

1 Wednesday, 16 September 2026 2 (10.05 am) 3 THE CHAIR: Thank you. Just before we begin can I mention 4 an unshakeably housekeeping matter. I am conscious, if 5 it is of any assistance to everybody, that yesterday 6 afternoon in particular became really quite 7 uncomfortably warm and within the constraints of what we 8 can do in the hearing suite we have made some 9 adjustments, some of them physical in terms of setting 10 the blinds early and in other respects altering the 11 temperature. 12 I can't promise that it will be 100% better but 13 I hope it will be an improvement on how it was yesterday 14 but time would tell but I thought I might let you know. 15 Mr Dawson, good morning. 16 MR DAWSON: Sir, good morning. The first witness this 17 morning is Rory McCrimmon. 18 THE CHAIR: Thank you. 19 PROFESSOR RORY MCCRIMMON (affirmed) 20 Questions by SENIOR COUNSEL TO THE INQUIRY 21 MR DAWSON: Good morning. 22 A. Good morning. 23 Q. You are Rory McCrimmon? 24 A. I am. 25 Q. You provided a witness statement to the Inquiry in Page 1	1 both at the University of Edinburgh and completed your 2 certificate of completion of specialist training (JCHMT 3 London) in 2000 and that you're a fellow of the Royal 4 College of Physicians of Edinburgh from 2010 and 5 an honorary award of a fellow of the Royal Society of 6 Edinburgh from 2020; is that correct? 7 A. Yes, that is correct. 8 Q. We've heard a little bit of evidence about this already 9 but it might be helpful to hear from you. Could you 10 explain what the "certificate of completion of 11 specialist training (JCHMT London)" is which you 12 received in 2000? 13 A. Yes, all doctors training to work in secondary care in 14 specialised medicine -- in some aspects of specialised 15 medicine need to do higher specialist training. In my 16 case it was diabetes and endocrinology so I accredited 17 in that as well as in general medicine to be a hospital 18 physician. 19 Q. I think I'm right in saying -- we have heard some 20 evidence about this already -- that the qualification, 21 if you like, that you list there is an examination which 22 is available jointly amongst the different Royal 23 Colleges; is that correct? 24 A. Membership is a qualification that is held jointly 25 between the different colleges. There's now an exit Page 3
1 response to a Rule 8 request sent to Dundee University; 2 is that correct? 3 A. That is correct. 4 Q. Could we have a look, please, at document UNID-01436. 5 Is that your statement? 6 A. Yes, it is. 7 Q. Could we go to page 49, please. Does your signature 8 appear on that page of the original statement? 9 A. If it is under the blanked out area that says "CAT C", 10 yes, it is. 11 Q. You did sign it? 12 A. I did sign it, yes. 13 Q. And this is the statement you signed? 14 A. This is the statement I signed. 15 Q. The statement is dated 12 May 2026? 16 A. Yes. 17 Q. And as far as you are concerned the facts stated in the 18 witness statement are true? 19 A. Yes. 20 Q. Thank you. You provide in the statement, if we go back 21 to page 1, please, some information about your own 22 professional background. 23 A. Yes. 24 Q. You say that you obtained a Bachelor of Medicine, 25 Bachelor of Surgery in 1989, Doctor of Medicine in 1999 Page 2	1 exam for specialist training but when I completed my 2 training there was not an exit exam, there was 3 competency-based training. You had to generate 4 a portfolio of work that was tested to your experience 5 in that area. 6 Q. But as far as the JCHMT element of that paragraph is 7 concerned, what does that mean exactly? 8 A. It means that the Joint Committee of Higher Medical 9 Training in London approved my qualification, if you 10 like, as a specialist in diabetes and endocrinology. 11 Q. Okay, and you mentioned there that you're a fellow of 12 the Royal College of Physicians of Edinburgh; is that 13 correct? 14 A. Yes, yes. 15 Q. We've concentrated, for obvious reasons in the Inquiry 16 so far, on the surgical colleges, but I wonder if you 17 could tell us a little bit about that Royal College? 18 A. This is the Royal College of Physicians of Edinburgh who 19 have been established for many, many years. All people 20 who wish to become a physician or a specialist have to 21 undergo the membership examination to become a member of 22 the Royal College of Physicians and after a number 23 of years, those most senior are suggested to fellowship 24 following recommendation to the Royal College of 25 Physicians. Page 4

1 Q. So it works in a similar way perhaps to the surgical 2 Royal Colleges we've referred to? 3 A. Yes, in exactly the same way. 4 Q. But they're for physicians rather than surgeons, is that 5 right? 6 A. Yes. 7 Q. Would physicians really be doctors who are not surgeons, 8 is that ...? 9 A. Yes, very much so. 10 Q. Thank you. You also mention that you have the honorary 11 award of the fellow of the Royal Society of Edinburgh 12 which you received in 2020. What does that entail, what 13 does that mean? 14 A. That is an award given to individuals who have achieved 15 a certain standing within the community based upon their 16 research and contributions to science as well as to 17 medical education. 18 Q. And as far -- the Royal Society of Edinburgh, as far as 19 medical research, medical education is concerned, do 20 they have an involvement in that area? 21 A. The Royal Society of Edinburgh represents many aspects 22 of the cultural life of Scotland actually. It honours 23 individuals from the humanities, the arts, the sciences, 24 as well as those who have made contribution in public 25 service and in other areas. It's a broad portfolio of Page 5	1 Professor Jill Belch who is professor of vascular 2 medicine, is that right? 3 A. Yes, that is correct. 4 Q. So you provide some information about them. Is it 5 correct to say that Ms Stott became involved because she 6 has a long-standing understanding of the way in which 7 medical consultants or surgical consultants like 8 Professor Eljamel provide services to the university, 9 from a personnel perspective, is that right? 10 A. Yes, absolutely. Gill Stott has been the university and 11 with the medical school for many, many years throughout 12 this period and she has a fairly extensive experience 13 and understanding of the role of the clinical academic 14 within this context and of course with clinicians who 15 hold honorary positions with the university. 16 Q. So I think it's the case, having read the statement, 17 that she has some level of firsthand experience relating 18 to Mr Eljamel -- 19 A. Yes, she does. 20 Q. -- is that right? 21 A. Yes, it does. 22 Q. But also she has, as you say, an extensive understanding 23 of the systems that are relevant to the questions we 24 asked from a personnel perspective; is that correct? 25 A. Yes, that is correct. Page 7
1 activities, again representing those individuals in 2 Scotland and abroad who have received a certain standing 3 in their respective fields. 4 Q. But amongst those activities is medical activity? 5 A. Yes, of course. Yes, there is. 6 Q. And have you worked, or do you work as a medical 7 consultant? 8 A. Yes, I do. 9 Q. And where do you work? 10 A. I work in Ninewells Hospital and I do peripheral clinics 11 at the moment in Forfar. 12 Q. And you're also a professor at the university? 13 A. And I'm also a professor at the university, yes. 14 Q. Of Dundee? 15 A. Yes. 16 Q. I understand that you had some assistance -- we'll get 17 on to the thinking behind the way in which the statement 18 was put together, but you give us some information about 19 two individuals in particular who I think helped you in 20 the compilation of the statement. In particular, you 21 refer to Ms Gillian Stott who I think is the senior 22 human resources business partner at the University of 23 Dundee, is that correct? 24 A. Yes, that is correct. 25 Q. And you also, I think, had some assistance by Page 6	1 Q. And you also had some assistance, I think, from 2 Professor Belch and you set out a considerable amount of 3 information about her background, helpfully, also. My 4 understanding, I think, is that she was involved because 5 again, she had some level of personal involvement in 6 matters relevant to the questions we had asked you 7 around the time of Mr Eljamel's involvement in 8 Ninewells Hospital; is that correct? 9 A. Yes, that is correct. 10 Q. And also she has a particular interest and understanding 11 of the research side of matters which was something that 12 Mr Eljamel was involved in, is that right? 13 A. Yes, that is correct. 14 Q. In particular you tell us that in 2016 Professor Belch 15 was awarded Officer of the Most Excellent Order of the 16 British Empire, OBE and in 2026 was ordered a CBE. Do 17 you know what they were for? 18 A. They were for services to health in general and often 19 because of her work on the effect of pollution on 20 outcomes, as well as the many roles she's had 21 representing vascular medicine both nationally and 22 internationally. 23 Q. Thank you. If we could look, please, at paragraph 2.7, 24 this provides some further information about 25 Professor Belch's background in addition to what you've Page 8

1 already told us and her role as a professor of vascular 2 medicine. In particular you tell us there in 2006, 3 I think, she became the director of the Tayside Clinical 4 Trials Unit which dealt solely with trials performed by 5 University of Dundee employees. We'll get on to more 6 details about the research mechanisms and bodies in due 7 course but could you, at this stage, tell us what that 8 body involved at that time, broadly? 9 A. Broadly, because I wasn't present here in the university 10 at that time but essentially, the University of Dundee 11 employees are largely clinical academics who are 12 awaiting to do trials that would involve human 13 participants in any form. That is heavily regulated of 14 course and therefore there needs to be a process to 15 which you can ensure that all these trials are ethically 16 sound, that they are confirming to the requirements of 17 the GMC and good clinical practice and therefore this 18 body was put in place to ensure that that was happening. 19 Q. And there's a focus, I think, in that sentence on the 20 fact that in 2006 when that body came about to deal with 21 those activities, that that was a unit which dealt 22 solely with trials performed by University of Dundee 23 employees? 24 A. Yes. 25 Q. Why the emphasis on that at that point in time? Page 9	1 Q. And she was in charge, at that stage, of the university 2 side of the operation -- 3 A. Yes. 4 Q. -- is that right? Have you been able to ascertain any 5 information about what happened on the other side of the 6 fence, if you like, in terms of how the hospital side of 7 the research operation or the hospital research 8 operation functioned and who was involved? 9 A. Not directly because that information would be held by 10 NHS R&D department, if they still have that information 11 available. 12 Q. I see. There was, I think, as we see here, 13 a significant change in these arrangements in 2010 which 14 also involved Professor Belch. I wonder if you could 15 tell us your understanding of what happened at that 16 time? 17 A. Yes, Professor Jill Belch, working along with her 18 colleague, Ellie Dow, Dr Ellie Dow who was, at that 19 time, NHS R&D director, worked together to try and bring 20 these two groups together under the umbrella of TASC, 21 the Tayside Academic Science Centre and that group would 22 therefore bring all regulatory trials to either NHS 23 consultants or university clinical academics as well as 24 students under the one body to ensure that we met 25 regulatory requirements. Page 11
1 A. Because at that time there were two separate processes. 2 So University of Dundee employees would work through the 3 Tayside Clinical Trials Unit, whereas NHS consultants 4 would work through the NHS -- what was called in 5 those days the research and development, the R&D 6 department. And the decision was -- well, I guess we'll 7 get on to the next bit about how they came together. 8 Q. Yes. So, given the fact that period of time, and indeed 9 before that is of interest to us in this Inquiry as you 10 know, what we've defined in the 11 Rule 8 as the relevant period is one which lasts 12 from roughly 1995 to roughly 2015, which encapsulates 13 the beginning of Mr Eljamel's career at Ninewells -- or 14 with NHS Tayside, I should say, and then running all the 15 way up to his voluntary removal from the GMC register in 16 2015. So this falls within that period. 17 A. Yes. 18 Q. Would it be fair to say -- at least you can speak 19 I think on behalf of what Professor Belch has told you 20 from the period 2006 for the next few years. There was, 21 in fact, a separation between the research operations 22 that were going on within the hospital and the research 23 operations that were going on within the university, is 24 that right? 25 A. Yes, that would be correct. Page 10	1 Q. And broadly speaking, why was it thought that would be 2 a good idea to do that at that time, as you understand it? 3 A. As I understand it, it was thought relevant and 4 important to do that because we had two separate 5 processes and you have individuals working, of course, 6 within the NHS and within the university and it was felt 7 important to link them. Because the medical school is 8 embedded within the hospital and we work together in 9 almost every aspect of what we do in terms of education 10 and research and therefore having a streamlined process 11 where we had staff involved who could ensure that any 12 form of clinical research in particular, no matter who 13 was conducting it, was conducted in a way that met 14 strict regulatory requirements was important to have in 15 place. 16 Q. Because the success of clinical trials or other types of 17 research would benefit from the input both from the 18 clinical side within the hospital but also from the 19 experience of people within the university. So bringing 20 them together, the idea was to try to improve the 21 quality of what was being done? 22 A. I think that's the important bit. It was to improve the 23 quality and the safety of the clinical trials that were 24 being conducted and to make sure they were ethically 25 sound. Page 12

1 Q. Thank you. We'll come back to some aspects of that in 2 due course. If you could just scroll down a little bit. 3 Could I ask you, Professor, while you are giving your 4 evidence, there are two microphones in front of you 5 which, if you could try to speak as clearly into those 6 as possible just to make sure that everybody can hear 7 exactly what you're saying, that would be much 8 appreciated, thank you. 9 There is mention in the documentation of another 10 unit, which I think is called the medical research unit, 11 which has the quite convenient acronym "MRI" and I think 12 it's suggested in the documentation that Professor Belch 13 became the co-head of that in 2012. Is that another -- 14 where does that fit in with the arrangements that you've 15 told us about? 16 A. Yeah, this is slightly different. This is a way that 17 the medical school structured itself at the time and 18 broadly, speaking the medical school, for a number of 19 reasons, was divided into an educational arm, at that 20 time that was led by Professor Gary Mires, and 21 a research arm. And that was jointly led by 22 Professor Belch as well as Professor Roland Wolf. 23 Professor Belch was a clinical academic, Professor Wolf 24 is a non-clinical biomedical scientist and that's 25 because there is an aspect of medicine that is Page 13	1 something like that? 2 A. Exactly. The MRI was very much a university body, 3 looking at university research in its broad -- in that 4 space in its broad context. 5 Q. Yes, because presumably, the university wouldn't just 6 get involved in any research, there would be strategic 7 thinking behind the sorts of things they felt they could 8 deliver safely and productively in different areas, 9 based on expertise of staff available to them and 10 patients available through the hospital? 11 A. Absolutely and the MRI would also be involved in 12 mentorship, support, promotions and all those other 13 aspects related to the people within the institution on 14 the university side. 15 Q. Thank you very much. You also tell us in the statement, 16 if we go back to paragraph 2.1, please, some more 17 information about your involvement in the university 18 beyond the qualifications we've discussed already. You 19 tell us there that you joined the University of Dundee 20 in 2009 as a clinical senior lecturer in diabetes and 21 endocrinology; is that correct? 22 A. Yes, that is correct. 23 Q. There's an interesting aspect of that sentence which may 24 become more important later. What's meant by 25 a "clinical senior lecturer" in a particular area and Page 15
1 biomedical research that takes place more at a cellular 2 level. So we work within the clinical arena and also 3 within the non-clinical arena. So this was very much 4 how we structured and ran a system of appraisal, of 5 grant, submission, for people who were clinical and 6 non-clinical in a slightly different space. 7 Q. Right. So how then, having described the different 8 roles, would the Medical Research Institute have 9 interacted with the TASC body that existed to try to 10 streamline the research, as you've highlighted? 11 A. In the sense that Jill Belch, at the time, who was head 12 of TCTU would have also reported into the colleagues on 13 the Medical Research Institute on -- updated on TASC 14 activities more than anything else but the TASC body 15 would have been separate, it would have been 16 a regulatory framework for the running of clinical 17 trials. So it would have been less about -- more 18 a reporting mechanism than anything else. 19 Q. Right. So would it be fair to say then, just so I get 20 a clear idea of this, that TASC was a body which 21 straddled the hospital and the university that was 22 involved in the actual running of the clinical trials, 23 if you like, whereas would the MRI perhaps be involved 24 in more strategic decision-making around the sorts of 25 research directions the university wanted to go in, or Page 14	1 how does that differ from an honorary position? 2 A. Oh, a clinical senior lecturer simply means that I am 3 a clinician within the healthcare system as opposed to, 4 say, a senior lecturer in the university who's 5 a clinician. And the difference between that and 6 an honorary is that I'm employed by the university, 7 whereas an honorary member of staff is employed by the 8 NHS. 9 Q. We saw earlier, when talking about the body that 10 Professor Belch was in charge of from 2006, the Tayside 11 Clinical Trials Unit, that was one that involved 12 University of Dundee employees? 13 A. Yes, I would have worked through that unit for clinical 14 trials. 15 Q. Yes, there's an important distinction, I think, here 16 between activity that involves University of Dundee 17 employees and activity that involves people alongside 18 the university who are not University of Dundee 19 employees, is that right? 20 A. Yes, that's absolutely correct. 21 Q. I think, broadly speaking, although this is described in 22 various particular avenues throughout the statement, you 23 were asked a number of questions -- or the university 24 was asked a number of questions about the consequences 25 of that arrangement for what one might broadly describe Page 16

