability and I realigned executive responsibility 16 for information governance within the organisation. 17 I have appointed a dedicated senior information 18 responsible officer who is an executive director, I have 19 confirmed and strengthened Caldicott guardian 20 arrangements and I've introduced deputy roles to make 21 sure there is cover at all times. I have also made 22 information governance responsibility of the executive 23 team very explicitly through objectives that have been 24 set with each director. 25 In addition to that, I have reviewed what Page 139
1 Q. That's why you commissioned this report to some extent? 2 A. Yes. 3 Q. One of the things that we heard in the evidence of 4 Ms Smith yesterday was that patients were concerned that 5 when serious things happened within NHS Tayside there 6 was an effort to cover them up. Are you aware of that 7 being a concern amongst the patient body? 8 A. Absolutely, concerns about transparency. 9 Q. Yes, and I understand it to be your evidence that the 10 efforts that have been made to look into this important 11 issue have been to try to mitigate in the opposite 12 direction, to try to improve openness and transparency? 13 A. Yes. 14 Q. Yes. The external report is very detailed and thank you 15 for providing the copy and people can look at that 16 later. But it does tend to indicate that there are 17 significant problems, in particular relating to senior 18 leadership, both in relation to the events which led to 19 the destruction of the logbooks but also in connection 20 with decision-making around investigating it internally. 21 Do you think that it would be fair for patients to take 22 the view that this is the sort of material which would 23 bolster an impression that NHS Tayside involves itself 24 in cover-ups? 25 A. No. Page 138	1 organisational capacity there is and prioritised 2 recruitment to a new head of information governance and 3 cybersecurity, additional capacity within the 4 information governance team and I have enhanced 5 governance and assurance. That means that there is 6 explicit reporting to the executive team, the clinical 7 governance committee and the audit and risk committee in 8 relation to information governance, and that includes 9 a dedicated report from the SIRO and the Caldicott 10 guardian. 11 Q. What's the SIRO? 12 A. The senior information responsible officer. It's one of 13 the key roles as part of our responsibilities in 14 relation to information management. 15 Q. Thank you. 16 A. In terms of the wider ownership of information, priority 17 was placed on developing an information asset register 18 which is now fully in place. Made sure that we've got 19 information for asset owners who have named 20 accountability and that will include the visibility both 21 what is held, where it's held and who is responsible for 22 it. And then finally, it is about that improvement and 23 cultural change and the piece of work that 24 I commissioned to do that wider piece of work with 25 an information governance maturity assessment, a review Page 140

1 of all information governance frameworks and policies, 2 the board, under my recommendation, has made information 3 governance a corporate objective for this year meaning 4 there is executive director oversight of this, as well 5 as executive oversight, and we have introduced training 6 awareness and leadership development. All of that is 7 seeking to provide a culture of proactive information 8 share-ship in risk management and seeks to take it 9 beyond the logbook issue, of which we now have the DND 10 compliance framework in place, into ensuring the 11 strengthening of information governance across the 12 organisation. 13 Q. Thank you for that. You read that out obviously? 14 A. I had taken some notes which I spoke to you about 15 beforehand. 16 Q. Yes, they were written by you? 17 A. Yes, 100%. 18 Q. Those efforts that have been put in place are understood 19 and obviously we'll look at the detail of that in due 20 course. None of that will bring any of the logbooks 21 back though, will it? 22 A. No. 23 Q. None of that will assist, I think, in the erosion of 24 trust we've identified amongst the patient group? 25 A. I accept that. Page 141	1 that future orders or requests made by him will be 2 obeyed by NHS Tayside? 3 A. Yes. 4 MR DAWSON: Thank you very much. Those are my questions, 5 sir. That brings that to the end. We now need to have 6 a break to allow core participants to propose questions, 7 but before that I'll ask you a question I ask all 8 witnesses which is: is there anything you'd like to add 9 at this stage? 10 A. What I planned to add at this stage was my sincere 11 apology. I believe I have just said that but I would 12 like that formally noted on record. Also as chief 13 executive officer and as accountable officer, I accept 14 accountability from the organisation and I am absolutely 15 committed to ensuring that we learn and we drive that 16 forward. 17 I hope what I have described here has showed that 18 since these circumstances came to light we have accepted 19 the findings in full, implemented significant 20 improvements and strengthened our governance, our 21 records management and our assurance arrangements. And 22 my commitment is NHS Tayside will continue to learn from 23 these events and be open and transparent and do 24 everything possible to prevent this happening again or 25 failings of this nature. Page 143
1 Q. None of that will help address the deficiencies 2 Professor Wigmore has identified will now exist within 3 his ICR process? 4 A. I agree. 5 Q. And we have lost a considerable body of evidence that 6 would have been extremely important to this Inquiry, 7 have we not? 8 A. I accept that the independent review is absolutely clear 9 that this should not have happened and I want to 10 reiterate my sincere apology to former patients, 11 families, to the Inquiry and to the Independent Case 12 Review, I said earlier. 13 Q. Thank you. Will efforts be made, as part of the ongoing 14 processes, to try to identify in light of the assessment 15 that's been made of the dates we talked about earlier, 16 which patients are actually potentially, or that you 17 accept are affected by this? Because it's not everyone. 18 A. No, that I believe is the reconciliation work that we 19 spoke about earlier. 20 Q. Right, it's part of that? 21 A. Yes, and that will be able to be communicated directly 22 with patients and be able to be shared with the Inquiry 23 and the Independent Case Review. We will be absolutely 24 happy to share that. 25 Q. Thank you. Can the Chair of the Inquiry have any faith Page 142	1 Q. Thank you very much. 2 A. Thank you. 3 MR DAWSON: Sir, probably a short break now. 4 THE CHAIR: Yes. We'll have a short break now, Ms Connor. 5 I remind you not to discuss your evidence in the 6 meantime. 7 (2.13 pm) 8 (A short break) 9 (2.24 pm) 10 THE CHAIR: Have a seat, thank you. 11 MR DAWSON: Thank you, Ms Connor. This is a section in 12 which I ask you some questions that have been proposed 13 by others. Just a few things. 14 We talked earlier about different circumstances in 15 which huddles or oversight groups had been put together 16 to deal both with a response within NHS Tayside to the 17 Inquiry generally but also in response to the 18 compilation of the board's position in relation to the 19 document destruction issue. The question I have been 20 asked to put to you is whether the meetings of these 21 huddles or groups are minuted? 22 A. There is a record taken. It is chaired by the executive 23 medical director, he will be able to give you that 24 precise information. 25 Q. Good, thank you. And you mentioned earlier, when I put Page 144

1 to you the proposition that the logbook destruction 2 response might in some eyes be deemed to be consistent 3 with a cover-up, that one of the things that you had 4 done was to publish the internal report on the website; 5 is that right? 6 A. The independent report, apologies if I said internal, 7 I meant independent. 8 Q. It was the independent report. Was the internal report 9 published? 10 A. No, that was under workforce policies related to -- so 11 no. 12 Q. So that wouldn't ordinarily be published? 13 A. No, that contains confidential information regarding 14 individual members of staff. 15 Q. I understand. When the independent report was 16 published, did that have any restriction applied to it, 17 in terms of names being blanked out or other 18 information? 19 A. A very small redaction with the junior staff, as 20 I explained earlier, but not senior staff. 21 Q. Yes, just to be clear the context in which you and 22 I were discussing that earlier related to the 23 proposition that names should be redacted from the 24 Inquiry for materials. What we're talking about now is 25 your own redaction which you're free to apply to Page 145	1 A. I was aware -- I don't think I was provided -- I don't 2 recall being provided with specific copies. 3 Q. To give an example of one that we heard yesterday from 4 Ms Smith was published at a particularly important 5 moment in the movement towards a public inquiry, the 6 Scottish Government report of outstanding concerns 7 relating to Mr Eljamel which was a Scottish Government 8 report published in 2022. Do you recall being given 9 a copy of that? 10 A. I don't recall specifically, apologies. 11 Q. Okay, do you think you would have been? 12 A. I don't recall being provided with that, I don't recall 13 it. It doesn't mean -- I just don't recall it. 14 Q. So you think you probably weren't, is that what you're 15 saying? 16 A. I think so, but I don't recall. 17 Q. I think you've told me already that the due diligence 18 report was something that you were directed toward? 19 A. I was aware, yes. 20 Q. Thank you. There's another aspect of a report we looked 21 at earlier, I'd like to ask you some more detailed 22 questions about. This is back to the independent 23 review, which is NHST-05239. It's just a particular 24 aspect of this. There are a number of different strands 25 to this report but one particular thing that I have been Page 147
1 documents you are publishing yourself. 2 A. Yes. 3 Q. So it's slightly different but it's actually related to 4 the same topic, there was the same reason for seeking 5 those redactions? 6 A. Apologies if I have caused confusion. I accept the 7 Inquiry's position to decide what's redacted. As 8 NHS Tayside, we were not publishing the names of junior 9 staff. 10 Q. I asked you some questions this morning about what 11 information had been made available to you when you 12 joined NHS Tayside as the chief executive about the 13 Eljamel affair and you told me that you'd been given the 14 due diligence report I think and that you read it, is 15 that right? 16 A. I read it I have read it as part of -- in terms of 17 taking up post, I don't recall a specific full handover 18 but I recall being advised of these things that were in 19 place and then read those. 20 Q. Because obviously, as is set out in many places but 21 amongst others Term of Reference 12 of this Inquiry, 22 there is a significant history of reviews, some 23 internal, some external, into different aspects of the 24 Eljamel affair which predate the due diligence review. 25 Were you given copies of any of those? Page 146	1 asked to follow up with you that I didn't earlier. 2 We're at page 20 of this document and we're in 3 paragraph 8.4.1. So there's an acronym in here which is 4 "PLRT", which is the patient liaison team we were 5 talking about earlier, I think, isn't that right? 6 A. Yes. 7 Q. I think in this passage what's happening is we're 8 getting a summary of the independent inquiry's findings 9 about efforts that had been made quite early on to try 10 to secure documents that might be related to the Eljamel 11 affair within NHS Tayside, is that right? 12 A. Yes. 13 Q. So what it says at paragraph 8.4.1 is: 14 "In November 2024, as part of efforts to gather 15 information relating to Mr Eljamel, the PLRT team 16 contacted 40 individuals across NHS Tayside. Forty key 17 individuals contacted included staff responsible for 18 Neurosurgery, the area that Mr Eljamel worked. In total 19 only nine responses were received of which three refused 20 to complete the template. The remaining thirty-one 21 non-responses indicates a disengagement from staff and 22 a lack of organisational readiness to identify or report 23 records relating to the Inquiry. Interviewees shared 24 that before this point NHS Tayside did not hold 25 an information asset register of information held by Page 148