1 as oversight responsibilities of certain individuals. 2 I think, as I understand the position -- please correct 3 me if I'm wrong -- broadly speaking, insofar as one is 4 talking about University of Dundee employees, of which 5 you for example are and were one, the oversight 6 responsibilities of an employer would apply to those 7 individuals. However, where there were other 8 individuals whose work brought them into contact with 9 the university, generally the responsibility for them 10 would lie with their employer rather than with the 11 university; is that a fair summary? 12 A. Yes, that is a fair summary. 13 Q. Thank you. So it's quite important, at each stage, 14 I think, to understand precisely the function any 15 individual is carrying out and in particular, with 16 regard to oversight and responsibility, where their 17 employment lies, effectively? 18 A. Yes. 19 Q. You then go on to tell us that in May 2011, after having 20 been a senior lecturer since 2009, you became a clinical 21 reader. You've explained what the clinical aspect 22 means, but what is a "reader"? 23 A. So a reader, by the university definition, is 24 an individual who has achieved a national standing 25 within their field and can evidence that they have Page 17	1 A. Yes, absolutely. So as an associate dean for research 2 and medicine, I was responsible for the overall 3 strategic direction of the medical school and how that 4 aligned with the university's strategic direction in 5 terms of research specifically and of course those other 6 systems we put in place to ensure that our research was 7 high quality, that there was mentorship in place for 8 PhDs and post doc students and other areas. 9 Q. So you have mentioned the role of associate dean of 10 research and medicine. Just to fit it in to the 11 evidence that you gave earlier, you mentioned there 12 being two sides to the operation, an educational side 13 and a research side, and you gave some information about 14 the identities of people who would be in charge of 15 those. Are those the two components of research and 16 medicine that were involved in your title? Is one 17 an educational responsibility and one a research, or 18 does that not fit in quite in the way I have described? 19 A. There is always overlap. All of us who research will 20 teach and research underpins most of the teaching that 21 we do. However, I would not have had responsibility 22 for, say, the delivery of the MBChB programme or some of 23 the work involved in ensuring programme quality in areas 24 like that. There are other individuals on the 25 educational side of the university who take leadership Page 19
1 a national standing within their field. 2 Q. So is a reader effectively a promotion within the 3 university? 4 A. Yes, it is. So the promotion system is from lecturer, 5 senior lecturer, reader, professor. 6 Q. You've anticipated the next step. In June 2013, you 7 become a clinical professor. Again, that's a step up. 8 But in terms of the responsibilities of a professor, 9 what do they entail in comparison with the 10 responsibilities of the lower grades, if I can put it 11 that way? 12 A. In many ways you could argue that the overall 13 responsibilities are very much the same about teaching 14 delivery, education and about research. However, our 15 expectations of professors is that they will also make 16 more of a contribution to university life through 17 leadership in some aspect of the various activities that 18 we do. 19 Q. I see and so perhaps in relation to that you tell us 20 that you became part of the senior executive team in 21 2017, is that right? 22 A. Yes, that is correct. 23 Q. Is that an example of the sort of thing that makes 24 a contribution to university life that a professor would 25 be expected to do? Page 18	1 roles within that space. My role, in that sense, would 2 have been teaching delivery, but in terms of leadership, 3 it would be how do we organise, how do we define 4 ourselves in terms of the research we do, how do we 5 ensure it's the highest quality and has the greatest 6 impact aligned to what we are as a medical school which 7 to improve health and well-being of society. 8 Q. I see. So, insofar as that separation of the two parts 9 of the medical operation are concerned, your focus in 10 that role was more on the research side? 11 A. Absolutely. 12 Q. And others were taking more responsibility for the 13 teaching side? 14 A. Yes. 15 Q. And you mentioned the MBChB. Is that the undergraduate 16 medical degree offered by Dundee University? 17 A. Yes, it is. 18 Q. Thank you. And in 2019 I think you became the dean of 19 medicine. I'm taking it as read that that is 20 a promotion, a step up from associate to dean of 21 medicine and research, is that right? 22 A. Yes, now you have overall responsibility for all aspects 23 of what the medical school does. 24 Q. Yes, so you're a step above. So you do now require 25 responsibility both on the research and the educational Page 20

1 side, is that right? 2 A. Yes. 3 Q. Do you hold that role now? 4 A. I have, more recently in January, following 5 a restructuring within the university, taken on the role 6 of vice principal for health. So the faculty of health 7 now comprises the four decisions. Medicine is one, 8 dentistry is the other. Health sciences nursing is the 9 third and psychology is the fourth. So there are heads 10 of school now who run each of those divisions and I have 11 overall responsibility for the faculty and report now 12 directly and am part of the university executive group. 13 Q. Is that -- has there been a restructuring then of the 14 different roles this year? 15 A. There has been. 16 Q. Right, so has the dean of medicine disappeared and 17 become a head of medicine -- 18 A. It's now become a head of school. It was a dean of 19 medicine, now a head of school. 20 Q. So is there a head of medicine now? 21 A. Yes, there is. 22 Q. So the role you held until the beginning of this year 23 was to be in charge of the medical side of the 24 operation. There would've been, presumably, equivalence 25 in the dental side -- Page 21	1 wellbeing initiatives. The role involved directing the 2 committee to monitor population health strategies, 3 ensure compliance with health standards, and advise the 4 NHS Tayside Board on improving public health outcomes." 5 Was the role that you held over that four-year 6 period on the NHS Tayside board a role that is held by 7 someone associated with the university always? 8 A. I cannot be clear on what was happening at the time 9 because we do not have that information. It has been, 10 ever since I arrived in Dundee, I was on the board and 11 Professor Linda Martindale has taken over, who is also 12 University of Dundee appointed, has now taken over from 13 me on the health board committee. 14 Q. So as far as you're concerned, since you've arrived in 15 Dundee, there's always someone from Dundee University in 16 a non-executive role on the board of NHS Tayside, is 17 that right? 18 A. Since I was on the board, but prior to my time sitting 19 on the board I wasn't sure whether there was a gap. It 20 varies between health boards in the country. In most 21 health boards, there is a university representative on 22 the health board. 23 Q. Right, and why is that? What's the thinking behind 24 there being an advantage to having someone in that 25 non-executive role on the health board? Page 23
1 A. Yes. 2 Q. -- and the other parts of the school. And now you sit 3 above that, effectively you're the vice principal 4 sitting above the various heads, is that correct? 5 A. Yes, that is correct. 6 Q. Thank you very much. 7 THE CHAIR: So, you're responsible for the faculty to whom? 8 A. To the university and obviously representing the people 9 of the faculty and conveying the strategy and the 10 direction of the university to the faculty. It's a sort 11 of two-way position, if you like. 12 THE CHAIR: Yes, all right. Thank you. 13 MR DAWSON: Thank you. Could we have a look at 14 paragraph 2.3. You tell us there that: 15 "Between 2020 and 2024, [you were] on the 16 NHS Tayside Board. The role of a Non-Executive Board 17 Member in NHS Tayside is to hold the Executive to 18 account for the delivery of strategy, ensure value for 19 money and that risks are managed and mitigated 20 effectively. All members have a collective 21 responsibility for the performance of the organisation. 22 In addition, I was Deputy Chair of the Public Health 23 Committee whose role was to work with the Chair of the 24 Committee in helping provide strategic leadership, 25 governance, and oversight for public health, safety, and Page 22	1 A. Very much because, you know, we train the next 2 generation and I think the university is embedded within 3 the health service in almost all aspects of what we do, 4 whether that is medicine, dentistry or nursing and the 5 various other -- you know physiotherapy and other areas 6 linked to it. And therefore, I think we can help and 7 inform, particularly around innovation, impact and 8 education. 9 Q. So the thinking behind it, presumably, is that you 10 can -- although you have the general responsibilities of 11 a non-executive director of the board, you can bring, if 12 you come from the university, whether it's you or any 13 other individual from the university, a certain 14 perspective to bear which is relevant to the activities 15 of NHS Tayside because, as you say, the university is 16 training the next generation of doctors who will work 17 there? 18 A. Yes, no, absolutely and clearly your role as a board 19 member is separate from that, but I think it's aligned 20 so it's the expertise that you bring within that space. 21 Q. I understand that it's quite a complex structure 22 involved here which I'm trying to understand, but 23 I think from his statement Professor Connell tells us 24 that at a certain point he was the chair of the 25 NHS Tayside board. Is that a different role from the Page 24

1 role that you held? 2 A. Yes, very much so: the chair of the board generally is 3 the line manager of the chief executive and chairs the 4 committee, the NHS Tayside board. Very different 5 from -- I was a non-executive member. 6 Q. Yes and as I understand it, based on your experience at 7 least, a non-executive director holding that position, 8 in a way ex officio, based on the fact you have 9 an association with the university, for the reasons 10 we've discussed? 11 A. Yes, absolutely. 12 Q. Understood, but the chair is something quite different 13 as we'll get on in due course to discuss? 14 A. Yes. 15 Q. Thank you. Over the period when you were involved on 16 the NHS Tayside board do you recall there being any 17 discussions of what one might broadly call the Eljamel 18 saga? 19 A. Gosh, now you've got me thinking back. I cannot recall 20 the formal discussions of it, I'm afraid. I don't have 21 that documentation in front of me. I'm sure we will all 22 have been aware of the Eljamel saga. 23 Q. Because there were some specific things, important 24 milestones if you like, that took place during the 25 period when you sat on the board between 2020 and 2024. Page 25	1 Q. Do you recall that in the period in which you were 2 involved and the board being something that was 3 discussed at this level? 4 A. The announcement was being discussed and this process 5 would be happening. 6 Q. Yes, but the details are, at the moment, beyond you? 7 A. Yeah. 8 Q. Understood. You also say that you were deputy chair of 9 the public health committee of NHS Tayside, is that 10 right? 11 A. Yes, that is correct. 12 Q. Over this period, 2020 to 2024? 13 A. Yes, that's correct. 14 Q. Would that have covered the pandemic then? 15 A. During that period, yes. 16 Q. Was that an aspect of the work that that body did, given 17 its focus on public health? 18 A. It was less involved in that body because there was 19 a group set up, led by the chief executive that dealt 20 directly with the pandemic how we were responding as 21 a health service to the pandemic. 22 Q. I see, but that committee involves consideration of 23 NHS Tayside's general public health strategy? 24 A. Yes, it does. 25 Q. And also you're bringing to bear a certain medical Page 27
1 For example, over that period the Scottish Government 2 undertook and completed an investigation into what it 3 called "unresolved concerns" relating to Mr Eljamel. 4 That they reported in 2022. Are you aware of that now? 5 A. You have -- yes, you've told me that now, but I'm afraid 6 I have been so focused on looking at this university 7 aspect of things that I haven't looked at that. 8 Q. Okay, but -- 9 A. Apologies. 10 Q. -- do you recall that process the Scottish Government 11 process one discussed with the board? 12 A. I do recall the Scottish Government process but 13 I'm afraid I couldn't comment in any detail on it. 14 Q. Understood and more particularly to NHS Tayside, 15 NHS Tayside itself in 2023 conducted something called 16 a "due diligence review" relating to aspects of the 17 Eljamel saga. Again, do you recall that being something 18 that was discussed or broad up at the NHS Tayside board? 19 A. I recall it being discussed and presented, but 20 I'm afraid I can't tell you the details of that now. 21 Q. Okay, and also the process of this Public Inquiry being 22 set up. It was announced on 7 September 2023 and 23 obviously the NHS Tayside has had significant 24 involvement since then. 25 A. Yes. Page 26	1 expertise in relation to that? 2 A. Yes. 3 Q. Thank you. Just to understand then, we've gone through 4 the various structures and the various people. Can 5 I ask you a little bit about the way in which the 6 statement was put together. You've very candidly set 7 out that you had these two individuals in particular 8 help you, for reasons we've discussed. Were there other 9 people that contributed to the compilation of the 10 statement? 11 A. Yes. I think if -- you will see within the 12 documentation that we had a fairly extensive electronic 13 data search, as well as hard document data search. So 14 there are individuals within strategic intelligence as 15 well as CMO who look through all the data to find all 16 the information that we could possibly have that might 17 pertain to this case. 18 Q. Thank you and I think, as I understand it, you have 19 produced to the Inquiry effectively, broadly speaking, 20 two sets of documents. One with documents that pertain 21 to matters specifically covered within this statement, 22 is that right? 23 A. Yes. 24 Q. And then you've also more recently provided to us a much 25 larger suite of documents as a result of the searches, Page 28

1 the processes for which are set out very carefully in 2 the statement, is that right? 3 A. Yes, that is correct. 4 Q. And I think that involved both electronic searches and 5 physical searches of archive documents, I think? 6 A. Yes, absolutely. We went through the archive warehouse 7 where we had all of the hard-copy documents available 8 and there was electronic searches, both through detailed 9 searches as well as using different AI algorithms, as 10 you probably saw, in order to determine what was most 11 relevant to the Inquiry. 12 Q. You may or may not be pleased to hear that I'm not going 13 to get into the detail of that with you today, but we 14 appreciate the efforts that have been made and also the 15 detail that's set out in the statement. Do you -- there 16 are areas, as we'll go through, where you've managed to 17 find documents and areas where you have not managed to 18 fend documents. Do you know, broadly speaking, how long 19 the university would tend to retain documents for before 20 their destruction? What's its broad document retention 21 policy? 22 A. I'm afraid I couldn't tell you the exact number of years 23 that we retain documents for. 24 Q. Okay, the reason I asked the question is that, perhaps 25 helpfully for our purposes, you have been able to Page 29	1 Professor Connell produced a separate statement to the 2 one that you and others compiled? 3 A. Professor Connell had a different role at the time and 4 he was more involved in the initial promotion of 5 Professor Eljamel and that whole process that happened 6 at the time. 7 Q. I see. It's just because the two individuals whom we 8 mentioned also had a role but they contributed to your 9 statement. I'm just trying to work out whether there 10 was anything in particular in the thinking behind in 11 Professor Connell providing a separate statement. Was 12 that what he wanted to do, for example? 13 A. I'm afraid I don't know the answer to that one. 14 Q. He, I think, contributed to your statement as well, is 15 that right? 16 A. In parts, yes. Evidence was provided for, yes. 17 Q. Yes, I think there are some passages where, if one reads 18 it carefully, I think one is in fact reading 19 Professor Connell's voice, if you like, rather than your 20 voice telling us what Professor Connell has told you. 21 But he did contribute to your statement as well, is that 22 right? 23 A. Yes. 24 Q. Thank you. I'd like to ask you some questions about 25 certain key individuals who were part of the University Page 31
1 produce some documents of some vintage but in other 2 areas, perhaps more recently, you don't have the 3 documents, which would tend to suggest that there may 4 not be a rigid application of a document retention 5 policy. As I say, that may be of benefit to this 6 Inquiry. However, you are a not in a position to get 7 into the details of that and we can perhaps ask others 8 who were more directly involved; would that be fair? 9 A. Yes, if that's possible. 10 Q. Thank you. As far as the statement is concerned, you're 11 the signatory to the statement so you are, to the best 12 of your ability, taking responsibility for its contents, 13 is that right? 14 A. I have yes. 15 Q. But you have called on others, including the two whom 16 I have mentioned, as I understand the process, in order 17 to try to give the fullest answers the university can 18 give us on the questions we've asked? 19 A. Absolutely, I think we were trying at all times to give 20 as much as information as we held to help with the 21 Inquiry. 22 Q. Thank you. And we know that a separate statement in 23 response to the same request has been provided by 24 Professor Connell from whom we'll be hearing later 25 today. What was the thinking behind why Page 30	1 of Dundee set-up and their roles. Could we please look 2 at UNID-00149. This is a document that helpfully sets 3 out some of the key individuals and key roles. I just 4 wanted to run through these with you. Between -- thank 5 you, that looks a little more legible. The 6 vice-chancellor, between 2000 and 2009, was someone 7 called Alan Langsland. Was there likely to have been 8 a vice-chancellor before 2000? 9 A. There will have been somebody who ran the university -- 10 whether they would have been called vice-chancellor or 11 not, they will have led the university during this 12 period. 13 Q. What was the role of the vice-chancellor, at least over 14 the period when the role was held by this individual? 15 A. The vice-chancellor had overall responsibility for the 16 university, effectively provided strategic leadership 17 for the entire university. 18 Q. I see. So operatively, that's the head of the 19 university? 20 A. That is operatively -- nowadays we call it the 21 principal. 22 Q. The chancellor would be some sort of honorary? 23 A. That was an honorary role, yes. 24 Q. Right, it's often someone in the royal family or 25 something. Is that what it was? Page 32

1 A. Lord Robertson at the moment. 2 Q. Right, okay. We see there also various individuals, in 3 particular Professor Peter Downes occupied that role 4 from 2009 to 2018. There's also there mention of 5 a vice principal. What does that role involve? 6 A. Well, Irene Leigh's role, as vice principal and head of 7 college, is not unlike my own role now because 8 previously we were the college of medicine, dentistry 9 and nursing. That was dissolved to form the eight 10 schools which had separate deans and, as in many 11 restructurings, you go back to what you were doing in 12 the past and we have reformed a very similar faculty to 13 what might have been the college at that time. 14 Q. So Professor Connell held that role between 2012 and 15 2015? 16 A. Yes. 17 Q. And so that's the equivalent, after the restructuring of 18 the role that you hold now? 19 A. It is, yes. 20 Q. Yes, thank you. And there is -- we also have seen 21 reference to there being, I think you've mentioned this 22 already, a dean of medicine at certain stages? 23 A. Yes. 24 Q. I think that's what you just clarified that there are 25 heads of each of the different colleges, is that what Page 33	1 oversaw research, both from a strategic and operational 2 point of view. You've been able to provide us with some 3 information, helpfully, in your statement about research 4 in which Mr Eljamel was involved but if I can just try 5 and understand at a broad level how that fitted in with 6 the university. He started work as a consultant in 7 Ninewells Hospital, consultant neurosurgeon in 1995. 8 Insofar as he would have -- he may have been involved in 9 any research up until 2010, I think what you've told us 10 is that that research would have been conducted under 11 the umbrella, if one can put it that way, of the 12 hospital rather than the university; is that correct? 13 A. Yes, it would have done. 14 Q. Would it -- hypothetically, without talking about any 15 specific research, would it have -- could it have 16 involved people who worked within the university working 17 alongside him? 18 A. It is entirely possible that it did at the time. 19 Q. So in such an arrangement, would there be a kind of -- 20 so a lot of your statement talks about clinical trials. 21 Is it the case that all of the research that you're 22 aware of, at least, that he was involved in would 23 involve clinical trials or is there research of another 24 type in which he may have been involved? 25 A. From the information that I saw, the majority of the Page 35
1 that is? 2 A. No, it is not and apologies for the confusion but that 3 was the college's -- the college of medicine, dentistry 4 and nursing. Now, that's referred to as the faculty of 5 medicine, dentistry, health sciences and psychology. So 6 they were called colleges then, they are called 7 faculties now. They were called deans after that and 8 now are called head of schools. So consistency, 9 I'm afraid, is not something that's happening within the 10 structure. 11 Q. Okay. So that's the role that we found out that you 12 held, was it, dean of medicine from 2019 to whatever it 13 was -- 14 A. I was dean of medicine, yes. That would have been 15 different from John Connell who was head of college, 16 which covered all three areas. 17 Q. Okay, so those roles are different in that the dean of 18 medicine has a wider remit, is that right? 19 A. No, the dean of medicine would be a smaller remit than 20 head of college and the head of college would have sat 21 on the university executive, where, as a dean, I didn't 22 sit on the university executive. 23 Q. We've touched already -- thank you, take that one down. 24 We've touched already on the importance of research 25 within the university and the different bodies that Page 34	1 research, almost all the research was involved in 2 clinical trials which may or may not -- and in most 3 cases not -- have had any involvement from university 4 staff within that context. It would have been run 5 through the TASC and would have had NHS nursing staff, 6 NHS consultants running those trials. 7 Q. We'll get into the structures in a minute, but if we 8 just go right back to basics, if you could tell us what 9 is a clinical trial? 10 A. There are many different forms of clinical trials, I'm 11 afraid. 12 Q. Perhaps under reference to neurosurgery would be what 13 we're most interested in, if that's helpful? 14 A. Not really. I mean, I think, let's say as an academic 15 I might run a clinical trial which involves 16 an intervention, an experimental medicine trial which is 17 small which is looking at disease mechanism. I will do 18 that myself, I will run that trial, take responsibility 19 for that trial. I'll run it through the regulatory 20 framework and we would be governed by good clinical 21 practice and national guidelines. 22 Q. Just to pause -- 23 THE CHAIR: Sorry, does that mean, at its most basic level, 24 that -- I had the impression that a clinical trial 25 involved trying out a new medicine. It doesn't Page 36

1 necessarily follow because it could be a mechanism of 2 surgical technique, something of that nature? 3 A. Yes, absolutely. If I were to do -- there are different 4 type of trials. I might, doing a trial as a sole 5 investigator looking at the mechanism of a new drug for 6 instance, in which case, again, I would go through the 7 normal regulatory framework, or I might be doing a trial 8 where I'm part of a multi-centre collaboration. And in 9 fact the majority related to drugs and new techniques 10 are multi-centre trials, where I am asked to recruit 11 a number of patients out of hundreds or thousands of 12 patients from multiple centres around the country or 13 even internationally. That's what I mean about -- it's 14 quite complex. You -- sometimes the university is the 15 sponsor, but sometimes actually a pharmaceutical company 16 or a surgical company are the sponsors of a trial. 17 MR DAWSON: Well, that was really what I was trying to get 18 to because if we just focus -- as we will come to 2010 19 and beyond because we know there was a change then -- if 20 we focus on that earlier period, it's possible I think, 21 from what you're saying, dependent on the type of 22 research or trial that was being undertaken, that it may 23 have involved people from the university over that 24 period, depending on whether it was a narrow focus, 25 which Mr Eljamel may have been able to do himself, or Page 37	1 could undertake that himself because he wouldn't require 2 that expertise because of the particular nature of the 3 trial being conducted; is that -- 4 A. Because the surgeon in that case is the expert who is 5 coming in, particularly if it's around a surgical 6 technique or a surgical provision. 7 Q. And in 2010, we talked about there being administrative 8 change and the TASC organisation being set up to try to 9 bring together all the various different things that 10 were happening. As far as the Eljamel trials are 11 concerned, does that, based on your assessment that they 12 would unlikely involve university people, actually 13 involve any particular change to those trials, other 14 than they now sit under a different organisation than 15 they did before? 16 A. Well, that is the complex thing that I was perhaps 17 alluding to, is that now that this TASC was set up then 18 that employs both university and NHS-employed staff. 19 Those staff are there to ensure that the trial meets 20 regulatory requirements. So they are not academics as 21 such, they would be what we would call non-academic 22 professional services staff who are there to ensure the 23 delivery of the trial and that it's done so within the 24 correct regulatory framework, but they are employed by 25 the university. Page 39
1 involved a wider cohort of people in its operation, is 2 that fair. 3 A. I think it is fair to say that. I did look at the 4 trials presented and they did not look to me as if they 5 were university trials or would have involved university 6 people but I could not see, from the evidence, whether 7 there was a co-investigator or other person on the 8 trial. 9 Q. I suppose what I'm trying to get to is why it is you 10 reached that conclusion. When you look at a trial what 11 is it that makes you think that is the sort of thing 12 that would involve university people or not? 13 A. Because most of the trials that I saw listed were 14 an intervention with a drug or they were part of what 15 was listed -- Professor Russell Petty had done the 16 inquiry at this point and they were mostly multi-centre 17 trials. So they are not usually involving the 18 university as such, they are involving an external 19 agency like a drug company or a company that makes 20 surgical instruments. 21 Q. I see, and what, in a clinical trial, would the 22 university people be contributing in a broad sense? 23 A. It would be expertise if that was required. 24 Q. Whereas the type of trial that you think existed in the 25 Eljamel case were the sorts of trials where a surgeon Page 38	1 Q. I understand. The answer is that it would involve 2 people from the university, but performing that 3 regulatory oversight function. Is that -- 4 A. In that context, yes. 5 Q. Yes. So there are, I think, a number of trials that you 6 have identified that were trials that started under the 7 old regime, if I can put it that way, and continued 8 through into the post-2010 period -- 9 A. Yes. 10 Q. -- that Mr Eljamel was involved in? 11 A. Yes, absolutely. 12 Q. That would be, presumably, because of the fact that if 13 one was monitoring the use of a particular drug or 14 something one would, perhaps in some circumstances, need 15 to do that over a number of years and it would take 16 a long time to work out what the results were, is 17 that -- 18 A. Yes, that is correct. 19 Q. So the important change in 2010 was that, as it now came 20 under the TASC umbrella, that research would involve 21 people from the university, as I said not actively 22 involved in the trial, but in providing input into the 23 regulatory framework that needs to be adhered to within 24 a trial, is that right? 25 A. I think that is fair to say, yes. Page 40

1 Q. We'll get on to the detail of that in a moment. I know 2 it involves things like providing consent forms and all 3 that sort of thing, we'll talk about, but just in the 4 broad sense. So before 2010, before that administrative 5 regulatory framework came from the university side, that 6 would all have been handled within the hospital; is that 7 right? 8 A. Yes, that's correct. 9 Q. I see. So the hospital -- either Mr Eljamel or 10 a similar system within the hospital would have been 11 responsible for monitoring regulatory compliance? 12 A. Yes. 13 Q. Thank you. Because it's always been the case that 14 clinical trials require to adhere to strict regulatory 15 rules; isn't that right? 16 A. Yes, that's correct, yes. 17 Q. And what bodies enforce those rules? 18 A. A variety of bodies in the UK, General Medical Council, 19 MHRA. All of them enforce the rules and we are 20 regularly inspected by those bodies to ensure that we 21 are following good clinical practice. 22 Q. MHRA, could you help us with that? 23 A. I'm struggling on the H -- the Medicines and Health 24 Regularly Authority. 25 Q. Yes. That's a body that has broad responsibilities over Page 41	1 Companies who produce surgical instruments would clearly 2 fund trials within that space as well. And also there 3 are organisations throughout the UK, there's multiple 4 organisations, Medical Research Council, Wellcome, 5 specialist groups like Diabetes UK who would also fund 6 clinical trials, British Heart Foundation, Cancer UK. 7 So there are multiple sources. EU as well. A very long 8 list, I'm afraid. 9 Q. Okay. So in terms of the process that one gets to when 10 setting up a clinical trial in particular in this 11 context -- 12 A. Yes. 13 Q. -- how does the idea for a clinical trial start? It 14 might start, for example, with a pharmaceutical company 15 that wants its products to be tested; is that correct? 16 A. Yes. 17 Q. So what about the -- you mentioned -- the Chair asked 18 you some questions about the possibility that it 19 wouldn't always be a medicine or a product being used. 20 What about the sort of trial that would involve more 21 interest in the progression of a particular disease or 22 something like that? Could that -- who could instigate 23 that, would that be a consultant or would it be the 24 university or the hospital, how would that happen? 25 A. I think that could be either. That could be an NHS Page 43
1 research and making sure standards are adhered to; is 2 that right? 3 A. For clinical trials, yes. 4 Q. And you mention I think in the statement, I think -- 5 again, another acronym. I think they mean "Good Medical 6 Practice", GMP and "SOPs" which are standard operating 7 procedures; is that correct? 8 A. Yes, they are. 9 Q. And so what bodies issue documents of that nature to try 10 to make sure standards are adhered to? 11 A. The GMC, the Good Medical Practice, or GMP, is 12 a national body that's regulated through organisations 13 like the MHRA. The SOPs are produced locally on the 14 basis of best practice and there are a variety of bodies 15 who influence that. 16 Q. I have a suspicion this may be a complex question to 17 answer as well but I'll ask it nonetheless. How are 18 clinical trials funded? 19 A. In a variety of different ways. So -- 20 Q. Could you give some examples? 21 A. Yes, I can, of course. Drug companies will often 22 involves large clinical trials of a new product that 23 they wish to see in practice and who have gone through 24 different phases of a clinical trial process. There are 25 different stages in clinical trial development. Page 42	1 consultant who wants to generate a database and to 2 follow people up with a given condition over time to see 3 what maybe predicts outcomes and that's still a heavily 4 regulated process because that contains confidential 5 information and therefore you have to ensure that that 6 data is housed and stored in a way that is safe and the 7 data is anonymised. So again, they would go through 8 an ethical process for submission for that type of trial 9 and that, again, would -- is regulated in different 10 ways. 11 Q. I see. So you mentioned earlier the strategic body that 12 came about in 2012 that was involved in setting 13 strategies. Might it be the case that that body would 14 come up with an idea as to what trial could be done, 15 based, for example, on the expertise within the 16 university, emerging social needs to know about 17 a disease or something like that, could that, in theory, 18 be a source of how a clinical trial comes into being? 19 A. Not the body in itself. The body sets the direction and 20 the institute, but it is the individuals within that 21 body who then look and seek -- it's like most other 22 things that we do, as an academic -- and I'm a research 23 academic, I will then seek -- I will have various ideas 24 that I'd like to test and I have to prove that those 25 hypotheses are valid and so I would normally go to Page 44

1 a grant body and seek funding for that. And that grant 2 body, when I put in an application, particularly 3 anything that involves studies involving humans -- 4 these days almost all studies, in reality, I would have 5 to submit a grant which details how I would go about 6 doing it but also how I would ensure patient safety 7 throughout that process. And also what guidelines and 8 regulations I would be following because I have to sign 9 off to that and take responsibility for that in the 10 trial itself. 11 Q. Thank you. So we've talked about the process of the 12 concept coming up and being worked through and then the 13 requirement to put in a bid for some sort of body, be it 14 a company or a government body to provide funding for 15 it. 16 A. Yes. 17 Q. You've mentioned, on a couple of occasions, the ethical 18 requirements associated with clinical research and that 19 there are bodies, including the GMC and others, that 20 regulate that at a high level. We've seen mention in 21 some of the paperwork of ethics committees. 22 A. Yes. 23 Q. In the specific context we're looking at here, if 24 I could talk about the pre- and post-2010 period. My 25 understanding is that proposals for clinical trials of Page 45	1 people from within Tayside about this, but to understand 2 it from your perspective as a research academic, those 3 committees sitting within NHS Tayside, they are 4 a committee within the structure of the board, is that 5 right? 6 A. There are a committee within the structure of the health 7 board, yes. 8 Q. Yes, and what sort of individuals would be appointed to 9 that, would that be medics or non-medics or 10 a combination? 11 A. A combination. You will have medical staff who chair 12 and lead those committees. You will have staff involved 13 in regulatory activities on those committees and you 14 also have members of the lay public involved in those 15 committees. 16 Q. On the subject of funding, it has been suggested to us, 17 I think reasonably from people with apprehensions about 18 Mr Eljamel's practice, that it is possible that 19 an important component of the way that he was able to 20 conduct himself in his various roles was that that way 21 of behaving was influenced by the fact that he was 22 bringing into some entity, to the health board or the 23 university or both, a large amount of money from 24 external bodies. I wondered if you could tell us, in 25 broad terms, how -- is it possible for a university or Page 47
1 the nature that we've been discussing would have to go 2 through some sort of local ethical committee or 3 approval. If that is correct, where would those ethical 4 bodies sit? Would they sit within the university, would 5 they sit within the NHS Tayside or the hospital or both? 6 How would that have worked over this period? 7 A. No, the ethical committee for clinical trials would 8 always sit within -- at that time, within NHS R&D. It 9 has to go through the NHS because it involves any 10 activity related to people and patients within 11 NHS Tayside. That has changed over the years and now 12 you can go to ethical committees that are based not 13 necessarily within the health board, they may be based 14 for instance in Lothian and other areas. And these have 15 always evolved and changed over time in the ethic 16 submission process has, of course, changed evolved over 17 time as the greater need for regulation or further 18 regulation -- and new guidelines have been developed. 19 Q. And would the approval of that committee, within 20 NHS Tayside for example, have been required in the 21 pre-2010 period for research that was on the university 22 side, if I can put it that way? 23 A. Oh, absolutely. You cannot conduct a trial without 24 ethical approval. 25 Q. And just to understand -- we may get more evidence from Page 46	1 a health board in connection with clinical trials to 2 receive a lot of money from external bodies or not? 3 A. In general, the university makes a loss on research and 4 always has made a loss on research. We are required to 5 support our research programme through income from 6 teaching. The nature of funding in the UK as a whole 7 means that research covers on average about 69% of its 8 cost, but the universities have always made a decision 9 that research is important to them and part of their 10 mission and therefore we support it. But research does 11 not make a profit to the university at all. 12 Q. Does that -- is that comment valid irrespective of the 13 funding model? 14 A. Some funding models do bring some what we would call 15 "surplus" and they are usually industry-funded research 16 that brings in more money than, say, MRC or 17 charity-funded research, but you really look at the 18 whole portfolio of activities. And overall research is 19 loss-making. 20 Q. Right, so if, I think reasonably, people have 21 a perception, who aren't involved in any of these 22 systems or perhaps patients of Mr Eljamel, that research 23 in which he was involved may have involved a large 24 amount of money coming into the health board or the 25 university, your position is that that would be very Page 48