1 departments across the whole of NHS Tayside and 2 therefore this was an attempt to gather details of 3 information relating to the Public Inquiry." 4 So just to pause there. What that tells us, 5 I think, is that efforts were made in 6 about November 2024 to try to contact key individuals 7 within the organisation to tell them that they should 8 secure Eljamel-related information and documents, yes? 9 A. Yes. 10 Q. And that it says that an information asset register -- 11 sorry, an information asset register of information held 12 by departments across the whole of NHS Tayside was not 13 held at that time. Do you take that to mean that there 14 was not, in November 2024, a central repository of 15 Eljamel-related information? 16 A. The organisation did not have in place a consistent 17 information asset register which is a requirement for us 18 in terms of good records management. What was contained 19 was not comprehensive enough and this report, in terms 20 of the asked-for information, the fact that it was not 21 followed up for the nine responses to make sure that 22 that brought through the assurance is a failing. What 23 we've put in place now in terms of our compliance 24 framework will address that. 25 Q. Okay, but just to be clear, this information asset Page 149	1 that you make, that you don't generally have this. So 2 you don't have an inventory generally of all the 3 documents you hold but also you don't have a specific 4 Eljamel one; was that correct? 5 A. Back to the confusion of language, I think what would 6 have been met by having the log would also fulfil what 7 was required in relation to an information register. 8 I think it's a use of language and part of the learning 9 that came out of the independent review was that we put 10 in place the information asset registers across the 11 organisation. So I think it's a mix of language. 12 Q. Okay. We can maybe ask some of your colleagues as to 13 what information asset register specific to the Eljamel 14 documents may exist because I know others have more 15 responsibility in that area? 16 A. Yes, I think Margaret Dunning, as SIRO at the time, and 17 Dr James Cotton who chaired the huddles and oversight 18 group. 19 Q. Thank you. But another specific part here is that these 20 40 met with 31 non-responses. 21 A. Yes. 22 Q. So this is in connection with effectively an important 23 message being sent that: we need to know what you've got 24 and you need to secure that and 31 of the 40 key; 25 individuals didn't even respond? Page 151
1 register, is that a more general requirement which 2 serves the purpose of a kind of inventory of all the 3 documents you hold or is that something specific to the 4 Eljamel document? 5 A. No, it would be both. We would expect that we would 6 have an information asset register that related to 7 Eljamel. I think it's been different language used in 8 different places around logs and other things. My 9 understanding is that means the same thing. But it is 10 a requirement for us as an organisation more generally 11 to have that in place. 12 Q. And the information asset register, do I have it right 13 that its general purpose is effectively a huge list of 14 everything you hold, is that right; a kind of inventory? 15 A. Yes, it allows to us have that information, yes. 16 Q. So just to take some specifics out of that. One of the 17 actions that was taken as a result -- or in connection 18 with the investigation which led to the due diligence 19 review report was the creation of an Eljamel information 20 log, so we're told in the report. Does this tend to 21 suggest that by this point that information log no 22 longer existed? 23 A. No, I don't think so. That would not be -- that would 24 not be my interpretation of that. 25 Q. It is perhaps more just to do with the general point Page 150	1 A. Unacceptable. 2 Q. Yes. Could I just look at paragraph 8.4.5. This 3 relates specifically to the neurosurgery secretary, who 4 I'm assuming is accountable for what's held and the 5 actions relating to documents held within the 6 neurosurgery department; is that correct? 7 A. I'm not familiar with the detail of that individual's 8 role. 9 Q. Okay, it says: 10 "The Neurosurgery Secretary responded to the PLRT 11 email but refused to complete the template. We 12 understand the secretary worked in the Neurosurgery 13 ward. An initial response from a Neurosurgery Secretary 14 acknowledged that the department held relevant 15 documentation but expressed the view that it was not 16 their responsibility to provide it. PLRT subsequently 17 escalated the request to a more senior member of the 18 Neurosurgery ward team, the Administrative Services 19 Supervisor (Neurology, Neurophysiology & Neurosurgery). 20 Emails confirm the initial response from the 21 Administrative Services Supervisor (Neurology, 22 Neurophysiology & Neurosurgery) confirmed there were no 23 records held. PRLT told them of notes known to be held 24 in Neurosurgery ward from earlier document repository 25 work for the due diligence pre-Public Inquiry on Page 152

1 Mr Eljamel and the response came back from the 2 Administrative Services Supervisor (Neurology, 3 Neurophysiology & Neurosurgery) confirming that 4 approximately 4,000 operation notes were retained. This 5 suggested to us that a proactive search may not have 6 been undertaken, and departmental ownership of the 7 records was not being taken." 8 So in relation specifically to the records held 9 within neurosurgery, it appears that again there were 10 significant issues with getting the relevant people to 11 comply with this important request? 12 A. Yeah, I think it absolutely goes back to the point made 13 earlier around the responsibility that I hold for 14 ensuring that we had the systems, processes and 15 communication in place across the organisation. Again, 16 this has translated into a key finding from the 17 independent review around those 15 recommendations and 18 is contained within the compliance framework. 19 Q. But the main thing we discussed earlier, I think, was 20 trying to put into place -- or you've been trying to put 21 into place systems to try to make sure that the 22 tentacles, if you like, of the DND notice -- 23 notification process reach where they need to reach. 24 But this suggests something different, which is a kind 25 of wilful refusal to comply with it. If you're sent Page 153	1 walkabout and review across all areas. 2 THE CHAIR: It would be interesting to look at all of that 3 in due course but I think what Mr Dawson is perhaps 4 getting at is that whatever systems you put in place 5 there has to be a culture of compliance where that seems 6 to have been absent, on the face of what's in front of 7 me at the moment. Do you agree with that? 8 A. Yeah, I would agree and that's why what I described 9 earlier, in terms of the wider information governance 10 work, focused on culture as well as systems and 11 processes. 12 Q. Because obviously at the end of the day, the Chair will 13 require to provide a view on document management systems 14 within NHS Tayside and may wish to make recommendations 15 and obviously the steps you've taken will be relevant to 16 those. But in trying to assess, as he requires to do 17 under Term of Reference 14, the adequacy of these 18 systems these -- the evidence you've given in this 19 regard and these sorts of features that an independent 20 body has arrived at really show, I think do they not, 21 that the document management system within NHS Tayside, 22 before the changes that you're telling me that you wish 23 to implement, is completely broken? 24 A. It's not wishing to implement. I have implemented those 25 changes that I have described, so they have been put in Page 155
1 a template saying: what documents do you have? And 2 31 out of 40 people don't reply, or if you're sent 3 something within the specific department in which 4 Mr Eljamel worked and your response is it's not your 5 responsibility to comply with this request, this is 6 a different problem, isn't it? 7 A. It is not acceptable and that is where there should have 8 been senior and potentially executive oversight of where 9 this reported to, in terms of how this return was 10 received. 11 Q. It's perhaps in light of that, not surprising that 12 paragraph 8.4.6 goes on to say: 13 "There was no indication that staff undertook 14 broader searches for additional documents or conducted 15 local verification of what records were held. This 16 demonstrates an absence of responsibility at 17 departmental level for understanding or reporting what 18 information existed within their areas." 19 I mean it's hardly surprising that people wouldn't 20 go above and beyond when they're not even prepared to 21 deal with the basic work they're given; isn't that 22 right? 23 A. Yes. The DND framework will address this going forward 24 but it's also partly why I commissioned the forensic 25 review, to make sure there was an executive-led Page 154	1 place. I recognised that there were concerns. I have 2 recognised and accepted that there were failings and 3 have put measures in place. Those measures are overseen 4 by non-executives, through both the audit committee and 5 the board. 6 Q. I think it's characterised your evidence today, 7 Ms Connor, if I may say so, that you're keen to tell me 8 what you're wanting to do to fix things, which is 9 laudable, but I'm asking you questions about what it was 10 that needed to be fixed. What it was that needed to be 11 fixed was a system of document management that was 12 completely broken? 13 A. I accept that there were failings, absolutely accept 14 there has been failings within that and that has been 15 addressed through -- in terms of the -- for the DND 16 element, through the compliance framework and has been 17 addressed through the wider information governance work. 18 MR DAWSON: Thank you very much indeed for your time. 19 A. Thank you. 20 THE CHAIR: Ms Connor, that is now all the questions that 21 you're going to be asked. It's now the end of your 22 evidence and with my thanks for you coming into the 23 hearing suite to give that evidence, I can tell you now 24 that you are free to go. Thank you. 25 A. Thank you. Page 156