1 unlikely? 2 A. Yes, and I can completely understand the position of -- 3 and why they should feel that way, it makes sense to me. 4 But the reason that we set up and have bodies like 5 ethical committees and regulatory groups like MHRA, the 6 money therefore is irrelevant. What is most relevant is 7 safety and how that trial is conducted. 8 Q. Thank you. And so if it were to be suggested that, as 9 I said earlier, we talked about the regulatory routes or 10 the oversight routes, depending on someone's employment 11 which is relevant to the evidence that you're giving, 12 but if it were suggested that Mr Eljamel was in some way 13 able to behave in any way he wanted or get away with 14 things that perhaps other people might not because of 15 the amount of research funding he was bringing into the 16 university and/or NHS Tayside, you think -- I think 17 based on your opinion, that that would be highly 18 unlikely? 19 A. I think it would be highly unlikely, yes. It should not 20 and cannot influence how a trial is conducted in any -- 21 Q. Yes, well, it's not really so much whether it influences 22 how a trial is conducted, it's whether the 23 availability -- first of all, I think you're saying it's 24 very unlikely that these trials would make a lot of 25 money; is that right? Page 49	1 designed to try to improve medical facilities and 2 improve overall health of the nation, I suppose? 3 A. Yes, absolutely. 4 Q. Thank you. One of the phrases that comes up a lot in 5 the documentation is that Ninewells Hospital is 6 "a teaching hospital"? 7 A. Yes. 8 Q. I wonder if you can explain what that is? 9 A. A teaching hospital is essentially one -- it's a large 10 secondary hospital that teaches medical students. 11 Q. So not all hospitals are like that but some are set up 12 to try to facilitate teaching in that way? 13 A. Almost all hospitals will be involved in the teaching of 14 medical schools but for some, it's a major aspect of 15 their activities. And in Ninewells, the medical school 16 is based within the hospital and as such, it is a very 17 important component of what it does. 18 Q. The medical school is physically in the hospital 19 building, is that right? 20 A. Yes, it is. 21 Q. There's a passage where you -- I have to just try to get 22 the local geography, if I could, from you. There's 23 a passage, I think, where you're talking about one of 24 the contributors to the statement and where she was 25 based. At one stage I think it says she moved into the Page 51
1 A. Sorry? 2 Q. You think it's highly unlikely that any of these trials 3 would be making the university or NHS Tayside a lot of 4 money; is that correct? 5 A. Oh, highly -- very unlikely. 6 Q. So therefore, the hypothesis fails on that basis. 7 A. Yes. 8 Q. But I'm also interested in the extent to which, given 9 your understanding, you have been a non-executive 10 director of the board as well as your experience within 11 the university structures, the suggestion that even if 12 that hypothesis were true, that a lot of money were 13 coming in, that that would in some way override the 14 oversight functions such that a consultant would be able 15 to behave any way he wanted. How likely do you think 16 that is? 17 A. I think that is very -- extremely unlikely. I do not 18 think those individuals responsible for that regulation 19 would allow that to affect their judgment. 20 Q. Yes, and I think an important component of that, 21 I think, in the evidence you've given -- please correct 22 me if I'm wrong -- is research and those involved in 23 research have a certain motivation behind them and 24 I think this is certainly what you said the university's 25 position is, research is not done to make money, it's Page 50	1 hospital from a central campus somewhere else. Does the 2 university have -- is it the medical school that's in 3 the hospital but the university has a campus for its 4 other teaching somewhere else? 5 A. Oh, yes, that is correct. In fact, there are only two 6 medical schools in the United Kingdom where the medical 7 school is based within the hospital. Ninewells is one 8 and Queen Mary's in London is the other. 9 Q. Thank you. You were asked a number of questions 10 about -- we've talked about this to a certain extent 11 already -- the extent to which someone working in the 12 capacity that Mr Eljamel was working would have 13 oversight and we've talked about the employment 14 relationship being important to that. We'll get into 15 the details of it in due course, but could you just tell 16 us, broadly speaking, the positions that Mr Eljamel 17 occupied were, I think exclusively, honorary positions, 18 is that right? 19 A. Yes, they were. 20 Q. Can you tell us, broadly speaking, what an honorary 21 position is and if you could, as you go along, tell us 22 why it's deemed important that there should be honorary 23 positions of that nature? 24 A. So an honorary member of the university is someone who 25 is not employed by the university but is given Page 52

1 a certain -- well, is allowed access to things like 2 emails and to the IT systems. And the reason that it 3 is -- and there are many, many honorary people. Almost 4 all NHS consultants in the hospital would be honorary 5 staff and that is because in order for them to teach 6 medical students, they need to be able to access 7 university systems. Because the university system and 8 the NHS IT systems are two separate entities. And the 9 NHS one, not surprisingly, is a very closed system 10 because it contains confidential patient data. And 11 therefore, the university also has its own system in place. 12 So for an NHS consultant to teach, to be able to give 13 lectures, to be able to fill in the forms that students 14 are required to complete they need to access our 15 university systems. And most teaching of medical 16 students outwith the very early years is in the clinical 17 environment. 18 Q. We'll get on to the details of that in a moment. What 19 you mean by "the clinical environment" is on-the-job 20 training? 21 A. On-the-job training, yes. 22 Q. As opposed to what we might be more familiar with, 23 lecturers or tutorials or something like that? 24 A. Absolutely. Dundee is a doctors from day one. It's 25 a very clinical training from very, very early on. Page 53	1 A. Sorry, apologies. Yes, it is the employer, yes. 2 Q. So just to understand this because this is quite 3 an important distinction, as I understand it. 4 A. Yes. 5 Q. A clinical academic would be someone like you who is 6 employed by the university but carries out clinical 7 functions in the hospital, is that right? 8 A. Exactly, yes. 9 Q. And as we've said already, your main responsibility and 10 the main responsibility provided to you is by your 11 employer which is the University of Dundee, yes? 12 A. Yes. 13 Q. Whereas in an honorary position, the system is almost 14 the other way around, the person is primarily employed 15 by the health board, yes? 16 A. Yes. 17 Q. And although they have a function within the university 18 which requires them to access the systems, the IT 19 systems and other people who work within the university, 20 they are primarily responsible to the health board and 21 their role is limited in that way; is that correct? 22 A. Yes, that is correct. 23 Q. So they are, I suppose, providing services to the 24 university but they're not employed by the university? 25 A. Yes. Page 55
1 Other medical schools are slightly different, but all of 2 them ultimately end up with the final years in clinical 3 practice where you are effectively on the wards, in 4 clinics, working in a non -- well, you can't prescribe, 5 you cannot order investigations, but you're working in 6 some capacity within those wards and learning about what 7 it is to be a doctor. 8 Q. Okay, so that's honorary positions. 9 A. Yes. 10 Q. Again, we'll go through it in a moment the various 11 different ones and the process through them. There's 12 another expression which is used frequently in the 13 statement and other documentation, that's "a clinical 14 academic"? 15 A. Yes. 16 Q. What does that mean? 17 A. That is different. There, the university is the major 18 employee. The number are far fewer. About 3% of all 19 hospital doctors, or all doctors in the UK, are clinical 20 academics. They are people like myself who spend most 21 of their time within the university and pursue 22 an academic or a scholarly career but also work within 23 the NHS because we are trained as clinicians. 24 Q. You said that the university was the main employee but 25 I think you meant was the main employer, is that right? Page 54	1 THE CHAIR: Does that also extend to their pay, at the risk 2 of reducing it to something like that? So in other 3 words, if you are employed by the NHS but occupy 4 an honorary position you are teaching but in the context 5 of being paid by the NHS in your capacity as an NHS 6 doctor? Conversely, somebody who is a clinical academic 7 is paid by the academic is paid by the university but 8 may have to conduct work for the NHS as part of that? 9 A. Yes, an honorary position is an unpaid position. 10 THE CHAIR: As the name suggests. 11 A. Yes, but you're not remunerated by the university for 12 the work that you do. 13 MR DAWSON: Is it the case, given the fact that Ninewells is 14 a teaching hospital, that doctors who sign a contract to 15 work in the hospital are expected to teach? 16 A. Yes. 17 Q. Is that all doctors? 18 A. All doctors are expected to teach and that is part of 19 the -- so all doctors are given a certain amount of time 20 for teaching. And that can be at postgraduate as well 21 as undergraduate level, so it doesn't necessarily mean 22 they that teach on the undergraduate programme because 23 they will have trainees within their specialty area as 24 well that come through, but part of that is training. 25 Q. There's an important feature there that you were asked Page 56

1 about in your statement which is to do with arrangements 2 around time to be spent within teaching side of the 3 operation, if I can put it that way. I think it's clear 4 from the statement that given these arrangements that 5 we're discussing, if someone was primarily employed, 6 like Mr Eljamel, by the board working in the hospital 7 but providing teaching services to the university, the 8 arrangements as to how much time would be spent on that 9 teaching activity would be a matter between Mr Eljamel 10 and the health board; is that correct? 11 A. Yes. 12 Q. So although -- 13 A. And the clinical lead, usually. 14 Q. So although it would be the case, I think from the 15 statement, that there would be someone within the 16 university who would be in charge of co-ordinating the 17 particular courses on which Mr Eljamel might have taught 18 and therefore would allocate work to them, saying: you 19 need to do this lecture or have this group with you when 20 you're doing your clinical operations, the amount of 21 time out of the total time devoted to the health board's 22 activities under the contract would include a provision 23 for a certain amount of teaching to be done; is that 24 right? 25 A. Yes. There is the block. Let's say you're involved in Page 57	1 a particular interest in research and will devote 2 a certain amount of time to that? 3 A. Yes. 4 Q. But that wouldn't be an expectation for which 5 a provision would be made in their consultant contract? 6 A. No, it wouldn't. 7 MR DAWSON: Right, that would be a convenient moment. 8 THE CHAIR: We'll take a 15-minute break now, as we normally 9 do at about this time in the morning. To keep matters 10 regular, we do ask witnesses not to discuss their 11 evidence during the breaks and we will aim to sit again 12 just before half past the hour. 13 A. Okay, thank you. 14 (11.13 am) 15 (A short break) 16 (11.31 am) 17 THE CHAIR: Thank you, we're ready to resume. Mr Dawson. 18 MR DAWSON: Professor, we were discussing, before the short 19 break, the roles -- respective roles of people who have 20 honorary roles, who are medics within the hospital, and 21 who are clinical academics and those being different 22 roles and there being different implications associated 23 with them. 24 We asked you some questions -- we asked the 25 university some questions about rules relating to Page 59
1 neurology and neurosurgery, in this case, would have 2 a lead for that block. And they would actually 3 timetable what needs to be done within that block to 4 deliver to the students. So the university would -- and 5 that usually is carried on from year to year. And 6 obviously whoever is running that block then is 7 responsible for filling up that timetable and almost 8 everyone contributes. 9 Q. Given your extensive responsibilities in the past for 10 research, would there also be a component required of 11 individuals, doctors working within the hospital to 12 devote a certain amount of time to research, or would 13 that depend on the individual? 14 A. That entirely depends on the individual. There is no 15 obligation to research within the NHS. 16 Q. So some -- even within a teaching hospital? 17 A. Even within a teaching hospital. 18 Q. So the requirement is to offer some level of teaching and 19 there will be varying degree what people would do, 20 I would imagine? 21 A. Varying degree and little, actually. You do not see 22 much research coming out of the NHS consultant 23 physicians any more. You used to, but you don't any 24 more. 25 Q. So some consultants, some physicians or surgeons have Page 58	1 sharing information, in particular in relation to 2 situations in which there were concerns about the way in 3 which an individual was conducting him or herself and 4 you've provided to us quite a lot of information about 5 that. If I could start off, you tell us that there was 6 a memorandum of understanding, I think, entered into 7 relatively recently in 2023, between the university and 8 NHS Tayside relating, perhaps amongst other things, to 9 this particular subject. Could you tell us, please, 10 based on your understanding of the way the memorandum 11 works, as to how the provisions of the memorandum 12 changed the situation relating to information sharing 13 about individuals who fall into the categories that I've 14 discussed? Both categories, I should say, both clinical 15 academics and honorary appointees? 16 A. Yes, and I think, on reflection, and certainly looking 17 at this case, I think what that memorandum of 18 understanding deals with is how we manage the clinical 19 academic based on the Follett Principles. And the 20 clinical academic is, of course, the university employed 21 clinician who has an honorary capacity within Tayside. 22 I think, and I personally believe, that that memorandum 23 of understanding is less clear on NHS staff who have 24 an honorary position within the university itself and 25 I think that is something that requires further work. Page 60

1 Q. So a number of different aspects of that I'd like to 2 unpack. First of all, you mentioned Follett Principles. 3 Could you tell us what that means? 4 A. The Follett Principles, I don't have the date on the top 5 of my head, but they've been around for many, many years 6 now, following an Inquiry in England, literally 7 two decades ago, that generated a sense of principles 8 whereby how you would manage university employed 9 clinicians who worked within the NHS. Namely, that they 10 were to have honorary access to ensure that they could 11 practice, but also there was a memorandum of 12 understanding between the university and the health 13 board that related to the governance and the behaviour 14 and different aspects of those individuals, so it was 15 clarity of processes. 16 Q. Okay. So the Follett Principles are principles that 17 underpin effectively, amongst other things, information 18 sharing between an academic organisation and a hospital? 19 A. Exactly. 20 Q. But relating to clinical academics who are the ones who 21 are employed principally by the university? 22 A. Yes. 23 THE CHAIR: Just to be clear, I'm sure it's obvious, this 24 memorandum was entered into between NHS Tayside and the 25 university? Page 61	1 that case and investigate it, obviously. 2 Q. So when you say an issue had arisen, broadly speaking, 3 what sort of thing are we talking about? 4 A. If a clinician, in some aspect of their duty, had done 5 something that was unprofessional, a clinical 6 malpractice that related to their clinical activities as 7 opposed to their university activities, it would be very 8 important that the university are alerted to that 9 straight away and that any investigation involves both 10 the NHS and the university. But it just also relates to 11 this general principle of having people within the 12 hospital who are not employed by the NHS but work within 13 the NHS. So it's laying out those rules of how you -- 14 governance and how you manage those individuals and what 15 are the basic principles behind that. 16 Q. And it's important, I think, that both organisations 17 would be involved in trying to resolve that situation? 18 A. Yes. 19 Q. Because the university would be the principal employer? 20 A. Yes. 21 Q. And have certain legal obligations as a result of that? 22 A. Yes, absolutely. 23 Q. But from the hospital side, they would be able to bring 24 information about what had happened and obviously they 25 would have a concern about the regulation of that person Page 63
1 A. Yes, it was, yes. 2 MR DAWSON: And on reflection, I think you've said that the 3 position of people who are in the opposite situation, if 4 you like, who are employed by the health board but 5 provide services to the university isn't sufficiently 6 clearly covered, do you think? 7 A. In my opinion, no, and I add that into my witness 8 statement towards the end. I think it's an area that we 9 need to work on and formalise in a way that it isn't. 10 Q. So if we just focus on the clinical academics first. To 11 be clear for those listening, this was not the position 12 of Mr Eljamel, but it would be the position of someone 13 like yourself? 14 A. Yes, it would be. 15 Q. So far as the clinical academic position is concerned, 16 could you tell us what the principles were about sharing 17 information between the two organisations before and 18 after the memorandum of understanding? 19 A. The principles have been there all the time. The 20 memorandum of understanding formalised that process but 21 the expectation would always be that if an issue had 22 been raised about a clinical academic in relation to 23 clinical practice, NHS Tayside would inform the 24 university about that straight away and that we would 25 have discussions about how best to deal with and manage Page 62	1 continuing to work within the hospital in certain 2 circumstances? 3 A. Absolutely. 4 Q. So if we then look at it in the opposite situation, is 5 it the case that there are any provisions in the 6 memorandum of understanding that cover the honorary 7 situation, that's a situation where the person is 8 principally employed by the health board but offer 9 services to the university? 10 A. I do not think it sufficiently covers that situation at 11 the moment, it's focused largely on clinical academics. 12 Q. I think your position is that you think that it would be 13 a good idea for the organisations to look at the 14 formalisation of the regulation -- 15 A. Yes, that is my position. 16 Q. Yes, without wishing to be critical, it isn't in the 17 memorandum of understanding just now, why is it 18 important for people in that sort of position that they 19 too should be subject to these formalised information 20 sharing rules? 21 A. I think that we obviously have a duty to all the people 22 involved in university activities. They include our 23 students who would be clearly exposed to those 24 individuals in their clinical practice. If those 25 individuals are conducting research or anything else Page 64