1 MR DAWSON: Sir, I think it would be appropriate at this 2 stage -- we do have another witness for today that we're 3 hoping to complete. I think it would be very helpful 4 for everyone if we had another short break to try to get 5 that witness in and try to make sure that everything is 6 running as smoothly as -- 7 THE CHAIR: Right, let's take 15 minutes, everybody, and 8 we'll resume again at 2.55. 9 (2.40 pm) 10 (A short break) 11 (2.52 pm) 12 THE CHAIR: Yes. 13 MR DAWSON: Sir, the next witness is Mark Egan. 14 THE CHAIR: Thank you. 15 MR MARK EGAN (sworn) 16 Questions by COUNSEL TO THE INQUIRY 17 Q. Good afternoon. 18 A. Good afternoon. 19 Q. You are Mark Egan? 20 A. Yes. 21 Q. Mr Egan, when I'm asking you questions and you're 22 replying, if you can try to speak as best you can into 23 the microphones -- I find them a little tricky -- just 24 to make sure everybody can hear who are hooked into 25 various systems. If you could do your best with that it Page 157	1 A. Yes, they are. 2 Q. Thank you. Could I please ask to go to paragraph 1.1. 3 So it should come up on the screen in front of you, 4 Mr Egan. You say there: 5 "I am Mark Egan, currently serving as Chief 6 Executive Officer of the Royal College of Surgeons of 7 Edinburgh ... I was appointed Chief Executive 8 in June 2023 following a period of Interim CEO from 9 December 2022 to June 2023 and have overall 10 responsibility for the college's governance, strategic 11 leadership, and oversight of professional standards." 12 What are your responsibilities as chief executive 13 and if there are any differences in the interim period? 14 A. So I am the overall executive lead for the college so 15 I have a number of directors under me that deal with 16 examinations, education and faculties, membership and 17 communications, resources, which covers a number of 18 back-office functions, digital enablement, and 19 stakeholder -- partnerships and stakeholder engagement. 20 I am group CEO so I also have overall responsibility to 21 for our commercial arm, Surgeons Quarter, although the 22 relationship is a little bit more arm's length compared 23 to my responsibilities for college matters and I'm also 24 a director of Surgeons Quarter board. 25 So in that I work very closely with the trustees, Page 159
1 would be very much appreciated. 2 You are the current chief executive officer of the 3 Royal College of Surgeons of Edinburgh? 4 A. Yes, that's right. 5 Q. And would it be acceptable for me to call it "the 6 college" during the course of my examination? Is that 7 what you would call it? 8 A. Yes. 9 Q. Thank you. And the college received a Rule 8 witness 10 statement request from the Inquiry; is that right? 11 A. That's right. 12 Q. And a statement was written by you in response? 13 A. Yes. 14 Q. And could we have up, please, RCSE-00028. Is that your 15 statement? 16 A. Yes, it is. 17 Q. Could we go to page 59 please and although it's blanked 18 out for restriction purposes, is your signature 19 underneath that? 20 A. Yes, it is. 21 Q. And the statement I think is dated 23 March of this 22 year? 23 A. That's right. 24 Q. And is it the case that the contents of the statement is 25 true as far as you're concerned? Page 158	1 the college council and the college office-bearers who 2 are the clinician volunteers who provide the 3 professional leadership for surgical and dental matters 4 and my job was to help them set the strategy for 5 the college and to ensure that the executive machinery 6 behind the scenes delivers the strategy, year on year. 7 Q. Obviously in this Inquiry we're interested in clinical 8 matters, in particular clinical matters arising in the 9 field of surgery, and I think you've already identified 10 that your responsibility is running the college and the 11 executive side, whereas there are also a number of other 12 people involved who are on the clinical side. Could you 13 tell us a bit more about those individuals? 14 A. Yes, so the college has a president, and five 15 vice-presidents who are the office-bearers, collectively 16 the office-bearers, so they provide the professional 17 leadership of the college. They're also trustees and 18 they obviously are a council of -- we just changed the 19 number, but it's around 25 surgeons and a couple of 20 dental surgeons. And they lead the college's engagement 21 with various clinical matters as they come up. So a lot 22 of policy issues, relationships with other surgical 23 colleges both in the UK and internationally. They would 24 hear reports and guide the debates around matters that 25 come from surgical specialty boards that look more in Page 160

1 depth at the ten surgical specialities. So there might 2 be various issues come up around a whole range of 3 matters of professional standards and surgical practice. 4 There's a similar structuring, to a slightly lesser 5 extent, that works on the dental side as well. 6 Q. Right, okay. Can I look at paragraph 2.3 please. It 7 says there: 8 "In my role as Chief Executive Officer for [the 9 College], I steer the College's strategic direction and 10 operations, encompassing surgical training, 11 examinations, and international fellowship programmes. 12 I oversee standards and regulatory frameworks to ensure 13 patient safety, professional integrity, and public 14 confidence, while implementing models to support global 15 exam delivery." 16 There's a couple of aspects of that I would be keen 17 to explore which are of general significance to our 18 remit. What is the remit of the college with regard to 19 the overall aim of ensuring patient safety? 20 A. So the college has just very recently published a new 21 strategy which puts patient safety right at the heart of 22 things. That updates a previous strategy that had 23 similar aspirations, although differently expressed. 24 There are a variety of ways in which the college 25 supports patient safety. We are a historic standard Page 161	1 could be to do with ergonomics, for example, it could be 2 to do with what are called human factors and the 3 college, the RCS Edinburgh pioneered work what's called 4 non-technical skills for surgeons, so looking at 5 communication, communication in theatre, taking things 6 away purely from the technical quality of a surgeon when 7 undertaking an operation, to their role in managing and 8 leading a team in the theatre and in the ward to manage 9 patients more effectively. 10 So that committee takes a particular interest in 11 those factors and encourages other parts of the college, 12 whether it's the education side of things, for example, 13 would be good example, to develop new courses in that 14 area and to ensure that those courses remain current and 15 in tune with current academic thinking in this area. 16 I should also mention another part of the college's 17 role is around accreditation of facilities and 18 accreditation of courses to offer the opportunity for 19 different institutions, academic institutions for 20 example, that are offering training in different 21 contexts to be assessed in order to attract the college 22 badge essentially, to say that the standards being met 23 are standards which the college feels are at the highest 24 standard required for whatever they're doing. And that 25 accreditation programme is quite significant as well. Page 163
1 setter, often working along the other UK colleges, so 2 with standards of surgical practice curricular for 3 different surgical specialties, ultimately derived from 4 recommendations that come up through the college 5 structure. We set -- again, often with our sister 6 colleges elsewhere in the UK, we set the examination 7 frameworks. We QA those exams and we administer those 8 exams. So those are the primary form of assessments for 9 surgeons at different stages in their careers. 10 We also provide education that supports both those 11 assessments but also provides continuing professional 12 development in other areas, so for example around 13 robotic surgery and new developments in surgery, it 14 would be the colleges that take the lead in proposing 15 the sorts of education that would be needed at different 16 points in time to help surgeons develop the capabilities 17 they need, as the tools of the trade change. So those 18 would be the main factors there. 19 Q. So by trying to contribute to higher quality surgery, 20 that serves the ultimate aim of patient safety? 21 A. Yes. We also have a patient safety committee which 22 focuses on the systems, systems approach to patient 23 safety. So looking behind the individual incidents to 24 try and understand what systems contributed to 25 difficulties. There's a whole variety of things. It Page 162	1 Q. Right, and does CPD fall within the accreditation? 2 A. It can do yes, and the college offers CPD for courses or 3 conferences that other people might want to run and we 4 have a short course accreditation as well as 5 accreditation for portfolios, courses and programmes. 6 Q. So just to separate out these various things, you're 7 saying there's an education and accreditation function, 8 there is a system whereby people can sit examinations in 9 surgery as they progress through their career, as you 10 said. And also there is, it seems, a sort of research 11 function in relation to the creation of standards 12 perhaps which you mentioned? 13 A. We wouldn't use the word "research" because with 14 a research institution, we don't undertake research 15 ourselves. But there will be -- the college, especially 16 through the surgical specialty boards, will debate and 17 make recommendations which ultimately would be for the 18 GMC to adopt, if we're talking in the surgical context, 19 around what the standards should be, particularly around 20 curricular. So what level should people be at different 21 points in their career. It's not set by the colleges, 22 it's ultimately a regulatory matter but it's the 23 colleges, through those specialty committees and 24 through the joint committee on surgical training, which 25 is where the intercollegiate conversation happens on Page 164

1 these things, that will make those recommendations. 2 So I wouldn't -- it's not academic or medical 3 research as such it's a process of establishing best 4 practice through the community of professionals who 5 gather for that purpose. 6 Q. Thank you for making that distinction. I suppose what 7 I'm getting at is really people within the college 8 coming together trying to set appropriate best practice 9 standards that are then issued in various different 10 areas, you told us. That's not research in the 11 technical sense but it's bringing together of knowledge 12 and experience to try to have a result which increases 13 standards, I suppose? 14 A. Correct. 15 Q. And you mentioned -- as far as the standards are 16 concerned, you mentioned I think that they would be in 17 different surgical areas, is that right? 18 A. Yes. So there are ten specialties and if you look at 19 the curricular, that's how things are organised. And 20 there are specialty boards within the college and within 21 the joint committee on surgical training, there are 22 specialty advisory committees which are effectively 23 making the -- setting the standards for the GMC to 24 authorise because it's ultimately the regulator which 25 signs these off. So we tend to think of things in terms Page 165	1 practice in that area but there would be also be standards 2 that would be issued that would -- perhaps in these 3 non-technical skills areas, that would be sort of 4 sitting over all of them, would apply to all of them, is 5 that right? 6 A. Yes, that's right. 7 Q. And in the non-technical skills area which you 8 mentioned, things like communication, ergonomics, which 9 I can understand might apply to all surgical fields, or 10 many, you mentioned I think that the college had been 11 particularly involved in looking at that area and 12 setting standards; is that right? 13 A. Yes, that's right. 14 Q. As far as standards of that type are concerned, is that 15 a relatively recent phenomenon? In terms of when was it 16 that standards started to be set by the college in that 17 regard? 18 A. So I believe so. So there is a committee which is 19 associated with the college for clinicians who are the 20 faculty, for the NOTSS -- we call it the NOTSS course, 21 that's the non-technical skills for surgeons course. 22 That celebrated its 20th anniversary a year or two ago. 23 It was a coming together of academic research from 24 Aberdeen University, with collaboration from Edinburgh 25 University. And the college is probably best seen as Page 167
1 of those specialties. Of course, in some areas there 2 are standards that are required for entry to higher 3 training in surgery, so that would be set around the 4 MRCS exam which is the entry exam, if you like, to 5 a surgical career. So those would be more cross-cutting 6 because that comes at a point before people have chosen 7 formally their specialties. 8 There are also other areas -- non-technical skills, 9 for example, that apply across the board, they're not 10 specialty-specific. But a lot of surgery is quite 11 specialty-specific obviously in terms of the operations 12 that are performed but also in terms of how they're 13 performed. Some involve robotic equipment, laparoscopic 14 equipment, some don't. So it's a fairly -- obviously 15 there are some quite considerable differences in the way 16 in which surgery is performed. 17 Q. And of, I think you called them specialist areas, there 18 were ten I think? 19 A. Ten specialties, yes. 20 Q. And one of those is neurosurgery; is that correct? 21 A. Yes, that's right. 22 Q. And just to understand. So you mentioned there that 23 there would be standards that would be issued that would 24 perhaps be specific to a particular specialty and would 25 involve whatever it is that was deemed to be best Page 166	1 the delivery partner for that. So it's an interesting 2 example where the standards were developed. Actually 3 there was academic research involved in that. The 4 standards were developed in university contexts and then 5 a partnership with the college to further develop it -- 6 obviously because the college could provide active 7 surgical faculty, people who were current surgeons who 8 could be involved in that work, and a delivery partner 9 in terms of being able to actually deliver courses in 10 different contexts. 11 My understanding -- because this pre-dates my 12 involvement in this area, but my understanding is that 13 that was novel at the time around 20, 22 years ago and 14 it broke new ground. And in the discussions that take 15 place there still is that sense that it is new, 16 particularly internationally, but I think -- and this is 17 going slightly beyond my direct experience -- but 18 I believe it's been built into some of the curricular in 19 various contexts. Certainly things like communication 20 skills are built in more than perhaps they were in the 21 past. 22 Q. So there's a cross-pollination then between the 23 different areas in the sense that standards might be 24 fixed by discussions in partnerships with universities 25 but then the outcome of those would be incorporated Page 168