1 that involves the university, and therefore we can 2 provide the information the NHS might need, in order to 3 manage that case and to properly investigate that case. 4 Q. So it might be there's really an equivalent situation 5 but the information may arise in different ways. So for 6 example, if, for example, completely hypothetically, if 7 a medic were delivering teaching within the university 8 building but was doing so in a way that in some way was 9 rude or aggressive or something like that, that could be 10 something that could be brought to the attention of the 11 principal employer, by the university, is that right? 12 A. Yes, yes. 13 Q. And equally, in the non-teaching field but in the 14 research side, if it came to the attention of the TASC 15 body that somebody was conducting research in a way 16 which was in some way unethical or was dangerous, then 17 that too would be information that might be available to 18 people within the university that could then be shared 19 with the principal employer or the NHS board; is that 20 correct? 21 A. Yes. 22 Q. So the same sort of principles you think should apply 23 whether one is looking from one perspective or the 24 other, is that right? 25 A. Yes. Page 65	1 A. Yes. Well, I cannot comment about what happened prior 2 to my time. What I can say is that in my experience, 3 then as soon as there's an issue with an honorary member 4 of staff, the medical director has contacted me about it 5 and let me know about it straight away. So I have been 6 kept informed, it's just not been a formalised process. 7 Q. Yes, so it's just the lack of formality of those 8 principles? 9 A. That's all, yes. No, my experience has been a very 10 positive one and that that the medical director has 11 always been in touch with me when there's been an issue. 12 Q. Because I think we know, in the circumstances of 13 Mr Eljamel's case, it really depends on how you define 14 an issue because we know, from the documentation, that 15 some information was provided to the university through 16 a route that we will discuss perhaps with 17 Professor Connell this afternoon about issues that have 18 arisen with Mr Eljamel. But we know I think, from the 19 documentation available, that, for example, the fact 20 that there had been, in 2011, a number of complaints by 21 patients of Mr Eljamel, including allegations of 22 wrong-site surgery, there's no evidence that that was 23 communicated to the university; is that correct? 24 A. No, there is no evidence that it was communicated -- 25 Q. And equally, when, as we understand it, Page 67
1 Q. What about situations in which matters arise during the 2 course of someone's principal employment -- so this 3 would be imagining a consultant working in the hospital, 4 the hospital finds out things that are going wrong, 5 there are issues with the way in which they're 6 conducting their clinical practice -- in situations 7 where they have an honorary appointment, do you think 8 that the university should be told about that, even if 9 the matters which have arisen don't pertain directly to 10 the activities they're undertaking for the university? 11 A. In my opinion, I think in the interest of sharing 12 information between staff, given that we're so 13 intertwined, I think that is what should happen, yes. 14 I think that's in the best interests of everyone. 15 Q. Thank you. And as far as -- as that relationship is not 16 covered by the MOU, one doesn't find the answer there, 17 but I think one falls back, perhaps, on what standard 18 practice might be in those sorts of circumstances, 19 putting to one side what should happen in your view 20 which you have helpfully expressed, as regards what you 21 think would happen, in what circumstances, in the 22 hypothesis I put, at what level would the concern about 23 the consultant have to reach in your understanding of 24 standard practice for that to be communicated to the 25 university? Page 66	1 four further complaints, including similar allegations 2 arose in 2012 there's no evidence that that was 3 communicated to the university? 4 A. Yes. That is correct. 5 Q. And in 2013 we know -- we've covered this with another 6 witness already -- we know that a further eight 7 complaints of a similar nature and a broader nature, in 8 fact, arose. And those complaints in 2013 weren't 9 communicated when they arose to the university? 10 A. No, they were not. 11 Q. Indeed, we've heard detailed evidence from a professor 12 on behalf of the Royal College of Surgeons of England 13 who was the head of what they called their Invited 14 Review Mechanism that NHS Tayside instigated, in around 15 the middle of 2013, an invited review of Mr Eljamel's 16 practice and that wasn't intimated on the documentation 17 to the university either, was it? 18 A. No, it was not. 19 Q. I think the position is that it was only quite a bit 20 later that there was -- in fact in 2014, that the 21 intimation came to the university; is that correct? 22 A. That is correct, yes. 23 Q. Thank you. We'll get into the details of that in due 24 course, but that's very helpful. Just on that broad 25 topic, moving into the specifics of appraisals rather Page 68

1 than the generality of oversight of individuals who fall 2 into these various different categories, as far as 3 someone who holds an honorary position is concerned, if 4 there are appraisals taking place of, say, a consultant 5 surgeon would the university expect to be involved in 6 those appraisals? 7 A. No, it would not. 8 Q. Why is that? 9 A. The individual is employed by the NHS; they're 10 their employee. The university appraises individuals 11 that it employs and occasionally -- not occasionally, 12 mostly will employ individuals who are funded through 13 ACT, which is a situation that further complicates the 14 issue -- 15 Q. We'll get on to that in a second. 16 A. Yes. 17 Q. So the reason I ask that question, professor, is that 18 we've heard some evidence about a role called the 19 "responsible officer" with which you'll be familiar, 20 I think? 21 A. Yes. 22 Q. And the responsible officer is, amongst other things, in 23 charge of, as I understand it, conducting appraisals of 24 doctors who are regulated by the GMC, is that right? 25 A. Yes, that is correct. Page 69	1 teaching of students and have a responsibility to 2 education, I would hope that some aspect of that was in 3 your appraisal. 4 Q. But there's not a formal requirement for it to be? 5 A. There's no formal requirement for it. 6 Q. And there's not a formal requirement for aspects of 7 research to be in it either? 8 A. It's not a formal requirement, no. 9 Q. Thank you very much. So to get on to the complication 10 which you mentioned a moment ago, there are some 11 individuals, clinical academic staff who conduct 12 research which is funded through something called 13 Additional Cost of Teaching, ACT. Could you tell us 14 what that is and why, for the reasons -- in the 15 territory we've been discussing, that is unfortunately 16 another complication? 17 A. Yes, this is somewhat unique to Scotland. Additional 18 funding for teaching is provided by Scottish Government 19 to health boards to -- for clinical teaching of medical 20 students in practice. That funding is controlled 21 largely through what is now called PSDS, or was called 22 National Education Scotland, now is called Public 23 Services Delivery Scotland -- it has been structured -- 24 working with a local ACT committee, which is a joint 25 committee, between university and NHS colleges, usually Page 71
1 Q. And that that system came into being, I think in around 2 2012, is that right? 3 A. Yes. 4 Q. And in accordance with those responsibilities, we heard 5 some evidence yesterday from a consultant who works 6 within the private sphere who explained to us that there 7 would be a responsibility where a consultant worked 8 predominantly at an NHS hospital, and from time to time 9 at a private hospital, that the responsibility of the 10 responsible officer towards that individual would lie 11 with the NHS hospital, but that appraisals and 12 consideration of that individual's practice would also 13 require to consider aspects of their private practice? 14 A. Yes, I think that would be fair, absolutely. 15 Q. Thank you. In that regard, given the fact that the 16 responsible officer requires to cast a wider net than 17 simply what goes on under his direct responsibility, 18 should it be the case, do you think, that activities 19 closely intertwined with consultant work, as you've 20 described it, but which are services performed to the 21 university or via the university, such as research or 22 teaching, should also be included in the responsible 23 officer appraisal? I think you've said as a matter of 24 fact it would not be, but do you think it should be? 25 A. In my opinion, if you're involved at some level in Page 70	1 the director of medical education, who then allocate 2 funding to clinicians, called ACT. It's one session, 3 like a 4-hour session. And these individuals usually 4 have a greater responsibility for teaching within the 5 curriculum. They take on leadership roles in teaching 6 and various other aspects. And they're ACT-funded and 7 the challenge there is that we can appraise and we can 8 review ACT-funded staff, but they're still not employed 9 by the university because actually their funding is from 10 NHS Education Scotland. 11 Q. So in that unusual circumstance, because of the 12 particular funding arrangements, I understand the 13 position would be that the Dundee University would have 14 a role in the appraisal, is that -- 15 A. We certainly have more of a role within the appraisal 16 process itself, it's not a formalised process. 17 Q. That might logically be justified that that person 18 effectively spends more time in the university than the 19 average consultant; is that right? 20 A. Yes, that is correct. 21 Q. Yes, and there are funding reasons as well behind it all 22 as to why the university needs to be involved in making 23 sure that, I suppose, the money is being well spent; is 24 that right? 25 A. Both the university and, at that time, National Page 72

1 Education Scotland and the health board will want to 2 make sure that the money was being spent appropriately 3 because the money can only be spent on the delivery of 4 teaching and therefore you have to really ensure that 5 that money, which is public money, is appropriately 6 spent. 7 Q. Yes. You mentioned that being a system that's unique to 8 the Scottish system. Did that exist at the time 9 Mr Eljamel was around, or is that an innovation since 10 then? 11 A. No, that existed at the time Mr Eljamel was around, yes. 12 Q. It existed then, but is there any evidence that he was 13 an ACT-funded -- 14 A. No, he was not ACT-funded. 15 Q. He was not. So he was not a clinical academic, correct? 16 A. No. 17 Q. He was not ACT-funded, correct? 18 A. No, he was not ACT-funded. 19 Q. And he held various honorary roles, as we have 20 discussed? 21 A. Yes. 22 Q. Can I just ask you, in general terms, we've already 23 discussed that he was not a member of the staff of 24 Dundee University; is that correct? 25 A. That is correct. Page 73	1 to have a scan card, a university card to get into. But 2 he, as a university employee could have accessed them and 3 been given a scanned card, but I'm not aware that he had 4 one. 5 Q. Right, because in the role -- for example, he might have 6 had to go in and deliver a lecture or something like 7 that occasionally? 8 A. Yes, but the lectures are open, the public can come into 9 the lecture. 10 Q. Those parts of the university medical school that he 11 would have had to access were not within those limited 12 areas for which -- 13 A. No, they are not. Most of those limited 14 areas are because there are laboratories there. 15 Q. Okay. I think you tell us in the statement that your 16 colleagues and yourself have managed to work out that he 17 held various different roles. The first being the role 18 of honorary senior lecturer which he held, we think, 19 between 18 December 1995 and 2009; is that correct? 20 A. Yes, that is correct. 21 Q. There is a role, I think, in the hierarchy below that, 22 this is honorary lecturer, is that right? 23 A. Yes, that is correct. 24 Q. Why would someone be given -- because that's roughly 25 coincidental with when started his consultant post Page 75
1 Q. And that his work there, his access, if you like the key 2 to getting into Dundee University was through him 3 holding various honorary positions? 4 A. Yes, that's correct. 5 Q. Did he have an office in the university? 6 A. Not as far as I'm aware, no. 7 Q. What facilities within the university would he have been 8 able to avail himself of? 9 A. An email address. He would have been able to access the 10 university systems. In terms of teaching delivery, we 11 use a system called Blackboard and previously one called 12 Moodle which would have helped in terms of lecture 13 delivery at times. And I believe they also were given 14 staff membership of the sports facility. 15 Q. Right. Would he have been able to come and go between 16 the university side of the building, if you like, and 17 the hospital side of the building, as he saw fit? 18 A. Oh, yes. There are no barriers between them. 19 Q. Yes, but would anyone be -- 20 THE CHAIR: The library as well? 21 A. Yes, the library as well, sorry. Yes, absolutely, the 22 library as well. 23 MR DAWSON: Would anyone be able to do that, in effect? 24 A. Yes, pretty much. There are aspects of the medical 25 school that are closed off to the public, where you have Page 74	1 in October that year. 2 A. Yes. 3 Q. Why would he be given the role of senior lecturer as 4 opposed to lecturer? 5 A. Traditionally, lecturers were pre-registration -- well, 6 they were registrars, they were specialty trainees 7 rather than hospital consultants. This arose out of 8 many years from tradition because most hospital 9 consultants had a higher degree and therefore, when they 10 became consultants it was felt, by virtue of their 11 experience and the fact that they had a higher degree as 12 well as their undergraduate degree, that they 13 automatically became senior lecturers. 14 Q. And I think you tell us in your statement that that -- 15 although there was a certain process that was gone 16 through and he was signed off, that that would be 17 an automatic appointment? 18 A. That would be automatic. 19 Q. And that is connected, I think, to the discussion we had 20 earlier about the fact that it's a teaching hospital and 21 people would be expected to teach and they are given 22 a teaching role automatically within they're 23 a consultant, is that right? 24 A. Yes. 25 Q. And indeed, people who are lower down the training Page 76

1 ladder, if you like, would also be teaching but 2 presumably, they would be given honorary lecturer posts, 3 is that right? 4 A. They would be honorary lecturers, yes. 5 Q. But as he was a consultant, as you've just explained, he 6 got the slightly higher position? 7 A. Yes. 8 Q. You've provided some documentation which gives us 9 information about the way in which that process 10 happened. But would there have been any requirement, at 11 that stage, for any of his qualifications to be checked? 12 A. He would have submitted a CV at that time and his -- to 13 some extent, his qualifications, having been appointed 14 as an NHS consultant, that in itself would be taken as 15 an appropriate qualification. But in order to 16 streamline the process, we obviously permitted these to 17 happen straight away really and they were just 18 automatically generated to everybody and then approved 19 it to the board. 20 Q. So the CV is submitted -- 21 A. Yes. 22 Q. -- and by whom is it considered? 23 A. It would be considered by the medical school board. 24 Q. I think there's something called the "Medical School 25 Executive Team" mentioned, would that -- Page 77	1 Q. I see. So if we're just dealing with the senior 2 lecturer role for a moment, would it be automatic? 3 A. Yes, mostly automatic, yes. 4 Q. Okay. And the -- I think there was also some support 5 required from the head of department, is that right? 6 A. Yes. 7 Q. And again, what's the point of that in circumstances 8 where the process is automatic? 9 A. It's a very valid point. 10 THE CHAIR: Could we just rewind a minute to Mr Dawson's 11 question about whether the aspects of the CV would be 12 verified. Should I understand, in this automatic 13 process that you described, that the CV would be 14 provided and considered but essentially, for information 15 purposes, rather than for the purposes of -- 16 A. Essentially for information purposes, yes. 17 THE CHAIR: Thank you. 18 MR DAWSON: Could we just have a look, please, at the 19 statement at paragraph 3.9. You give us some additional 20 information here about this particular post: 21 "The position of Honorary Senior Lecturer was 22 offered to NHS Tayside Consultants who were expected to 23 contribute to the education of the university's 24 undergraduate or postgraduate medical students or whose 25 research is in line with the Medical School's Research Page 79
1 A. That was a different -- slightly different name at the 2 time. It was called the medical leadership team. They 3 met once a month and they would have looked at 4 applications, they would have focused on all 5 applications but really focused on promotions more than 6 just standard applications. 7 Q. If this was an automatic position in which the 8 individual, having achieved the grade of consultant by 9 dint of having done that, have met the relevant criteria 10 for the post, what was the point of sending the CV? 11 A. It was so that they were all recorded and they went 12 through the school board and then the university senate. 13 Q. What's the role, then, of the senate? 14 A. The senate is to approve the decisions made within the 15 separate schools -- colleges and then schools and now 16 faculties. 17 Q. But in these circumstances that's a wholly automatic 18 process, is it? 19 A. Mostly, yes. 20 Q. When you say "mostly", in what circumstances might it 21 not be? 22 A. I think if something came to senate, particularly say, 23 a professorial role, where someone in senate was aware 24 of an issue, they would raise that issue. So it's not 25 automatic in that sense. Page 78	1 Strategy and which has resulted in regular output of 2 papers, co-supervision of students with university staff 3 or grant funding. The expected process to follow to 4 obtain such Honorary status included completing an 5 application form that included an abbreviated and a full 6 CV that was to be submitted to the relevant Associate 7 Dean. The Associate Dean will then obtain references 8 from the relevant Academic or Clinical Staff. 9 A statement of support must be provided by either the 10 Head of Division and/or the Associate Dean. The 11 application is then submitted to the Dean's Office for 12 tabling at the Medical School Executive Team ..." 13 So that's the details of the process we've just 14 discussed. The aspect I was interested in just 15 exploring with you was the part which says that there 16 would be a consultant whose research is in line with the 17 medical school's research strategy. Could you explain 18 a little bit about the thinking behind that? 19 A. Some of the consultants who apply for honorary status 20 will be more active in research, some more active in 21 teaching. There's different aspects of what we do. We 22 would expect that their research is aligned, broadly, to 23 what the medical school is trying to do within any given 24 time in an age or a focus. 25 Q. I see. So in many ways that's really a process of Page 80

1 trying to work to get the information, as the Chair 2 asked, from the CV and trying to work out: oh, that's 3 quite interesting because although it's an automatic 4 position, that person's research actually fits in with 5 the plan that we have in the strategy. So they maybe be 6 factually linked up with that? 7 A. Yes, absolutely. 8 Q. Understood. We then know from the statement that there 9 were two -- one after -- quite soon after the other, 10 I suppose I could call them promotions but changes in 11 the honorary position which Mr Eljamel held. The second 12 was that he was an honorary reader between 13 22 September 2009 and 19 October 2009. And then became 14 an honorary professor between 20 October 2009 and 15 31 May 2014. Is there any -- the honorary reader post, 16 which I'm assuming -- we're just going steps up here. 17 Is the honorary reader post being held for such a short 18 time of any significance, or is that -- what do you 19 think has happened there? 20 A. I'm really not sure what has happened there because 21 that's a very short time from honorary reader to 22 professor. And I am not sure what discussions were had 23 at the time. Normally, you would not expect to see such 24 a rapid change from national to international presence. 25 Q. Yes, I think just to step back as to how you're forming Page 81	1 relation to the possibility he may have held a role 2 entitled "Head of Department/Section for Surgical 3 Neurology" at the University of Dundee from around 1996. 4 If we could go over the page, please, to paragraph 9.1 5 you gave us a response about that. You said: 6 "The [University of Dundee] did not have any 7 involvement in the process leading to Mr Eljamel being 8 appointed in the positions set out at [paragraph] 9(a) 9 and 9(c) to (d); these were NHS appointments. In 10 relation to the role detailed at 9(b), the [University 11 of Dundee] can find no record of Mr Eljamel holding this 12 role save for reference in his CVs ..." 13 And you give reference to three CVs which the 14 university holds, and: 15 "Head of Department/Section roles at the [University 16 of Dundee] would always have been held by an employee of 17 the [University of Dundee]. During the relevant time 18 (1995-2014), to the best of our knowledge, there was a 19 Head of Academic Surgery who was Sir Alfred Cusheri. 20 Any neurology teaching would have sat within his 21 department." 22 So what you've been able to tell us, I think, is 23 that the university has access to three CVs in which 24 Mr Eljamel purports to have held the role I have just 25 referred to; is that correct? Page 83
1 this impression, you of course were not there at that 2 time, you don't know personally what was going on; is 3 that right? 4 A. Yes, that's correct. 5 Q. And you've helped us in trying to piece together what 6 documentation exists but also you've tried to involve 7 certain individuals within the university who you 8 thought might have some personal knowledge of what was 9 going on, is that right? 10 A. Yes, that is correct. 11 Q. I think, broadly speaking, those individuals did not 12 recall any of the details of this so your assessments 13 really are based on what paperwork you've been able to 14 find? 15 A. Yes, that is correct. 16 Q. Thank you very much. Could I have a look, please, at 17 page 22 of the statement. Down at the bottom, please. 18 We asked some questions there about information you 19 might have about the applications made by Mr Eljamel to 20 for various roles. The reason that these were set out 21 as they were, you told us that for three of these, these 22 wouldn't be roles that you would have any involvement in 23 within the university. But these are derived from the 24 Inquiry's Terms of Reference. But the one that does 25 relate to Dundee University is we asked you questions in Page 82	1 A. Yes. 2 Q. However, you have told me that, as far as the university 3 is concerned, there is no information to support the 4 assertion that he held such a role? 5 A. Yes, I'm afraid that is correct. 6 Q. And indeed, that although such a role is one that the 7 university recognises, that's a role which would have 8 been held over the entirety of the relevant period by 9 another named individual? 10 A. Yes. 11 Q. He lied on his CV, didn't he? 12 A. Yes, I'm afraid he did. 13 Q. Could I just ask you -- I have tried to piece the 14 numbers together. It gets quite complicated, but if one 15 looks at UNID-00023, if I could look -- if we could 16 look, please, at paragraph 14.2 of the statement. Just 17 to take this as an example. If we could go to -- zoom 18 in a bit, please, on that. This is a document I think 19 that -- you won't be aware of this, professor, but 20 a document we've seen before. If we could go to the 21 last page, please. It's a CV of Mr Eljamel, isn't that 22 right? Is that right, professor? 23 A. At the moment, I'm looking -- yes, it is a CV, yes. 24 Q. And if we could scroll further down to the bottom, 25 please. Just go back to the first page, please. The Page 84

1 document number you see in the top is "UNID-00023". 2 That's a document reference that's been given to it by 3 the Inquiry, do you see that? 4 A. Yes. 5 Q. Could we have up, please, paragraph 14.2 of the 6 statement. And you tell us here -- you give us 7 an explanation of what this CV is because it's got the 8 same document reference there. It says: 9 "The [University of Dundee] has located a CV that we 10 believe Mr Eljamel submitted to request an Honorary 11 Professor contract on 30 April 2009 [and the reference 12 is given] [UNID-00023]. The [University of Dundee] has 13 also located an email exchange between Neale Laker, 14 Clerk to Court, and Karen Smith Academic Affairs on 15 25 September 2009 which confirms that Mr Eljamel had 16 been approved by the Senior Management Team ('SMT') for 17 a new honorary professorship and requested that he be 18 added to the agenda for the next meeting of Senate on 19 14 October 2009 ..." 20 So the document we looked at before, as you 21 understand it, is the CV that Mr Eljamel submitted in 22 support of his application for an honorary 23 professorship, is that right? 24 A. Yes, that is correct. 25 Q. And we know, I think, from your research, that amongst Page 85	1 A. Yes, I am aware. 2 Q. Do you think that lying on your CV affects someone's 3 probity? 4 A. Absolutely. 5 Q. And is it an important consideration in determining, 6 even in an honorary professorship situation, whether 7 someone should meet good standards of probity to be able 8 to be given the role? 9 A. Yes, it is important to look at that, absolutely. 10 Q. Can we deduce from that then, based on this sequence of 11 events, that it must not have been realised within the 12 university that that false entry had been indicated on 13 the CV? 14 A. I can only assume that they have not recognised that and 15 not seen that aspect of it all. 16 Q. Despite the fact that the purported role was one which 17 Professor -- or, at that stage Mr Eljamel, claimed to 18 have held within the university itself? 19 A. Yes. 20 Q. Thank you. 21 THE CHAIR: Is it possible to locate, on the document 22 number 23, the entry which we're interested in? 23 I simply ask that because, of course, the position, as 24 matters stood as at April 2009, were that Mr Eljamel 25 was, however briefly, an honorary reader at that time, Page 87
1 the entries on that was the claim that he held the role 2 within the university of "Head of department/section for 3 surgical neurology" at the University of Dundee from 4 around 1996, which we know that he did not hold; is that 5 correct? 6 A. No, we can find no evidence that such a department 7 existed. 8 Q. You mentioned earlier that there would perhaps be 9 greater consideration given to the CV when one applied 10 for higher roles and you mention an honorary 11 professorship. If it were known that a consultant had 12 claimed to have held a position, an academic position 13 like that, and it were known that it were not accurate 14 at the time, would that have an effect on the, I think, 15 it's the board and then the senate's consideration of 16 the application? 17 A. It should have had an effect on the board because it 18 would attest to someone's professionalism. 19 Q. Yes. One of the words that we've heard come up which 20 you may recognise from your medical practice -- we've 21 certainly seen it in a surgical context -- which is one 22 that I think one of our witnesses said he had only seen 23 in professional documentation relating to medicine, was 24 the word "probity". Is that a word you're familiar 25 with? Page 86	1 which might -- and indeed, an honorary senior lecturer 2 not long before that, which might sit rather uneasily 3 with the proposition that he was the head of any 4 department, whether fictional or otherwise. But I just 5 wanted to see if we could locate that on the screen. 6 MR DAWSON: Could we go back to UNID-00023, please. 7 THE CHAIR: I think I saw it there. Go back up again. 8 I think it may even have been the very first entry. 9 Further up. Yes, that's it. 10 MR DAWSON: It's the top one. 11 THE CHAIR: Sorry. I think we saw it before, I just 12 wanted -- 13 MR DAWSON: Yes. Sorry, sir. I should have highlighted it. 14 THE CHAIR: Thank you. 15 MR DAWSON: I think from paragraph 9.1, the passage that 16 I just read out, you actually managed to locate two 17 other CVs in the records and they have document numbers 18 UNID-0028 and UNID-00143. I wasn't able, in my 19 research earlier this morning, to locate what those 20 had been used for, but if they feature in the university 21 records would it be safe to assume those were in 22 connection with other applications he may have been 23 making at a particular stage? 24 A. Yes, I would assume so. 25 Q. Thank you. So obviously we can check out the references Page 88

1 in due course but use that important one as 2 an illustration. Bear with me one second. (Pause). 3 Could we look at UNID-00028, please. This is one of the 4 documents that you refer to at 9.1, although it includes 5 something separate. Could we just zoom in on that first 6 page, please. We see this is a letter dated 7 29 October 2004, isn't it? 8 A. Yes, it is. 9 Q. And it is a letter to Professor Brian Burchell who was 10 the dean of the faculty of medicine at that time, is 11 that right? 12 A. Yes, he was. 13 Q. And can we just scroll down a little bit, please. It's 14 a letter from Mr Eljamel to him, is that right? 15 A. Yes, it is, yes. 16 Q. And just to contextualise this, this was before he had 17 had the short-lived promotion, if you like, but he was 18 still an honorary senior lecturer at this point, is that 19 right? 20 A. He was an honorary senior lecturer at the time he 21 submitted this letter. What I could not be clear from, 22 or we could not be clear from reading the 23 documentations, is whether he was promoted to reader at 24 this point in 2004 or whether it happened in 2009. The 25 documentation is not clear on that, which might explain Page 89	1 the last five years." 2 Did the research that you undertook suggest that the 3 cranial and spinal neurosurgery aspect of the training 4 was run in all of those years of the degree? 5 A. From the records that we've been able to obtain, there 6 would have been a brief period, mostly in year 4, where 7 there were some aspect of the curriculum involving it. 8 The student-selected components are a different aspect, 9 they're not a formalised part of the programme. In the 10 student-selected, it's exactly as it's named, students 11 select where they wish to go within the department in 12 order to gain more experience. 13 Q. So kind of electives or something? 14 A. It's like an elective period, yes. 15 Q. So, I just wanted to check that because I think, as you 16 said, it was delivered more regularly in year 4, from 17 the research that you undertook; is that right? 18 A. The neurosurgery and neurology block was delivered more 19 regularly in year 4 and the time committed to wards and 20 attachments was in year 4. 21 Q. I see. So is it possible that that is correct? 22 A. It is possible, yes. 23 Q. Okay: 24 "I have also been a member of the Medical Admissions 25 Committee with its mammoth task of selecting and Page 91
1 that one-month period because that's very unusual. 2 Q. Yes, well, let's have a look at this. It says: 3 "I enclose my Curriculum Vitae for your review. 4 I have been an Honorary Senior Lecturer at the Medical 5 School for the last nine years and I have been actively 6 participating in local and multi-centre international 7 research to keep the Institution on the National and 8 International map in the field of Neurosurgery." 9 Do you think that that's a fair description of what 10 any individual could be doing within the work he had 11 been undertaking? 12 A. Not his work, but it's a description of what individuals 13 might be doing within the NHS, but not the work that's 14 presented in his CV. 15 Q. I see. So someone might do that but that's perhaps 16 a slightly over-blown explanation as to what he had, in 17 fact, been doing? 18 A. Yes. 19 Q. As you have looked at all the material? 20 A. I have looked at all the CVs and I don't see any 21 international component as well. 22 Q. Okay, thank you. Also, it says: 23 "I have also been running student selected 24 components of the new curriculum running the Cranial and 25 Spinal Neurosurgery programme for Years 3, 4 and 5 over Page 90	1 developing selection criteria for the appropriate future 2 doctors. I have also participated as an internal 3 examiner in the new curriculum and have reviewed many 4 portfolios on top of my clinical and post-graduate 5 commitments in service and training. 6 "I would be very grateful if you could look at my CV 7 and if you feel it is appropriate to put it through ... 8 the Promotional Committee for consideration." 9 So this is him applying to the dean for a possible 10 honorary promotion, is that right? Is that what it 11 seems that it is? 12 A. Yes. 13 Q. So this is why you told us earlier that it's possible 14 that this could have been him applying for the next 15 grade up, which was to honorary reader, is that right? 16 A. Yes. 17 Q. But that appears to be inconsistent with other evidence 18 that suggests he, in fact, got that in 2009? 19 A. Yes, we've been unable to really clarify the process of 20 that. 21 Q. Yes, because apart from this information and of course 22 the attached CV, we don't have the documentation 23 relating to how this application was determined; is that 24 right? 25 A. Yes. Page 92

1 Q. So it's possible that he applied at this stage and was 2 refused, is that right? 3 A. It is possible, yes. 4 Q. Because other evidence suggests he may have been, in 5 fact, given the role in 2009, albeit only for a short 6 period? 7 A. Yes. 8 Q. But it is also possible, I think, that he could have 9 been given the honorary reader position at this stage 10 meaning that the other information is unreliable; is 11 that correct? 12 A. It is, I'm afraid, possible. 13 Q. And if I could just scroll down to look at the CV, while 14 we're here. Keep going a bit further down, please. 15 There we go. "Head of department -- University of 16 Dundee from 1996 to date". 17 A. Yes. 18 Q. That is not a role which, as far as you're concerned, he 19 could have held? 20 A. No. 21 Q. Thank you. (Pause). We'll get back to aspects of 22 Mr Eljamel's career in a moment, but one of the things 23 you tell us about in the statement is that there was 24 a significant change, I think, to the honorary 25 appointments process and the honorary appointments Page 93	1 case. 2 And sorry, one more thing. It was also apparent to 3 me that individuals were applying for promotion as 4 opposed to ensuring a more inclusive approach, because 5 some individuals would always apply for promotion and 6 some individuals will get on with the job and never 7 apply for promotion. So I was trying to ensure that 8 there was an inclusive approach, that everybody within 9 NHS Tayside who was taking a substantial role with the 10 university could also benefit or take part in the 11 promotions process. 12 Q. And I think -- you were directly involved in making 13 those changes, I think, were you? 14 A. Yes, no, absolutely. 15 Q. So rather than it just being something that happened 16 that you know about, that, you were directly involved 17 in? 18 A. Yes. 19 Q. And although there are a number of different aspects to 20 the changes there, one aspect is to do with better 21 information sharing and better understanding within the 22 university about who it is that's actually applying for 23 this promotion, is that right? 24 A. Yes, better understanding, better sharing between the 25 university and NHS Tayside and also clarity about the Page 95
1 committee in 2022, is that right? 2 A. Yes, that is correct. 3 Q. Could you broadly -- you give us quite a lot of detail 4 about this. Could you explain how and why the system 5 was changed at that time? 6 A. Yes, and I should have reflected that earlier on. I had 7 obviously been on the health board and I was aware of 8 all the circumstances in and around that case and as 9 I was reviewing the honorary committee process 10 I recognised that we didn't have sufficient oversight of 11 people from the NHS. So I wanted to revamp the 12 committee. First of all, to make sure that any 13 individual declared whether they were undergoing any 14 investigation by the GMC, and that had to be renewed 15 every three years. I also wanted to ensure there were 16 members of NHS Tayside on that committee to ensure that 17 we were informed of anything that might be happening 18 within NHS Tayside in order to help us and better enable 19 us to make our decision. 20 And then the final thing, I wanted to be very clear 21 that when people were given an honorary statement that 22 it was very clear that they were working with and for 23 the university and they recognised what it is that we 24 were trying to achieve. And therefore there was a real 25 contribution and not just a title, which is often the Page 94	1 process and what the expectation is of individuals who 2 are given this honorary status. 3 Q. As far as the responsibilities at the various different 4 levels are concerned -- and we've traced that through 5 Mr Eljamel's promotions through the roles -- you've 6 talked already about there being a number of 7 considerations, I think. And I think, as one goes up 8 the level, not only are there perhaps -- sort of perhaps 9 greater attention paid to the applicant's probity, as 10 we've discussed, but also I think that there is 11 a greater focus on what that very subject, which is 12 a subject you mention, which is the actual contribution 13 to the university that the individual is making, is that 14 right? 15 A. Yes. 16 Q. And so that could be in teaching and/or in research, is 17 that right? 18 A. Yes, that is correct. 19 Q. And so in order to be able to rise up the different 20 levels, in particular to the honorary professorship, 21 Mr Eljamel was, by that stage, rather than getting 22 an automatic role that one would get at the beginning as 23 a consultant, having to satisfy people that the 24 contribution that was being made was commensurate with 25 the role of honorary professor being awarded? Page 96