1 within the training and the accreditation side? 2 A. Yes. 3 Q. And you mentioned -- we were talking there about 4 non-technical skills but as far as the technical skills 5 are concerned, do I take it from the relative novelty of 6 the non-technical skills that it was the technical 7 skills that would be the areas in which standards would 8 have been set previously? 9 A. I think historically that's the role the colleges have 10 always played is to set and drive up standards in 11 technical skills. Obviously as changes -- advances in 12 medical practice have occurred quite rapidly over the 13 last couple of centuries, the colleges have played that 14 part in both attracting people who are doing research 15 separately into what those techniques might be but also 16 in setting those standards and ensuring that they're 17 properly assessed. That's the core role of the college 18 over a long period of time. 19 Q. I'm just trying to get an impression for our 20 understanding as to what -- obviously in the field of 21 neurosurgery that we're looking at, what in broad terms 22 without getting into the details, the sort of 23 standards -- the technical standards in a field like 24 neurosurgery might look like. Would they be standards 25 that would set out how you go about carrying out Page 169	1 A. Yes. I mean there's a library which provides access to 2 all manner of resources around all the different 3 specialties. There's a community of fellow 4 practitioners who are attracted to the college because 5 they're interested in surgical training and in the 6 setting of standards. So I'm not familiar with -- if we 7 went back to 1995, I'm not familiar with the internal 8 structures of the college at that point, but if you 9 looked at that time now there is a surgical specialty 10 board on neurosurgery, so that would be certainly where 11 you would go for advice and potentially resources, 12 educational resources, these days its podcasts, that kind of 13 thing, around the latest -- both the latest developments 14 in neurosurgery but also basic skills in neurosurgery. 15 A lot of focus is on helping people come into surgery 16 and develop their skills before they reach their point 17 of being a fellow. 18 Q. But it would be a source of information, if one wanted 19 to know what is the best way to go about doing this 20 aspect of a particular surgery, there would be likely to 21 be either standards, information or access to other 22 people that might be able to help you with that? 23 A. Yes, I should say so, yeah. 24 Q. Yes, thank you. That's very helpful. The other aspect 25 of the paragraph we were looking at that I was Page 171
1 a craniotomy? 2 A. Well, that's probably gone beyond my direct experience. 3 I would imagine. I think where you're looking for 4 standards, you would be looking principally at the 5 curriculum because for the curriculum for the fellowship 6 exam essentially would set the learning and 7 experience -- well, the learning and skills that are 8 required for somebody who is a day one consultant in 9 that field. So without looking it up, it's a fair 10 assumption that those types of procedures, how you 11 perform them, would be absolutely central to the 12 curriculum. But I'm not a surgeon so I wouldn't want to 13 be -- 14 Q. I'm very conscious of that and just trying to ask you 15 about how these things work in broad terms, Mr Egan. 16 We're particularly interested, in this Inquiry, in the 17 period of Mr Eljamel's work in NHS Tayside which is from 18 1995 to towards the end of 2013 and I'm interested to 19 know whether the college would be a place that someone 20 could go to try to find out best practice, certainly in 21 the technical sphere, about how one should be doing 22 things based on the accumulated and cumulative knowledge 23 of the college. Would that be the sort of thing that 24 would be provided to someone who might turn to the 25 college? Page 170	1 interested in -- I'm interested in all of it, but the 2 particular points I wanted to make to you, we talked 3 about public safety, public confidence. Could you 4 tell us what it is that the college does to try to 5 promote public confidence? I'm particularly interested 6 in the extent to which the college has a public-facing 7 role or it promotes public confidence in the same, 8 perhaps indirect way, you say it promotes patient 9 safety? 10 A. Yes, it's primarily the indirect way. It's by the 11 setting of the highest standards, by setting exams which 12 are quality assured to the highest standards which are 13 intended to -- in terms of the fellowship exam, and 14 to ensure somebody who has passed that exam has the knowledge 15 you would expect of a day one consultant and to provide 16 a range of resources, as you mentioned in continuing 17 professional development, which would help the public, 18 all of us, to feel that somebody who is involved in the 19 college, if they are their surgeon, has been trained to 20 the right standard. So it's primarily that. 21 We do have -- we do undertake some advocacy work 22 around all sorts of aspects of healthcare. You know, we 23 contact the government about things. We respond to 24 consultations, we're involved in work around things like 25 the modern hospital programme, looking at the design of Page 172

1 theatres and position of theatres and so on in new-build 2 hospitals. But that is less -- we're not a campaigning 3 organisation in that way and we don't position ourselves 4 in that sense. It is more indirect. 5 Q. So there are various ways in which you try to exercise 6 that function indirectly. You mentioned there being 7 part of government initiatives. In your statement you 8 talk about the advisory role which you have. That 9 presumably means that where there are contemplated 10 government legislation or other initiatives which in 11 some way impinge or touch upon surgery that you would be 12 an obvious place to come to try and get advice and input 13 on that in consultation processes and that sort of 14 thing, or perhaps even more actively than that? 15 A. Yes, absolutely. With consultations, for example, we 16 will often circulate the consultation paper to college 17 council, to the relevant specialty board, to ask 18 members -- I think there's an example in the evidence 19 where you can see that in action, where people have 20 obviously contributed their views and that's reflected 21 back from our staff team into that consultation. And 22 there might be other activity around that as well. But 23 I would say that we are not primarily in the space of 24 wanting to lobby and get ourselves on the front pages of 25 newspapers and that kind of thing. That's a lesser Page 173	1 A. Yes, in this country to be a consultant surgeon you have 2 to have passed the exam but you also have to have 3 completed your training. There's another pathway into 4 the specialist register which is for people who have not 5 followed the training route and so it is -- which is 6 a portfolio assessment where the surgeon would indicate, 7 through a range of different ways, that they've reached 8 the standard that's required of that day one consultant. 9 So you can, as I understand it, it is possible to become 10 a consultant at the moment without having passed the 11 fellowship exam but it would be a very difficult route 12 to take. For the vast majority of people, they are 13 surgeons, they complete their training and they pass the 14 exam. And it's those two things together which lead 15 then to the sign-off by the GMC. 16 Q. So you need to have the exam pass but you need to have 17 other things as well? 18 A. Well, the exam pass is a knowledge test, ultimately. 19 There's a little bit more to it because the exam does 20 feature what are called OSCEs where you visit different 21 stations to deal with different scenarios and so there 22 you might assess someone's ability to communicate to the 23 patient, to grasp a situation quickly. It's not simply 24 a test of book knowledge, if you like. But the point of 25 the sign-off of the training pathways is that's years of Page 175
1 aspect of the role. Important, but not in the same 2 vein. It's not principally where we see our concern to 3 patient safety. 4 Q. Because as I understand the college is not a regulatory 5 body? 6 A. That's right. 7 Q. The surgeons are regulated by the GMC? 8 A. Correct. 9 Q. And although, as you have already mentioned, there can 10 be a degree of overlap I suppose between the two 11 functions, there is a clarity that they're the regulator 12 and you're not, I think? 13 A. Yes. I wouldn't say there's an overlap, there's 14 a clarity. At the end of the day it's the GMC which 15 decides whether or not you can practice, it's the GMC 16 which is able to suspend you from practice, it's the GMC 17 which can put conditions on your practice. 18 The college is there to set standards, to set 19 an exam. We will say whether somebody has passed that 20 exam or not, but that is not a guarantee that you would 21 then get on to the specialist register as a consultant. 22 And our role after that really is -- we do not have 23 a role after that, in a sense, that once the exam has 24 taken place, it's the GMC which is the regulator. 25 Q. When you say it's not a guarantee, is it a prerequisite? Page 174	1 experience. So a surgeon will have had to have got 2 a certain number of operations under their belt which 3 will have been recorded as part of that to be signed off 4 through that training process. 5 So it's a combination of the two. The knowledge 6 that's tested through the exam and then the training 7 pathway. As I say, there's now a portfolio pathway 8 which is a separate process, but effectively it looks at 9 the same sorts of things. You have to provide evidence 10 that you've got the training requirements, that you've got 11 the experience required and you've reached the right 12 level of knowledge. 13 Q. I see. Just to return momentarily to the public 14 confidence aspect, there's one aspect of the statement 15 that comes quite late on in the statement I was 16 interested just to explore with you. I understand that 17 is it the case that -- taking the various passages 18 together, that the college is not a complaints body if 19 something has gone wrong with a surgeon that's a member 20 or a fellow, is that right? 21 A. Yes, not in respect of if something's gone wrong in 22 their practice in a hospital or somewhere out there. We 23 would -- if we were in receipt of such a complaint, we 24 would have to refer it either back to the Trust's 25 complaints procedure or to the GMC as the regulator as Page 176

1 the college doesn't have a role in dealing with those 2 individual complaints that come through. We don't get 3 very many but that wouldn't be our practice. 4 Q. What I'm envisaging is a situation which presumably 5 doesn't happen -- or not very often -- where a patient 6 wouldn't ordinarily be able to approach you and say: 7 I have problem with my surgeon, can you do something 8 about that? And if they did, what you would do would be 9 to send them somewhere else; is that right? 10 A. Yes, that's right. 11 Q. I'm trying to understand -- I'm not criticising, I'm 12 just trying to understand the function? 13 A. Yes, that's right. 14 Q. Do you get people approaching you like that? 15 A. I can't remember any in my time. We may have had, in 16 the team, the occasional approach but it's not something 17 that's come to me. 18 Q. I was thinking it's quite a daunting building to walk up 19 and knock on the door? 20 A. Well, it's all email now. But no, I have not dealt with 21 any personally. I can't recall it being something we 22 talked about. 23 Q. In a sort of straight sense, I suppose, that's not 24 a part of your function? 25 A. That's right. Page 177	1 future as regards the role of the college. I think 2 there that you contemplate there might be room for 3 discussion or a debate about whether the college could 4 play a more proactive role in that sort of area. Could 5 I have your reflections or thoughts on that? 6 A. So this has been a very live discussion over the last 7 couple of years and as you'll have seen from the 8 material we've provided we've thought a lot about our 9 disciplinary process which probably I think it would be 10 fair to say was not right for the current era, the one 11 that we have at the moment and which we're in the 12 process of reforming. That's where the concept of "in 13 good standing" came up and you're absolutely right, when 14 you got down to it, it reflected whether you had paid 15 your subs or not. And where we've looked to change that 16 is to add in another element which allows us to take 17 more effective action against people who have been 18 suspended or raised by their regulator. 19 I think there is still difficult situations that 20 arise where there are -- somebody is in trouble with 21 their regulator, shall we say, where there may be 22 an investigation going on, there may be conditions put 23 in place. From the outside, which we are, it is very 24 hard to understand what's going on. It's hard to 25 understand how serious those issues might be and where Page 179
1 Q. And although you might well helpfully signpost people to 2 other places whose function does cover those areas, 3 that's not a part of your function? 4 A. Exactly. Exactly right. 5 Q. Okay, one of the aspects of the statement that I was 6 interested in exploring with you is a concept that one 7 sees in the literature around this area quite a lot 8 actually and it features in your statement as well which 9 is the concept of a surgeon being "in good standing". 10 And I think if I could summarise what I understand this 11 to mean from your instalment is that there has perhaps 12 been an evolution as to what this means and that at one 13 stage it meant effectively that the individual had paid 14 their subs to the college, is that right? 15 A. Yes, that's right. 16 Q. And that at some later stage the bar was heightened, 17 albeit only slightly, that it also meant that -- you 18 were required to have done that but also to have -- to 19 not have any outstanding disciplinary complaints against 20 you by other bodies, is that right? 21 A. Yes, not to be -- not to have those outstanding matters 22 relating to your regulator, yes. 23 Q. I took it -- there's a useful section at the end of your 24 statement where you tell us about some things that might 25 improve or there might be changes contemplated in the Page 178	1 they've derived from and whether they should rightly 2 affect somebody's standing as a surgeon or not. You can 3 have conditions placed upon you by the GMC because of 4 mistakes that have occurred which you have owned up to 5 as a surgeon and where effectively the conditions are 6 for an extra element of training to take place, perhaps 7 for certain procedures to be supervised by somebody else 8 before -- almost like a retraining process, before you 9 get to a point where you can sign somebody back off with 10 that particular procedure. 11 That's very different from some of the other 12 situations which might lead to regulatory action. And 13 I think the view from within the college is always that 14 mistakes can happen. It's candour and probity which are 15 absolutely key. And the biggest problems, from our 16 clinicians' point of view, and I'm sure this is 17 reflective of the surgical leadership across the UK, is 18 it's issues around probity, issues around lack of 19 candour which are most problematic and where the 20 colleges would feel, I think -- certainly, this college 21 would feel it would want to take firm action. But it's 22 sometimes hard -- well, at the moment in the system as 23 it is it can be hard to identify those until such point 24 as there's been a thorough examination and then 25 a decision has been reached but that can take Page 180

1 a considerable period of time. 2 Q. Okay, that's very helpful. 3 A. During which time, of course that person would remain as 4 a member potentially, if they've continued paying their 5 money. 6 Q. So just to understand the context, as far as any 7 potential sanction that the college might be able to 8 impose do I understand it to be that the sanction would 9 involve removal of the gifts that had been bestowed upon 10 that individual by the college? So you can have 11 a fellowship removed, you can have a membership removed, 12 but you can't be struck off the GMC register by the 13 college, that sort of thing? 14 A. That's exactly it. So -- that's exactly it, yes. 15 Q. So insofar as the college were looking at matters of 16 candour or probity, as you said, which is something that 17 interests them, that would be in the limited context of 18 deciding whether that person was fit to continue to hold 19 the title of fellow or member of the college? 20 A. Yes, there are other -- obviously there are other 21 aspects of college membership where people can get 22 involved as examiners, for example, which is germane to 23 this Inquiry or involved in various standard-setting 24 activity where the college might take a view in certain 25 circumstances that somebody should be removed from that Page 181	1 membership exam? 2 A. So the membership exam is your entry, your gateway to 3 higher surgical training, is when you choose your 4 specialty. And the fellowship is when -- is your 5 gateway to independent practice as a consultant. So 6 it's a pathway that people take. So, some people do 7 stop at the membership for various reasons but 8 effectively it's -- you think of it as a pathway to that 9 point where you have independent practice as 10 a consultant. 11 Q. Right, so to touch on fellowship then, it is, is it -- 12 you mention that you would in order to be a surgeon 13 you'd have to have the membership and various other 14 things you would need to satisfy along with the 15 technical skills as well as passing the exam. As far as 16 fellowship is concerned, how does that work? You 17 mentioned what it is a gateway to, but to what extent is 18 that something which automatically entitles you to 19 something else or is that part of a suite of different 20 qualities someone is to demonstrate? 21 A. It's what I said before that to become a consultant 22 which is to be appointed to the specialist register by 23 the GMC, you need to have -- the standard way is to have 24 what's called a CCT which is sign-off essentially -- 25 it's a certificate of the completion of training. So Page 183
1 but it would need not affect their overall membership 2 and fellowship. I think if we look at the fellowship it 3 is, I think, a signal to the public that this person is 4 of a certain status and if you are -- if your surgeon 5 has that certificate on the wall, that should give you 6 some confidence about their calibre and that's, I think, 7 where we feel most -- you mentioned about earlier around 8 public confidence, I mean that's where we are most 9 troubled by these sorts of cases because people should 10 expect that and sometimes it may not go -- it may go 11 wrong. 12 Q. Yes. So you're indicating there that there are a wider 13 variety of sanctions because there are a wider variety 14 of gifts that can be taken away, if you like? 15 A. Yes -- yes, I'm not sure I'd use the word "gifts" but 16 there's roles that people take on which may not be 17 appropriate in certain circumstances if there are 18 investigations going on by the regulator. 19 Q. I mean in the sense of it being in your gift rather than 20 a Christmas present. 21 A. Exactly, yes. 22 Q. So as far as those systems are concerned, you've 23 mentioned a fellowship. So membership is basically part 24 of the suite of different things you need to have in 25 order to be a surgeon, is that right? Passing the Page 182	1 you've completed a regulated training course which 2 itself has been signed off by the GMC, and you have 3 passed the fellowship exam from one of the -- the 4 intercollegiate fellowship exam, overseen by the joint 5 committee and intercollegiate examinations. So you need 6 those two things. 7 The membership, you simply take the exam and you've 8 got the membership route. And it's commonly -- it's 9 an international exam. It's principally used in the UK 10 to give people entry to the higher surgical training 11 where they choose a specialty to specialise in and then 12 they work towards that fellowship exam. 13 Q. And you mentioned examiners a moment ago. What's the 14 important role played by them? 15 A. So examiners oversee the exams. So the exams are -- 16 there is question-writing activity to create the exams 17 and then there's the delivery of the exams in various 18 areas. So the exams normally fall into two parts, 19 a written -- it's not exactly -- well, it's a form of 20 multiple choice exam, where people are given 21 different -- it's tougher than what you might imagine 22 for a multiple choice exam because many of the answers 23 are plausible and you have choose the most likely or the 24 best outcome from a range of plausible scenarios. And 25 then you have -- I mentioned before what we call the Page 184