1 A. Yes, absolutely. You should be able to evidence your 2 promotion. 3 Q. And one of -- we've quite a lot about Professor Eljamel, 4 or Mr Eljamel's research, but one other aspect I think 5 that you've done some research for us on is the extent 6 that Mr Eljamel was involved in actual teaching. We 7 touched on this a moment ago about the year in which 8 certain aspects of the neurosurgical training may have 9 been delivered, but I think the teaching for him covered 10 some input into undergraduate teaching, is that right? 11 A. Yes, it did. 12 Q. And, in theory at least, one could be involved in 13 postgraduate teaching as well? 14 A. Yes. 15 Q. And is there evidence that Mr Eljamel was involved in 16 that? 17 A. In the sense that he would have had clinical trainees 18 working with him who are specialising in neurosurgery, 19 he would have been involved in their training. 20 Q. And you have been -- you've tried to find out whether, 21 through the teaching side of things, there were any 22 concerns about his practice raised by students or other 23 members of the staff. And the only thing you could 24 find, I think, you refer to at paragraph 3.17, was one 25 feedback form; is that correct? Page 97	1 Q. Yes, so like yourself, a university professor would be 2 an employee of a university? 3 A. Exactly. 4 Q. And therefore, would be subject to the university's 5 employment regime and standard setting, is that right? 6 A. Yes, it is and as an example, I am Professor McCrimmon 7 and an honorary consultant in the NHS Tayside, so I'm 8 referred to as "Honorary Consultant, NHS Tayside". What 9 you tend not to see is the opposite of that, as in 10 "Mr Eljamel, Honorary Professor". The professorship ... 11 Q. Yes, because one sees -- I have done it myself during 12 the course of this examination, people refer to 13 Mr Eljamel as "Professor Eljamel" a lot. Is that wrong 14 then? 15 A. Yes, actually, to be absolutely pedantic, it is wrong 16 because that individual has not been granted 17 a professorship and a university professorship. They 18 have an honorary professorship and it is a different 19 thing. 20 Q. Could I just give you an example of a circumstance in 21 which I've seen this in an actual patient case, 22 anonymised of course. There is one patient case that 23 the Inquiry is aware of where an individual underwent 24 an intracranial procedure, a serious operation, and 25 there are complications in the aftermath of the surgery Page 99
1 A. Yes, that is correct. 2 Q. And it gave positive feedback about him? 3 A. Yes, it did. 4 Q. Was that from a student? 5 A. Yes. 6 Q. Okay, thank you. As far as an honorary professorship is 7 concerned, when one is an honorary professor, is one 8 entitled to use the title "Professor"? 9 A. That is a very interesting question. You are appointed 10 as an honorary professor. Frequently people use the 11 title "Professor" and I think there is confusion that 12 has arisen from this. It is very common practice 13 throughout the UK and individuals then refer to 14 themselves as "Professor". I think that's created 15 uncertainty and I can understand why the people involved 16 in this process could have influenced them, I don't 17 know. But I think it is not inviolated. 18 THE CHAIR: It's not ...? 19 A. There does not seem to be any rules about what people 20 do, or do not do, when they're awarded an honorary 21 professorship. 22 MR DAWSON: So you don't sit an exam or anything to become 23 an honorary professor? 24 A. You do not and you're held to different standards from 25 a university professorship. Page 98	1 which caused the individual to have a very, very extreme 2 amount of head pain. And in that individual's notes 3 there are references to the patient, I think it's fair 4 to say from what I have read of it, screaming in pain 5 and asking for the professor. And in circumstances like 6 that, it might well be the case that the individual 7 thought, because no doubt that individual was desperate 8 to try to get relief for their extreme symptoms, that if 9 they were able to access the professor, they were 10 accessing someone who would be able to provide an extra 11 special level of help in their moment of extreme need. 12 Is that the sort of circumstance in which it is 13 misleading to understand that the individual who was 14 known to you as "professor" holds some special extra 15 qualification and therefore might be able to help you 16 more than any other average consultant? 17 A. It is so difficult for me to judge that one because 18 I can absolutely understand why someone within the 19 public might consider that individual as a professor to 20 hold a certain qualification and in this case, as 21 an honorary professor, they do not hold that 22 qualification. It does not necessarily mean they are 23 not very competent at what they do, but they are not 24 a professor. And I can see why there is a lack of 25 understanding in that system. Unfortunately, that Page 100

1 individual would have been referred to as "professor" by 2 the staff as well and even the medical students. All of 3 them would have referred -- because they will not really 4 be able to distinguish between the two. 5 Q. Understood. Is that an area where you feel that some 6 clarity would be beneficial in the future? 7 A. I would be very clear, yes. It's a simple answer. 8 I would like to see some clarity in this process and to 9 listen to what people in the public and people involved 10 by this process felt was the right thing to do here. 11 Q. So you've told us already that it's, in fact, wrong to 12 call an honorary professor, "professor". But we know in 13 the circumstance of Mr Eljamel, eventually one gets to 14 a point where even the honorary professorship, it comes 15 to an end and it's not renewed, is that right? 16 A. That's correct. 17 Q. So the honorary professorship comes to an end. 18 A. Yes. 19 Q. I am assuming, from what you're saying, that it must 20 logically follow that if it were inappropriate to call 21 an honorary professor "professor" before that point, it 22 would certainly be inappropriate to call them that after 23 it? 24 A. Yes, completely, absolutely. It's an honorary title 25 that's bestowed. Once that's taken away, it can no Page 101	1 A. A similar process, yes. 2 Q. With different levels of approval required, if I could 3 put it that way? 4 A. Yes. 5 Q. And at that stage, what -- because you've told us 6 already that when one is considering an honorary 7 professorship it's not as automatic as it would be at 8 a lower level, one has to establish certain criteria. 9 So, presumably, one of the criteria would be the ability 10 to demonstrate that one had, in fact, as professor, been 11 contributing to the life and work of the university? 12 A. Yes. 13 Q. And beyond that, would consideration be given at that 14 stage to any concerns about the way in which the 15 individual was conducting his or her professional 16 practice? 17 A. If the committee were made aware of concerns, they would 18 have absolutely considered that. 19 Q. Yes, indeed. And so, for example, I mentioned to you 20 earlier that by 2012 -- and I think you tell us at 21 paragraph 14.3 that Mr Eljamel's honorary professorship 22 was renewed at the time of its expiry on 23 12 November 2012 and the renewal was supported by the 24 deputy dean of medicine, whom you've mentioned already. 25 A copy of the recommendation, you've helpfully given to Page 103
1 longer be used and should no longer be used. 2 Q. Thank you for that. Can we look at paragraph 14.4 of 3 the statement. So my understanding -- please correct me 4 if I'm wrong -- is once Mr Eljamel gets -- in 2009 is 5 given the honorary professorship, that there is 6 a process by which that is renewed periodically, is that 7 right? 8 A. Yes, that is the case. 9 Q. And what's the time period at which it comes up for 10 renewal? Every three years, is it? 11 A. Yes, every three years. 12 Q. And what happens at the three-year period after the 13 initial application is considered, which we've looked 14 at, we get to 2012, and what's the process that is 15 undergone at that point? 16 A. The individual would be asked to resubmit the form. 17 Obviously at that time, I'm not quite sure what the 18 clear process was but they should have resubmitted the 19 form with a CV and you would hope detailing what they 20 have done and how they have benefited the university. 21 And then the medical school executive team at the time 22 would have made a decision whether to support renewal 23 and if they had done, it would have gone to medical 24 school board -- to the university senate for approval. 25 Q. So going through a similar process? Page 102	1 us. That, at that time, I have already told you that we 2 know from other sources that there had been, during the 3 course of 2011, at least three complaints relating to 4 Mr Eljamel including complaints of wrong-level surgery 5 and in 2012, four complaints of that in that area. 6 After that date there were more that came in. But would 7 those be the sorts of pieces of information of rising, 8 developing concern about someone's practice that would 9 be relevant to those sorts of considerations that one 10 would look at, at that time? 11 A. Yes, of course because the honorary professor carries 12 with it a title and a level of kudos and that individual 13 was teaching medical students as well as engaging in 14 research and you would want to make sure that, yes, this 15 had been addressed and it would be taken into 16 consideration. 17 Q. It's important, I think, is it not, to understand that 18 these decisions are important ones in the sense, as 19 you've just said, that these individuals are teaching 20 medical students and therefore, if there is some sort of 21 issue with probity or some sort of issue with technical 22 conduct of someone's professional practice, if one 23 doesn't take that seriously when the renewal comes up, 24 there is a possibility that aspects of that person's 25 practice could be disseminated out to many other future Page 104

1 doctors; is that not correct? 2 A. Yes, no, absolutely correct. 3 Q. So that, presumably, is one of the reasons why there is 4 a renewal process, to make sure that that person is 5 still operating at an appropriate level? 6 A. Yes. 7 Q. Because if the person is not, then it's not just about 8 that person and that person's patients but about all the 9 medical students whom that person may be misdirecting 10 and all of their patients; is that right? 11 A. Not so much, obviously, in the techniques or the 12 approaches because medical students would not be 13 expected to have that degree of specialist knowledge but 14 it is in probity and behaviour and that professionalism. 15 And that's really essential and you must ensure the 16 highest standards are always being achieved and if 17 they're not, that is not a good message to convey. 18 Q. You then go on to discuss -- we talked about the 19 application there, then at 14.4, you tell us, from the 20 documentation you've helpfully looked at: 21 "It is my understanding that the College Board made 22 a recommendation to the Senate for the renewal of 23 Mr Eljamel's honorary professorship on 24 25 September 2013. The senate Resolved to endorse the 25 recommendation. A copy of the Senatus Academicus Page 105	1 Dundee by those who were on the RCS panel. Can we take 2 it that that process, which you've described very 3 helpfully tracing through all the documents, was 4 undertaken, from your studies of the documents, without 5 any knowledge of that process going on at all? 6 A. Yes, I'm afraid it was. 7 Q. And we've already heard evidence about circumstances in 8 which the Invited Review Mechanism would tend to be used 9 and it was accepted by the professor who is in charge of 10 that that it would tend to be in serious circumstances 11 and that that applied in this case? 12 A. Yes. 13 Q. Presumably had that been known, that would have been 14 a material factor in the consideration of this 15 application, is that right? 16 A. Yes, it would. 17 Q. And so just to understand the process, by 9 October 2013 18 Professor Eljamel has a renewed honorary professorship 19 which, in theory at least, would last for another 20 three years without review, is that right? 21 A. Yes, that is correct. 22 Q. It is, however, possible, as we will go on to find out, 23 that even although the three-year period is in place, 24 that matters could be brought to the attention of the 25 university authorities which would mean action might be Page 107
1 College of Medicine, Dentistry and Nursing Board Minutes 2 is provided ..." 3 And there is a report of the senate which you refer 4 to. And various other documents which recommend the 5 renewal of Mr Eljamel's honorary professorship. And 6 there is also provided an: 7 "... Agenda of the [University of Dundee] College of 8 Medicine, Dentistry and Nursing College Board meeting 9 scheduled for 6 November 2013 listing the renewal of Mr 10 Eljamel's honorary professorship as an agenda item." 11 And another document which is entitled: 12 "... Communications from the [senate] at a meeting 13 of 9 October 2013. This document confirms the renewal 14 of Mr Eljamel's honorary professorship." 15 I have mentioned to you already, Professor, that by 16 this time in 2013 there were a number of ongoing 17 concerns, a number of further complaints, eight, we 18 understand, in 2013, which had led, in the summer of 19 2013, to NHS Tayside commissioning, as I mentioned 20 before, the review from -- the invited review from the 21 Royal College of Surgeons. As it happens, the date on 22 which October 2013 is merely -- is very much, I think, 23 in the same week as an interim report was issued by that 24 body effectively reflecting a number of serious concerns 25 after a visit which had taken place in September to Page 106	1 taken to consider whether the honorary professorship 2 should continue? 3 A. Yes, absolutely. It's confirmed by the university and 4 the university can remove that as well, that title. 5 Q. We'll get back to the story in due course. If I could 6 ask you just a couple of other questions, just about 7 some other roles that you found Mr Eljamel had. We've 8 seen reference to one already. But if we look at 9 paragraph 8.4, please, of the statement. You helpfully 10 have managed to ascertain from the documentation that in 11 addition to the roles that we've already discussed, some 12 of which were NHS roles, in relation to which you 13 couldn't give us any help and we've discussed the one 14 that he appears not to have held that he claimed to 15 have, that Mr Eljamel also, you say, was a foundation 16 assistantship supervisor for year five students, and he 17 had a role in the medical admissions committee: 18 "The Foundation Assistantship between 1995 to 2014 19 was a four week block in the final year in which 20 students were attached to a specific ward ..." 21 I think you've already mentioned, is that right? 22 A. Yes, that is correct. 23 Q. And what you tell us a bit further down is: 24 "From the information available to the [University 25 of Dundee] and disclosed to the Inquiry, it suggests Page 108

1 that in 2013 to 2014 Mr Eljamel was the main supervisor 2 for these students and this would have been agreed with 3 the other Consultant Neurosurgeons." 4 So when it says "2013 to 2014", would that be the 5 academic year then? 6 A. Yes, it would have been. 7 Q. So running from September or something through to 8 spring? 9 A. Not medical students, I'm afraid. The academic year is 10 pretty much the entire year. 11 Q. Right, okay, but it is still, even viewed through that 12 lens, the academic year 2013 to 2014? 13 A. Yes, it is. Yes. 14 Q. Okay, thank you. Probably some reflections on law 15 students there. But during the course of that year he 16 held that important role I think and would he be in 17 charge of supervising all of the students doing that 18 block then, is that what that means? 19 A. No, he would have been in charge of when they arrived at 20 the start of the block. There would have been 21 an induction process where they would have met with him 22 and he would have laid out a timetable of activities for 23 those students but it would have involved all of the 24 surgeons and foundation doctors and trainees on that 25 block. Page 109	1 an isolated four-week block within the time. What 2 I don't have here and for you is the exact time when 3 that block actually occurred. 4 Q. But at some point over that period there would have been 5 the four-week block? 6 A. Yes, there would've been. 7 Q. And, as I think the statement shows, there would've been 8 a degree of organisation required which we would've been 9 in charge of which would've involved the other surgeons 10 working in the unit to contribute to as well? 11 A. Yes, there would've been. 12 Q. So on the assumption that that took place during one of 13 these periods, either the supervision period or the 14 suspension period, then the other consultants would be 15 aware, would they not, that -- they would be aware that 16 he would be subject to those restrictions, I'm assuming? 17 A. Yes, they would've been aware. 18 Q. And they would be aware that he would be conducting this 19 activity because it would have involved them despite 20 those restrictions, is that right? 21 A. That is correct. 22 Q. And again -- assuming the answer to this but I'll ask it 23 anyway -- if those restrictions were known to the 24 university in engaging him in this role and trusting him 25 to undertake it on its behalf, would -- what would their Page 111
1 Q. So would it be fair then to describe him as being the 2 one who is sort of co-ordinating the activity of those 3 students on the ward, put it that way? 4 A. Yes, it is co-ordinating and ensuring that they are 5 there and then signing off at the end of four weeks. 6 But he wouldn't have been delivering the entire 7 four-week block. 8 Q. And in that period you're probably now aware that he was 9 under clinical supervision from the middle of 2013, were 10 you aware of -- 11 A. Yes. 12 Q. You're aware of that now? 13 A. I'm aware of that now, yes. 14 Q. And indeed he was suspended from practice 15 in December 2013? 16 A. Yes. 17 Q. And by 2014, as we now know from the documentation that 18 the university was aware of this aspect at least, that 19 he resigned from his post on 31 May 2014. But -- you 20 understand that to be the position now? 21 A. Yes. 22 Q. However -- so he retained that role despite the fact all 23 those things were happening? 24 A. He has retained his role throughout although the 25 four-week block may not have been occurring. It's Page 110	1 response have been? 2 A. We would not have wanted anyone undertaking any role in 3 supervising students at that time. 4 Q. The medical admissions committee role, I think that was 5 mentioned in one of the -- in the application letter we 6 looked at earlier. Is that to do with working out who 7 gets admitted to the medical school in the first place? 8 A. No, the medical admissions committee had an NHS 9 representative on it at the time that would have decided 10 on the selection criteria, the scores that people would 11 sit their exams and I can't exactly recall when the UCAT 12 examinations came in and decided on a cut-off to allow 13 people then to proceed towards the -- what are called 14 the MMIs, which is the face-to-face presentation that 15 students do when they're applying for medical school. 16 Q. Right, so do we know when it was when he was part of 17 that committee? 18 A. Only from his CV that says he sat on that committee and 19 that's the only information we've been able to obtain at 20 the time. 21 Q. But I don't think that particularises the time period? 22 A. No, it doesn't. 23 Q. Thank you. Can we have a look, please, at 24 paragraph 11.5. Again, related to the neurology 25 teaching you I think had some assistance in trying to Page 112