1 OSCE exams where you go around a number of stations and 2 you're confronted with a number of scenarios and you're 3 assessed on your diagnostic skills, your communication 4 skills, your ability to deal and manage a problem 5 quickly. 6 The examiners' role principally is to write 7 questions and also to be the people who run those OSCE 8 exams. So somebody has to be -- somebody will quiz the 9 candidate during that, about what they're going to do 10 and score them. And we also have an assessor process to 11 assess the quality of the examiners. 12 THE CHAIR: Does that involve role-play or does it involve 13 scenarios being put to a candidate? 14 15 A. So it involves scenarios. There is a proposal at the 16 moment -- actors have been used and there's a proposal 17 to bring them in, in some specialties. They lend 18 themselves to some specialties and not others, but it's 19 principally -- but it's rare to use actors these days. 20 MR DAWSON: Another aspect of the function of the college 21 that you helped us with was something that had arisen in 22 a different context and so I'll try to deal with the 23 context first and then the specific thing. There are 24 other Royal Colleges in the United Kingdom, is that 25 right? Page 185	1 between different surgeons, I understand. And so that's 2 what you ended up with in the 16th century, 17th 3 century. But I'm not an expert on the history of all of 4 them, I'm afraid. 5 Q. Historic but with current resonance, perhaps? 6 A. Absolutely. 7 Q. So, as far as the functions of the different colleges 8 are concerned, do I understand from your earlier 9 evidence that in some way there is -- you get together 10 in some way in order to try to make it clear what you're 11 all doing? How does that work, there may be a system 12 through which that operates? 13 A. So we compete for membership but we also collaborate 14 across a wide range of fields in the interests of -- 15 really in the interests of patient safety. So I think 16 the main thing to mention is what's called the joint 17 surgical colleges meeting which has been going for 30, 18 35 years, something like that, which brings together the 19 four colleges and meets quarterly. The presidents, 20 vice-presidents, chief execs and various other committee 21 leads. It oversees a number of committees, so the joint 22 committee on intercollegiate examinations runs the 23 fellowship exam. There's something called ICBSE which 24 runs the membership exam which is administered from RCS 25 England, joint committee of surgical training which is Page 187
1 A. Yes, there are four in total. 2 Q. What are the others? 3 A. So there's ourselves, the Royal College of Surgeons of 4 England, there's the Royal College of Surgeons 5 Physicians and Surgeons of Glasgow and then the Royal 6 College of Surgeons in Ireland, so not in the United 7 Kingdom, but part of our British Isles system. 8 Q. I see and there are, no doubt, some ancient, historical 9 reasons as to why these different organisations have 10 come into being that way. It seems slightly lopsided 11 that there are two in Scotland, but is there 12 an explanation for that of which you're aware? 13 A. Well, you probably wouldn't design the system as it is 14 now if you were starting from scratch, that's fair to 15 say. It's historic reasons, so the Edinburgh College 16 started as an incorporation of surgeons and barbers in 17 1505, it's like a Guild setup, essentially. And then 18 with the evolution of the medical practice particularly 19 centred around Edinburgh, we gradually took on 20 a leadership role regionally, nationally and 21 internationally. 22 The English college followed after that, but I'm not 23 an expert on why it was felt it needed to set up 24 a college there. The Glasgow college I think is older 25 than the English one and was the result of a falling out Page 186	1 also administered from RCS England which is in charge of 2 effectively the curriculum and the training pathway. So 3 all matters to do with quality around all of those 4 things ultimately come up through that structure and are 5 decided at the joint -- at the JCSM. 6 Q. So the function of that is to try to co-ordinate the 7 activities of the different colleges but to make sure 8 that the standards in each are similar or equally good? 9 A. It's more than that because things like all -- well, the 10 joint committee on intercollegiate exams, that's the 11 fellowship exam and the JCST, the curriculum and pathway 12 organisation, they are entirely joint. So there is no 13 separate fellowship exam around the different colleges, 14 there is no separate curriculum development going around 15 the different colleges. So those are examples where 16 there has been -- it's more than simply co-ordination, 17 it's collaboration to the exclusion of independent 18 college entities. In other areas, there is more 19 collaborative activity which tries to bring together 20 college functions but in those crucial areas it's more 21 than that. 22 Q. What about in the issuing of standards that you talked 23 about earlier, do they tend to be joint or are those 24 issued by different colleges in certain areas? 25 A. So I think through the curriculum, the curriculum is Page 188

1 dealt with as an intercollegiate matter. Standards and 2 other areas, it's not necessarily co-ordinated, 3 different colleges will focus on different areas and put 4 out different standards depending on what their fellows 5 are interested in at the time or what they think are 6 most significant. 7 Q. Yes, dependent on their experience or their interest, 8 what they're talking about, to generate the sorts of 9 standards you talked about earlier? 10 A. Yes. 11 Q. The particular aspect of this that we're interested in 12 is to do with the mechanism which we are aware of, 13 having existed in our sphere of an invited review, 14 whereby it was possible, certainly we know in 2013, for 15 NHS Tayside to approach the Royal College of Surgeons of 16 England to undertake what they call an invited review 17 about concerns that had been raised about his practice. 18 Is that something which, at that time, they could 19 approached the Royal College of Surgeons Edinburgh to 20 do? 21 A. Probably not because my understanding is that we, RCS 22 Edinburgh, only started to develop the invited review 23 concept in 2013 and before that time we didn't do them. 24 There was something RCS England had started 20, 30 years 25 ago and I think people in our college had looked at that Page 189	1 you were talking about standards and the sorts of thing 2 that the college would be interested in you mentioned 3 candour and probity. Candour is obviously an area this 4 Inquiry is particularly interested in and hence your 5 evidence about the more recent innovations and 6 initiatives in that area of the college are of interest. 7 But what did you mean by "probity"? 8 A. I think probity is truthfulness in terms of not 9 misrepresenting yourself, not saying, for example in 10 this field claiming you can perform operations that are 11 perhaps outside your scope of practice, claiming you can 12 do things that you can't. That would be an example. 13 I think there's -- yeah, that would be the main thing. 14 I would think about candour is obviously more about what 15 you reveal and what you say and being truthful and 16 there's obviously an overlap there but I think there's 17 an element of probity in terms of being honest to 18 yourself and a degree of integrity there in terms of 19 what you can and can't do, maybe an element of 20 self-insight as well. 21 Q. Thank you, that's helpful. So those would be the sorts 22 of areas that would be most of interest to the college 23 if it were to be exercising its -- if I could call it, 24 its limited disciplinary function, am I getting that 25 correct? Page 191
1 and thought that's an area we should get into and some 2 work began around 2013, as I understand it, to pilot 3 invited reviews but we wouldn't -- in 2013, I think 4 I'm right in saying we wouldn't have ever done one 5 before, so it would've been -- it's unsurprising that 6 NHS Tayside would go to RCS England for that because 7 they had an established service. They could have 8 approached us and asked for it to be done, but we 9 wouldn't have had the protocols and the methodology 10 which clearly had been developed through RCS England. 11 Q. But you now have such a mechanism? 12 A. Yes, so we've done, I believe, five over the last 13 few years and we've got to a point of developing a suite 14 of protocols, methodology, which are just about to be 15 signed off by our council. So if an organisation came 16 to us today we would agree and go ahead because we have 17 some experience, we have some trained people. We have 18 some protocols on though they haven't been formally 19 signed off. That wouldn't have been the case in 2013. 20 Q. When you say "organisations", what organisations or 21 other groups or individuals would be able to seek the 22 instigation of an invited review? 23 A. NHS Trusts and health boards. 24 Q. Okay, you mentioned earlier in your evidence just 25 a particular thing I wanted to pick up on which was when Page 190	1 A. I think we get a range of cases. Some are probity cases 2 in terms of people not -- surgeons not being truthful 3 about certain situations. Some are straightforward, 4 they've been erased by the GMC for all sorts of things, 5 some are to do with sexual harassment, behaviour in the 6 workplace, that's also not unusual, sadly. 7 Q. The reason I'm interested in that in particular is that, 8 as I understand it in the statement in the sections 9 where you talk about the college's involvement with 10 Mr Eljamel, I think the position is that you say that 11 the college received no reports of any adverse events 12 concerning Mr Eljamel. Is that right? 13 A. I believe so, yes. 14 Q. Obviously we're working here, Mr Egan, on the basis of 15 you having conducted a search amongst the archives, if 16 you like, to try to answer our questions; is that right? 17 A. A very extensive search, yes. 18 Q. Well, we appreciate that. But obviously you're trying 19 to tell me what that research has revealed, rather than 20 being someone who was there at the time obviously? 21 A. Exactly, yeah. 22 Q. And I was interested to know, it seemed -- we understood 23 from the statement that, in fact, information about 24 issues with Mr Eljamel's practice had perhaps reached 25 you through the media; is that correct? Page 192

1 A. As I understand it, that was the first point in time at 2 which any issues around Mr Eljamel were known within the 3 college. There was a media story I think in The Herald, 4 I think it's in the pack. That, as I understand it, was 5 the first time and led to some internal correspondence 6 about him. 7 Q. Do I take it therefore that, that being the first 8 intimation there hadn't been any prior intimation by 9 NHS Tayside to the college as far as you could 10 ascertain? 11 A. As far as we know, no. And from my experience as chief 12 exec, I would be surprised to receive something from 13 a health board or a Trust along those lines, I don't 14 recall that occurring. 15 Q. Why would you be surprised by that? 16 A. Because it hasn't happened and issues arise all the time 17 and also I suppose because there is an employee/employer 18 relationship which I imagine the employer would not 19 necessarily think automatically to inform a college, 20 they wouldn't necessarily know which college one of 21 their clinicians was associated with. So I think what 22 I'm indicating is it didn't surprise me to see that 23 NHS Tayside appears not to have informed the college. 24 Q. You hadn't received any prior intimation from any of the 25 other Royal Colleges either I don't think? Page 193	1 Q. Okay, thank you. So he was a member of the college? 2 A. He was a fellow, yes. 3 Q. And he was a fellow of the college? 4 A. Yes, he was a fellow of the college. 5 Q. And he was an examiner in the college as well? 6 A. So, he was a JCIE examiner, so for the intercollegiate 7 body and then around the end of that period he had 8 applied to become an MRCS examiner for the membership 9 exam and he had that status around about until the time 10 he left. 11 Q. And I think he had applied for other positions as well, 12 is that right? 13 A. He appears to have applied for council, he appears to 14 have applied to become a regional surgical ambassador, 15 or advisor I think it would have been at the time. 16 Q. The council is the sort of governing body, is that 17 right? 18 A. Yes, at the time it would have been the trustees of the 19 organisation as well as the professional lead body. 20 Q. So do I take it that -- is the council -- who makes up 21 the council, is it various surgeons or is it a mixture? 22 A. Yes, essentially. 23 Q. So it's presumably very eminent surgeons? 24 A. Yes. 25 Q. And the president will be a particularly eminent surgeon Page 195
1 A. No. As far as I'm aware, no. 2 Q. In particular the Royal College of Surgeons of England? 3 A. Indeed. 4 Q. Nor the GMC? 5 A. Well, as far as I can see from the press cutting -- 6 well, certainly we found no evidence that the GMC 7 contacted us before that press reporting and the reason 8 that press report -- that individual was subject to 9 conditions but wasn't suspended or erased and it's the 10 suspension or erasure of surgeons which we would tend to 11 find out from the GMC, not other matters. 12 Q. And before -- well, I suppose it's possible that 13 conditions correlate to matters of candour or probity 14 that are of general interest to you? 15 A. Or not, yes, exactly. It's what I alluded to earlier, 16 there are a range of reasons why conditions might be put 17 in place. 18 Q. Absolutely, but you also weren't told before that time 19 about Mr Eljamel himself, as I understand it? 20 A. As I understand it, no. From what I can see, the only 21 correspondence around that time was his decision to 22 retire from practice and therefore give up his 23 membership at the college, but from what I've seen in 24 the information that's before you, it was presented in 25 those very limited terms with no explanation. Page 194	1 usually, I imagine? 2 A. Especially when they become president, yes. 3 Q. And how do applications to the council work, the 4 elections, or how are you accepted as a council member? 5 A. So elections happen every year amongst the fellowship 6 and membership, the number of vacancies varies from year 7 to year. People put themselves forward and there's 8 a vote. These days it's administered by independent 9 election service and there is a vote and the result is 10 announced. We never -- I never see the actual figures, 11 but we see who has been elected to the council and by 12 implication, we know who wasn't elected to the council. 13 Q. Yes, and would -- if there were any disciplinary 14 proceedings, if I could put in a limited sense, would it 15 be the council that would be responsible for conducting 16 those? So effectively a peer-on-peer system, if you 17 like, is that right? 18 A. In respect of the college fellowship and membership, 19 yes. Obviously not in respect of action the GMC takes. 20 Q. No. 21 A. But there is a process overseen by the council and 22 ultimately council is the decision-maker as to who is 23 a fellow or a member and who isn't. 24 Q. So that could mean admission to those positions but also 25 could mean those brought to an end for some reason? Page 196

1 A. Yes, exactly. 2 Q. I think, just for clarity, is it the college laws that 3 there's a kind of guidebook -- the rules, effectively, 4 is it? 5 A. So the laws which are agreed by a council but signed off 6 by the Privy Council are the overall legal framework and 7 beneath that sits a set of regulations which council 8 itself can amend from time to time, so there's a balance 9 between the two. 10 Q. Okay, thank you. Could I ask just to have the statement 11 put up, please, that you helpfully provided, you have 12 a lot of information about different stages of 13 Mr Eljamel's involvement with the college, but if we 14 look at page 43, please, at paragraph 18.1. This is 15 helpfully summarised in the chronology that you have 16 provided and there are some aspects of this that I would 17 be interested to ask you some more questions about 18 arising from your research. In particular, in 1986, it 19 states that Mr Eljamel was awarded a fellowship of the 20 Royal College of Surgeons in Ireland and that the 21 qualification later enabled his application for 22 fellowship within your college without examination. Is 23 that correct? 24 A. Yes. 25 Q. How did it come to be that fellowship which you've Page 197	1 exam in 1992 could have joined any of the four colleges. 2 It was an identical qualification at that point. 3 So that another factor, I think, in understanding 4 why he would have taken that sister college route. It's 5 just that when -- for whatever reason when he took these 6 exams, he took them with the Irish college rather than 7 the Edinburgh college. 8 Q. Right, but what was the exam you say he took in 1992? 9 A. So in 1986, the colleges would have all had their 10 individual different fellowship exams, not necessarily 11 at the same standard or covering the same things. 12 An intercollegiate systems was set up in the late 80s, 13 overseen by the joint committee on intercollegiate 14 examinations which established a common fellowship exam 15 in each specialty. And from his CV he, in 1992, took 16 that intercollegiate compassion in neurosurgery. So 17 that would have -- a new candidate for the fellowship 18 coming in in 1992 taking that exam and joining the 19 Edinburgh college would have taken the same exam. So if 20 they passed that exam it would have been identical, but 21 they would have elected to join the Edinburgh college, 22 for whatever reason he joined the Irish college. 23 But the point I'm making is at that point when he 24 took that intercollegiate exam in 1992 it was a fully 25 intercollegiate exam. So the sister college Page 199
1 described was bestowed upon Mr Eljamel without 2 examination? 3 A. So historically the main route to fellowship of the 4 college is to take the college's fellowship exam, but 5 obviously at some point in the quite distant past, it 6 was recognised that there were surgeons out there who 7 hadn't taken the college's exam but had achieved 8 equivalent status in terms of their knowledge and 9 experience and a route was created to enable them to 10 apply for and gain entry to the college. That's 11 developed over time and there's a number of routes but 12 essentially the one we're concerned about here is called 13 a sister college route. So that is where fellowship of 14 one of the other three British Isles colleges would 15 enable somebody to enter the Edinburgh college without 16 taking the Edinburgh exam because they've already taken 17 a fellowship exam which has been held to be of 18 equivalent status. 19 Looking at Mr Eljamel's CV what I noticed about it 20 as well was that he took -- he was awarded the 21 fellowship of the Irish college in 1986 which was 22 shortly before the joint intercollegiate fellowship 23 arrangements came into play and he then took -- seems to 24 have taken, from his CV, the intercollegiate examination 25 in neurosurgery in 1992. So a candidate taking that Page 198	1 application -- my feeling reading the paperwork is he 2 was working in Scotland, wanted to get involved with 3 a college and the Edinburgh college was a more obvious 4 one to get involved in than the Irish college and so he 5 sought a route in through that sister college rule. 6 Q. So, is what you're trying to illustrate that the time 7 when he was given the fellowship, I think 8 in August 2002, he wasn't -- he didn't just have as part 9 of his background the fact that he was already a fellow 10 of the Irish college since 1986 but he had also passed 11 the joint intercollegiate exam which, in 1992, would 12 have entitled him to get into the Edinburgh college 13 anyway? 14 A. Or the English college or the Glasgow college. That's 15 my reading of his CV when I looked at it. 16 Q. So that is an important factor of the analysis but 17 presumably when someone is given a fellowship it's not 18 just a question of looking at whether they've passed 19 exams or their membership somewhere else, is there some 20 other aspect of the entrance system which would perhaps 21 consider their practice, their probity, their candour 22 and this sort of thing? 23 A. So the position then evidenced in this -- in these 24 papers is he would have required someone to nominate him 25 and a certain number of signatures from fellows of the Page 200

1 college and that was common -- it still is common 2 practice for people who have -- who are seeking to join 3 the fellowship without having taken the Edinburgh 4 college's -- taken the intercollegiate examination and 5 immediately connected to the Edinburgh college. So that 6 is, I think, intended as an extra element in the 7 application process to indicate that somebody is a good 8 fit for the Edinburgh fellowship. 9 Q. Understood, thank you. I think you give us details in 10 the statement of the numerous people, I think from the 11 Tayside area, who did that, who put Mr Eljamel's name 12 forward? 13 A. I believe so. 14 Q. So just back to the statement. It was actually on 15 28 February 2003 that Mr Eljamel was formally elected as 16 a fellow of the college. And it says that 17 between May 2003 and February 2013 Mr Eljamel served as 18 an examiner for the membership and it also says, for 19 certain examinations, is that -- can you explain which 20 examinations it was for? 21 A. So, if you don't mind, if I could just have a look at 22 the rest of this section? 23 Q. Of course. 24 A. Yes, so I'm slightly thrown by the way we formatted it, 25 May 2003 to February 2013. So, it would seem from the Page 201	1 you like, in a number of different areas and whether 2 neurosurgeons can operate in the area where 3 ophthalmological procedures are more common and perhaps 4 because he had that in his CV that that might have 5 qualified him, or could it be a mistake, for example? 6 A. No. I don't think it was a mistake. I think those are 7 questions that you might need to look elsewhere to 8 answer because I am not -- you're right to identify that 9 as unusual. I don't think it's specific to him. And 10 it's not something we would do now. But what the 11 rationale was for it at that point in time, I wouldn't 12 know. 13 Q. And that carried on over the period that's mentioned 14 there between May 2003 and February 2013? 15 A. So it would appear. 16 Q. Yes, and there's an end date recorded in 2014 but 17 there's no record of why that came to an end at that 18 time? 19 A. Examiner terms are normally ten years so it's not 20 necessarily the case you would read something into that. 21 Q. It's just because by 2014 he had been suspended. 22 A. Indeed. 23 Q. Would it automatically be the case that -- I suppose, if 24 you found out he was suspended, that that would come to 25 an end? Page 203
1 records that he started off as ophthalmology examiner in 2 both the membership exam and the fellowship exam. So -- 3 yes, so that was his first experience of being 4 an examiner. At the same time, I think it was slightly 5 later, he was also an intercollegiate specialty examiner 6 in neurosurgery, but ophthalmology, yes, was perhaps his 7 first one. 8 Q. Is that ordinary or is that normal that someone would be 9 an examiner in a different specialty than their own? 10 A. Well, that's what I asked when I read this. It would be 11 odd now, certainly. Ophthalmology is a little bit of 12 a special case because of changes in governance around 13 ophthalmology. Today, all we run at the moment in 14 ophthalmology is a fellowship which is offered 15 internationally and the examiners must be from that 16 specialty. It would appear that, at this point in time, 17 that wasn't strictly adhered to and I can see, from some 18 of the material that's in the pack, that because he 19 practised in an area that was related to ophthalmology 20 it offered a route to being an examiner. But it is -- 21 so my understanding from what I have learnt is it wasn't 22 unusual in his case but it's certainly not something we 23 would do now. 24 Q. I was wondering whether it's possible that -- our 25 understanding is that he had quite a broad practice, if Page 202	1 A. If we found out. Certainly today, if we found out 2 then -- if we found out somebody was -- if I had read 3 the article that we've seen in the pack around Eljamel 4 today and -- I would immediately want to know who this 5 person was and what role they had in the college and if 6 they were an examiner, then we would put the wheels in 7 motion immediately to take them off active membership of 8 any kind of examiner panel, pending a final outcome. 9 But of course you've alluded to the fact that the 10 college may not have known. Practice may have been 11 different at that point. 12 Q. Right, because if you go over the page, there's the 13 examiner for the JCIE intercollegiate specialty, as 14 you've said, but that does appear to run over a ten-year 15 period which would be more normal? 16 A. That's right. 17 Q. And you've mentioned there, something we've come across 18 before, that in 2007 and 2009 he unsuccessfully applied 19 for election to the council and to join the specialty 20 advisory board in neurosurgery. Is there any record 21 that tells us why he was unsuccessful? 22 A. No, so council is a voting process. So like any voting 23 process it's not usually possible to tell why an outcome 24 has arisen. With this specialty advisory board, it 25 would normally be the case that people would apply to Page 204

1 join and they would be asked -- usual practice now, 2 which I have no reason to think would have been 3 significantly different then, would be to supply a CV, 4 a letter to explain why you want the role, a couple of 5 references, and then there would be an interview process 6 of some sort which would be conducted, in most cases, by 7 senior council members, office bearers. So it may be 8 there were a number of applicants and they were better 9 people. There's no record that I can point to to give 10 any further explanation for that. 11 Q. Understood. The specialty advisory board in 12 neurosurgery, to try to fit that into the various 13 structures we've discussed, what would that have been 14 doing? 15 A. So I think that what's we would now call a surgical 16 specialty board. So it sits under council, it's made up 17 of neurosurgeons and its role is to advise council on 18 matters relating to that sub-specialty. So they would 19 discuss educational resource, that the college would 20 make availability for that specialty, it might discuss 21 journals that the library should take around 22 neurosurgery, it might have issues around curriculum 23 development that it wishes to communicate through to the 24 joint committee on surgical training. There's a whole 25 range of things to do with that specialty that the Page 205	1 the -- out around the country. So it's not just in 2 Scotland. 3 Q. Right, I see. And that was a surgical advisor rather 4 than -- specifically on neurosurgery, but that's 5 different from the specialty advisory board because the 6 board is advising the council whereas this is feeding in 7 about local issues, if you like? 8 A. Exactly, so it's not specific to any particular 9 specialty. 10 Q. Understood. And the application in 2012 where he 11 applied to become an intercollegiate MRCS examiner 12 through ICBSE, how did that process work? 13 A. My view would be that he's coming to the end of his 14 tenure as a JCIE examiner, presumably enjoys being 15 an examiner. It wouldn't be unusual to then apply to be 16 an examiner for the membership exam. So again, he would 17 apply with a couple of references through the college. 18 College council would consider and approve those and 19 then it would go to -- ICBSE is a committee based in the 20 Royal College of Surgeons of England which looks after 21 the membership exam. 22 The membership exam is different to the fellowship 23 exam. Whereas the fellowship exam is completely 24 intercollegiate, the membership exam has 25 an intercollegiate core, so the exam is the same for all Page 207
1 specialty board would potentially get involved in. 2 Q. Thank you, and in June 2010, a bit further down, it says 3 he expressed an interest in becoming a regional surgical 4 advisor and was sent an application form. Do we know 5 whether he got that position, I think perhaps not? 6 A. We don't think he did from the evidence we've seen. 7 Q. Yes, so hence the application form and then it sort of 8 runs dry, I think is what you said elsewhere? 9 A. It would be a similar process, I think, to the process 10 that I have described, culminating, one would expect, in 11 an interview senior members of the college. 12 Q. Yes, if he went through with it, presumably? 13 A. If it got to that point. 14 Q. Yes, and a regional surgical advisor, would that be 15 someone providing advice from a particular part of 16 Scotland or how would that work? 17 A. It's a UK-wide network of surgeons who are the college's 18 eyes and ears across the country in terms of local 19 issues that might need to come to the attention of 20 council but also helping to set up events for local 21 members of the college. So it's a mix of helping the 22 college understand what it's like on the ground and what 23 the issues might be that college -- the council should 24 be pertinent of and should take forward, but also 25 helping to maintain a college presence and to recruit in Page 206	1 of the colleges but the colleges run them separately 2 because they are a key recruiting ground and it also 3 runs internationally in a way that the fellowship exam 4 doesn't. So the ICBSE would receive a recommendation to 5 appoint somebody as an examiner from college council and 6 would endorse that and they would then become an ICBSE 7 examiner. But all of their work would be through 8 the college because it would be to be an examiner for 9 college membership exams. 10 Q. How does that relate to what we were talking about 11 earlier to do with the ophthalmology side? That's 12 a membership exam? 13 A. Yes. So ophthalmology -- the whole governance of 14 ophthalmology changed, I believe, during this period 15 there was -- 16 Q. Rather specifically on the ophthalmology, is that the 17 same exam we're talking about or is it different? 18 Because one looks like it's an exam to become a member 19 in a specialty, whereas this seems to be a more general, 20 intercollegiate exam? 21 A. So I believe it was to bring somebody into the specialty 22 but I'm not -- there's a limit of my knowledge is those 23 ophthalmology exams because they changed so much and the 24 Royal College of Ophthalmology came on the scene at some 25 point. Normally colleges run membership exams, not Page 208

1 ophthalmology, so I would need to come back to elucidate 2 that further. 3 Q. Right, but does it appear, because the entry in 2013 4 suggests he attended a mandatory examiner training 5 course, he was appointed to that position? 6 A. Yes, it would appear so. 7 Q. Right, and you say, in 2014 -- we've discussed this to 8 an extent already -- that: 9 "The Royal College] first became aware of concerns 10 about Mr Eljamel's professional practice through 11 a public article in the Herald newspaper. The article 12 reported that Mr Eljamel had been suspended from 13 Ninewells Hospital following operating error under 14 investigation by the GMC ..." 15 And that was RCSE-00092. And that: 16 "This article was circulated internally to senior 17 staff, including the then Chief Executive Officer, 18 Director of Membership and Marketing, Executive Officer, 19 Honorary Secretary, and Membership Manager [RCSE-00011 20 and RCSE-00091]. 21 "Following this, an internal email exchange took 22 place between the Membership Manager and the Honorary 23 Secretary, who had responsibility for fellowship matters 24 [RCSE-00011 and RCSE-00091]. There is no record of any 25 disciplinary hearing being initiated under the college Page 209	1 meet with you. 2 "Once again, my sympathies for you in a very 3 difficult situation." 4 That was from the then president and then, if we 5 scroll up to the top, please, we can see a short reply, 6 which says: 7 "Dear Ian. 8 "Many thanks for the email that means a lot to me. 9 Many thanks for thinking of me. 10 "Regards." 11 Do you know, or can you deduce from your experience, 12 whether that is an email that would be sent out to all 13 members in those circumstances or is that a particular 14 missive that was sent for reasons that were, no doubt, 15 personal to the president? 16 A. I don't know. I don't know. There is -- it's certainly 17 a live debate now in the college around what support can 18 and should be provided to surgeons who are subject to 19 disciplinary proceedings and there's a recognition that 20 these proceedings need to occur and are very important 21 but, at the same time, there are people at the heart of 22 it whose welfare also needs to be thought of. And 23 that's principally I think the role of the employer but 24 as a membership organisation there is a role for the 25 college to signpost a support, that's our current Page 211
1 laws." 2 So I think it's the case that no disciplinary action 3 was ever taken in connection with Mr Eljamel; is that 4 right? 5 A. That's right. 6 Q. And I understand from the statement, and perhaps what 7 I have just read there, that's because the college 8 really didn't know very much about what was going on, if 9 anything, about Mr Eljamel before they read that 10 article? 11 A. Exactly. 12 Q. And on 22 May, 2014, the president -- the then president 13 of the Royal College wrote to Mr Eljamel offering 14 pastoral support following his suspension. Can we have 15 that one up, please, it's RCSE-00090. So if we just go 16 down to the original letter, it says: 17 "Dear Professor Eljamel. 18 "I was so sorry to hear about the trouble that is 19 afflicting you at the moment. I know that this must be 20 a very difficult time for you. As President of your 21 College, I would be happy to talk to you if you felt 22 that would be a help. I am not sure that there is 23 anything I can do other than to listen to you and to 24 empathise with you in a very difficult situation. If 25 you feel that would be helpful I would be very happy to Page 210	1 approach would be to signpost a support. 2 My feeling would be that this email reflects the 3 same sense at the time of providing a support during 4 a difficult period. But I couldn't -- I wouldn't know 5 whether this was something that was routinely done or 6 whether there were some special reason on this occasion 7 why it was done. 8 Q. Of course. That was the reason I was asking the 9 question. Really I was trying to tap in whether the 10 college has a pastoral role in these types of situation 11 because I suppose, in essence, an employer might be in 12 a similar situation to the extent that they might be 13 imposing restrictions on someone and doing that for 14 a good reason but also have obligations to support the 15 individual in question. There's a sort of dichotomy in 16 the role, but you don't know the particular 17 circumstances in which this was written? 18 A. I don't, no. 19 Q. Thank you very much. Those are all the questions I have 20 for now. At this stage what I normally do with 21 witnesses is to ask if there is anything in particular you 22 would like to say about anything we've discussed or any 23 other aspect of the evidence of the college? 24 A. Well, I think I would go back to some of the questions 25 you asked earlier around patient care. I think -- Page 212

1 I can't remember whether I said it clearly or not, but 2 I think a key role in the college is to protect the 3 public. It's so that when you are as a member of the 4 public and you are subject to surgery it's a very 5 difficult process. You have no control over the 6 situation. You are subject to actions which in normal 7 life would be considered an assault, a serious assault, 8 and you have to believe and have evidence and faith and 9 confidence that the surgeon is properly trained and is 10 doing their very best to achieve the best outcomes. 11 I think from the college's point of view and the reason 12 why we have been so keen to take part in this process 13 and to offer this evidence is in order to learn lessons 14 around what's happened here and to play our part in 15 further enforcing the system as a whole to ensure that 16 these things don't happen in future. 17 So I think it's important to just explain we have 18 a slightly different role to many of the other 19 participants. We're not an employer, we're not the 20 regulator, we didn't know what was happening, as we've 21 established in these papers, but we certainly from 22 a future perspective, in terms of what we want to do 23 going forward, we want to be part of a solution which 24 tackles these problems effectively for the future. 25 MR DAWSON: Thank you for that, Mr Egan, and we share those Page 213	1 INDEX 2 PAGE 3 MS NICKY CONNOR (sworn)1 4 Questions by COUNSEL TO THE1 5 INQUIRY 6 MR MARK EGAN (sworn)157 7 Questions by COUNSEL TO THE157 8 INQUIRY 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 215
1 ambitions and so thank you for that. There will now be 2 a short break to allow core participants the opportunity 3 to come up with some more questions but it won't be 4 long, maybe ten minutes. 5 THE CHAIR: That's fine. If you slip next door and we will 6 resume again when we're ready to do so. 7 (4.11 pm) 8 (A short break) 9 (4.22 pm) 10 MR DAWSON: Sir, there are in fact no further questions for 11 Mr Egan. Thank you. Thank you, Mr Egan. 12 THE CHAIR: Thank you very much. 13 Mr Egan in fact there are no further questions for 14 you. That means that that concludes your evidence. Can 15 I thank you for coming in and giving evidence today and 16 putting all the work into the presentation that you have 17 given overall. We are very grateful and you are free to 18 go. Thank you. 19 Right, any matters that we need to address before -- 20 MR DAWSON: No further matters today, sir. 21 THE CHAIR: Thank you everybody. We'll finish now. We seem 22 to have lost the secretariat but I'll just go anyway. 23 Thank you for your help. 24 (4.23 pm) 25 (The hearing concluded) Page 214	

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