1 give us some useful information about this. It says: 2 "In relation to neurology teaching, 3 Professor Hothersall has confirmed that Mr Eljamel's 4 scheduled teaching fell within the Neurology block, 5 which at the time was coordinated by Dr Stewart, 6 Consultant Neurologist, NHS Tayside and subsequently 7 Dr O'Riordan, Consultant Neurologist, NHS Tayside." 8 So Dr O'Riordan, whose name has come up in 9 a different context I think, was one of the consultant 10 neurologists who had some responsibility for 11 co-ordinating this teaching block, is that right? 12 A. Yes, that is correct. 13 Q. It says: 14 "I understand that the [University of Dundee] hold 15 no emails or records relating to the scheduling of 16 Mr Eljamel's teaching. Dr Day had no direct involvement 17 in the timetabling for individual blocks such as 18 Neurology ..." 19 Just to pause, who is Dr Day? 20 A. Dr Day leads the final year of the MBC -- the 21 undergraduate curriculum. 22 Q. Now? 23 A. Yes. 24 Q. So he was one of the ones who was helping you with 25 compiling this? Page 113	1 he had been suspended. 2 Q. Yes. And it would be impossible for him to do that -- 3 A. It would not be possible for him to complete teaching, 4 no. 5 Q. -- because it's a clinical teaching role -- 6 A. Absolutely. 7 Q. -- so you'd have to actually be seeing the patients, is 8 that right? 9 A. Yes. 10 Q. And then you've provided to us some other documents as 11 well, which -- do these also give us the information 12 that he was involved in the teaching in 2004/05, 05/06, 13 06/07 and 08/09, is that right? 14 A. Yes, that is correct. 15 Q. And it says: 16 "Dr Day has explained that from the timetables, it 17 appears that in Year 3 Mr Eljamel gave a small number of 18 lectures and taught in small groups (about 12 students 19 at a time) on site at the Hospital. In Year 4 20 Mr Eljamel would have taught in clinical settings (ward 21 round, clinic, theatre) as well as some tutorials again 22 at the Hospital, and in Year 5, he supervised some 23 Foundation Assistantship students each year. There are 24 not timetables of the Year 4 or Year 5 teaching as it 25 was arranged at ward level (within NHS Tayside)." Page 115
1 A. Yes. Yes. 2 Q. It says: 3 "Dr Day had no direct involvement in the timetabling 4 for individual blocks such as Neurology, but the 5 [University of Dundee] has located historic timetabling 6 (set out below) which indicates that Mr Eljamel was 7 involved in various clinical teaching within the 8 Neurology block all of which was undertaken on site at 9 NHS Tayside ..." 10 And then you've provided to us various documents 11 suggesting at least he was involved in the timetable 12 between 2009 and 2015, is that right? 13 A. Yes. 14 Q. This is just going over the page. 15 A. It's going over the page, yes. 16 Q. It doesn't necessarily mean, I don't think, that he 17 wasn't involved on the timetable before that but these 18 are the documents that you found for that period, is 19 that right? 20 A. Yes, that is correct. 21 Q. And so was he timetabled then, if one looks at 11.5.6, 22 to be part of that in the 2014/15 year? 23 A. It looks like he was included within that timetable. 24 Q. Do we know whether he delivered any teaching in 2014/15? 25 A. He will not have delivered teaching at that time because Page 114	1 So is that an example of the responsibility that's 2 taken on the ward to organise exactly how the teaching 3 is delivered in the way that we've discussed? 4 A. Yes, the teaching lead would organise the timetabling of 5 that, but most NHS consultant physicians would teach in 6 a very similar way to this on the undergraduate 7 programme. 8 MR DAWSON: Sir, that reaches an appropriate point in my 9 questioning. I'm not going to finish with the professor 10 before lunchtime. We have one of the professor's former 11 colleagues from the university this afternoon. I think 12 it would be useful if we could break now. 13 What's left is a certain element of the narrative 14 which both this professor and the professor this 15 afternoon can speak to. I think it would be beneficial 16 to break for lunch now and I can organise which would be 17 most appropriately addressed on these matters. 18 THE CHAIR: Certainly, we can do that. 19 Thank you, Professor, we'll break now for lunch and 20 resume again in an hour's time. Just a polite reminder 21 not to discuss your evidence between now and then and 22 I'll look forward to seeing you at about 1.40. Thank 23 you. 24 (12.40 pm) 25 (The short adjournment) Page 116

1 (1.40 pm) 2 THE CHAIR: Thank you. Right, thank you, professor, I think 3 we're ready to resume. Mr Dawson. 4 MR DAWSON: Thank you, sir. 5 We've already spoken to a certain extent, professor, 6 about the arrangements which were in place both, before 7 2010 and after 2010, with regard to the conduct of 8 research. There are a few specific aspects of that 9 I'd like to ask you about. In particular, could we have 10 a look, please, at paragraph 3.28 of the statement. 11 You refer, in this section, to this being 12 Professor Belch's evidence. I might take that to mean 13 this is a section where the information, although signed 14 for by you, if you like, was contributed largely or 15 exclusively by her? 16 A. Yes, that is the case. 17 Q. Thank you. You say that: 18 "At the time in 2010 when Professor Belch became the 19 R&D Director, the department took over all governance 20 responsibility for the clinical trial conducted by the 21 [University of Dundee] and NHS Tayside. This included 22 any clinical trial that Mr Eljamel was carrying out on 23 any patients of the Hospital that were part of a trial." 24 And over the page: 25 "The R&D offices were located in premises named the Page 117	1 governance procedures in place for Clinical Trials ..." 2 And you've helpfully produced the document. So this 3 gives us some greater detail around the role which TASC 4 played after 2010, where, as you've described, there was 5 an integration of the research activity of the hospital 6 and the university; is that correct? 7 A. Yes, that is correct. 8 Q. And you mention in this that there were systems in place 9 in order to make sure that those who took part in these 10 activities would attend a course. What was the course, 11 broadly, there for? 12 A. On good clinical practice, GCP? 13 Q. Yes. 14 A. Yes. There is a course you attend which is usually 15 a half-day course where the leads of that course will go 16 through all the different aspects of the good clinical 17 practice to make sure you understand all the steps that 18 you have to go through, that you have to undertake in 19 order to deliver trials safely. 20 Q. I think in accordance with the TASC requirements, those 21 who were involved in research, researchers required to 22 attend that course periodically; is that correct? 23 A. Yes, you have to regularly update your GCP 24 certification. 25 Q. Yes, and the accordance at that course was monitored, if Page 119
1 Tayside Academic Science Centre ("TASC"), [to which 2 we've referred] which is responsible for managing all 3 aspects of clinical trials to ensure patient safety and 4 the collection of robust data. Before any trial 5 commenced TASC would assess its suitability, verify that 6 ethical approval had been obtained, and ensure that the 7 investigators had attended the Good Clinical Practice 8 ('GCP') course which outlines their responsibilities 9 when carrying out clinical trials. TASC would also 10 review all pre-start-up documentation, including patient 11 logs, consent forms, data management plans, and planned 12 statistics, whilst confirming that trial master files 13 were correctly established and that the relevant 14 laboratory and clinical facilities were in proper order. 15 Throughout each trial, TASC would monitor compliance 16 with Research Governance Policies and Standard Operating 17 Procedures ('SOPs') conduct periodic reviews of trial 18 files, and report any breaches of GCP, establishing and 19 supervising remediation plans where necessary. Upon 20 completion of a trial TASC would supervise its closedown 21 and the archiving of trial documents. TASC's oversight 22 was judged to be suitable by the Medicines and 23 Healthcare Products Regulatory Agency ('MHRA') following 24 an inspection in 2014. This 2014 MHRA dossier, 25 submitted by TASC in 2014 outlines in full the Page 118	1 you like, or overseen by the TASC organisation? 2 A. Yes, it's compulsory. If you do not have your GCP that 3 is up to date, you cannot conduct clinical trial. 4 Q. I think you've provided some information to us that 5 Mr Eljamel attended the course in 2009 and 2011? 6 A. Yes. 7 Q. I think also you talk about there being a degree of 8 monitoring of the process and you have provided some 9 documents about that. Could we look at paragraph 4.17, 10 please. This is a section in which you're narrating 11 some of the activities that took place within TASC and 12 you say: 13 "Governance meetings were held every one to 14 two weeks, attended by Professor Belch, the governance 15 managers and the monitors. Any issues with clinical 16 trial were discussed at these meetings and all start-up 17 of trials was discussed. Professor Belch does not 18 recall any issues with Mr Eljamel's trials being 19 discussed during these governance meetings. Due to the 20 passage of time, Professor Belch no longer holds copies 21 of these minutes and the [university] have not located 22 copies of the minutes from the searches undertaken to 23 date." 24 So, there were governance meetings as part of the 25 oversight function. Can you tell us what those Page 120

1 governance meetings, as opposed to other meetings we'll 2 come on to in a moment, were designed to try to monitor? 3 A. I have not, myself, attended these governance meetings 4 but what these governance meetings would have done is 5 they would have had accordance would have been for all 6 the people within TASC who were involved in clinical 7 trial activity and they would have covered all aspects, 8 from recruitment to ongoing management of a trial and 9 obviously close-out of trials and ensuring that all 10 documentations with in place. 11 Q. Because in the passage I read before, there was a wide 12 variety of activities described as being within TASC's 13 responsibility. 14 A. Absolutely. 15 Q. And if there were issues with any of those matters, 16 would that be the sort of thing that would come up at 17 a governance meeting? 18 A. Yes. 19 Q. But we -- certainly as far as the information we have 20 that is available and Professor Belch's best 21 recollection, she does not recall there being any 22 discussion of that nature of any of Mr Eljamel's trials, 23 is that right? 24 A. That was my understanding, yes. 25 Q. And in paragraph 18 you go on to talk about something -- Page 121	1 clinical trials that were run, for instance, under 2 a grant or a university process. For instance, consent 3 forms provided for a trial run by a pharmaceutical 4 company would come from the company itself. 5 Q. Understood. 6 A. But it's a standardised consent form that all clinical 7 trials use. 8 Q. All right, as a standardised form. The position though, 9 with regard to monitoring compliance with requirements 10 such as consent, would that have been the responsibility 11 of the clinical side of a clinical trial, ie the 12 consultant in the hospital? 13 A. Yes. The responsible individual is the lead clinician 14 on that trial. 15 Q. Yes, because I'm just trying to differentiate what the 16 roles are here because obviously the provision of the 17 standard forms would be part of TASC's function, 18 presumably collecting in the forms and making sure 19 they're all put in a folder with the signatures on them, 20 is that roughly what they would be doing? 21 A. Absolutely and making sure everything was -- in this 22 case, Mr Eljamel has taken on responsibility for the 23 trial itself. TASC are there to ensure that that 24 responsibility is actually being carried out effectively 25 and appropriately. So it reviews the trial Page 123
1 another feature which is to do with oversight meetings 2 and again, the same response is given, that: 3 "Professor Belch has confirmed that, due to the 4 passage of time, she only has copies of the minutes from 5 these meetings from [certain dates in] 2010. The 6 minutes do not refer to Mr Eljamel. The searches 7 undertaken by the [university], to date, have not 8 identified any other minutes of these meetings." 9 As you understand it -- and I know, here, you're 10 relying on Professor Belch's information -- what's the 11 particular function of the oversight meetings, is it 12 just all part of the governance? 13 A. It's part of the governance structure. The oversight 14 meeting, it's held by senior members of the university, 15 the health board, for instance the medical director in 16 this case, and we look at oversight of TASC, all the 17 activities that are ongoing in TASC, any issues that may 18 be raised and any aspect of TASC's function that is 19 relevant to both the university and NHS. 20 Q. Okay. One of the aspects that I read out a moment ago 21 from a passage in the statement that you said that TASC 22 would have been responsible for would have been 23 providing consent forms for research clinical trials, is 24 that right? 25 A. It would have been providing -- consent form for Page 122	1 documentation in that context. 2 Q. Yes, because as I understand it, in accordance with what 3 we've described as good practice and standard operating 4 procedures, it would be necessary, in the same way as 5 one might consent a patient for a procedure, that there 6 would be proper consents taken at the beginning of the 7 process from a patient participant, is that right? 8 A. Absolutely and there needs to be checks and balances 9 throughout. 10 Q. Yes. So for example, as I understand it, the standard 11 procedures would include provisions which require 12 a clinician to make a patient taking part in a clinical 13 trial to be aware of the fact they could withdraw at any 14 time? 15 A. Yes, absolutely. 16 Q. And there would be other provisions relating to 17 information being shared, about the sorts of things that 18 would happen to them and it would be important that the 19 consent was maintained throughout, is that right? 20 A. Yes. 21 Q. So just to be clear, the provision of the forms and the 22 oversight and making sure they're all signed, that was 23 on the TASC side. But if you like, making sure that the 24 proper procedures were actually gone through, that would 25 be the responsible officer, ie the clinician, is that Page 124

1 right? 2 A. Yes. 3 Q. Okay. We've been talking here, I think, about this 4 post-2010 period when TASC was in existence. There does 5 seem to be an awful lot of documentation and 6 organisation required in a clinical trial; would that be 7 fair to say? 8 A. Yes. 9 Q. And just to be clear, in the period -- I think we've 10 discussed this before, but in the period pre-2010 before 11 TASC undertook all these important functions connected 12 to the proper operation of a clinical trial, they would 13 have been undertaken within the hospital; is that right? 14 A. Yes, that's correct. 15 Q. If it's what we call a hospital-side clinical trial? 16 A. Yes. 17 Q. So if it were to be asserted that NHS Tayside would 18 never have had access to any documentation relating to 19 clinical trials because they all took place on the other 20 side of the fence, would that be right? 21 A. Not in this case, no. These trials would be run through 22 the NHS R&D department and therefore they would have 23 access to all those files. 24 Q. Thank you. We asked you in the statement for some 25 information about what might happen if concerns or Page 125	1 behaviour, professionalism, all related to clinical 2 practice are for a member of staff within NHS Tayside 3 who has direct contact with a student, staff, members of 4 the university, that we would have been notified about 5 that process and told that it was ongoing. Clearly, you 6 have to wait for the outcome of the investigation but 7 there may be implications on, for instance the students 8 for whom we have responsibility and we are there to 9 safeguard those students. 10 Q. I see. 11 THE CHAIR: Sorry, Professor. Would you mind raising your 12 voice slightly. 13 A. Sorry, apologies. 14 THE CHAIR: Thank you. 15 MR DAWSON: And in circumstances like that where you've 16 differentiated, I think, between being told of the fact 17 there might be an ongoing investigation or something and 18 it being concluded, would it be important -- would the 19 university contemplate taking action in serious 20 circumstances while the investigation was still going 21 on, given its important responsibilities towards, for 22 example, students and its staff? 23 A. Yes, absolutely if an individual staff has been, for 24 instance, suspended from NHS Tayside, we would suspend 25 them from all university activities at exactly the same Page 127
1 complaints were raised about the professional practice 2 of a consultant and could we look at paragraph 3.26, 3 please. You say there. 4 "If a concern is raised regarding the professional 5 practice of an NHS Consultant employed by NHS Tayside 6 with an honorary appointment with [the University of 7 Dundee], outside the student feedback process, this 8 would be investigated by NHS Tayside. During the 9 relevant period, we would have expected NHS Tayside to 10 notify us of any concerns; however, in practice this did 11 not always happen." 12 So, on the subject of -- we've discussed already 13 concerns that may have arisen at the board level that 14 you may have been informed of, but if one is looking 15 here at a more individual level, you mentioned if 16 complaints or concerns were raised then you would have 17 expected NHS Tayside to notify you of these concerns but 18 in practice this did not always happen. Can you give us 19 some insight based on, not your direct experience of 20 course, but your analysis of the materials, as to why it 21 would be expected that matters of this nature would be 22 brought to the university's attention and effectively 23 how serious something would have to be to fall within 24 that category? 25 A. I would expect any issues affecting behavioural -- Page 126	1 time. 2 Q. But if someone was in the process of being investigated 3 and the suspension had not yet happened yet, for the 4 reasons that you've set out, would it still be important 5 for the university to know so that the university could 6 judge what action it might need to take in those 7 circumstances? 8 A. Yes, absolutely because I think that you need to be able 9 to make an informed decision and sometimes the NHS will 10 have a certain view of what is appropriate and what is 11 not appropriate, but the university may have a very 12 different view on that. And they do not -- they cannot 13 comment until they know. 14 Q. Indeed. So, for example, it might be that an NHS board 15 would think that it would be responsible for -- in 16 a certain complaint or concern having been raised, for 17 a consultant to continue to carry out procedures but the 18 university, with the same information, might consider it 19 to be inappropriate that they should be allowed to teach 20 students, for example? 21 A. Yes. 22 Q. And it would be the university's right to be able to 23 make that decision itself? 24 A. Yes, it would. 25 Q. Thank you. I'd like to ask you some questions -- we've Page 128

1 already been through a considerable amount from your 2 helpful statement about the progression of Mr Eljamel 3 through various honorary positions at the university. 4 I do want to ask you a little bit, because you cover in 5 your statement, about the termination -- the 6 circumstances of the termination of those positions, 7 although I do plan to cover that area with 8 Professor Connell later because he had more direct 9 involvement. But there are certain aspects which 10 I think I could usefully highlight with you. 11 Could we look, please, at UNID-00027. This is 12 a letter dated 17 February 2014 which is sent to 13 Professor Connell and if we can just go down to the 14 bottom, please. This is from Andrew Russell who is the 15 medical director of NHS Tayside at the time, is that 16 right? 17 A. Yes. 18 Q. And in the letter, it says: 19 "Suspension from duty, Professor Eljamel. 20 "Following a review report commissioned by the Royal 21 College of Surgeons in regard to Professor Eljamel's 22 clinical knowledge, technical skills and judgment as 23 well as his interpersonal skills a decision was made to 24 suspend him from duties with NHS Tayside on 25 10 December 2013. In addition Professor Eljamel has Page 129	1 I understand it; is that correct? 2 A. Yes. 3 Q. These are, I think, in particular perhaps judgment, but 4 all of those matters, matters that are of relevance to 5 his ability to deliver teaching on behalf of the 6 university, is that not right? 7 A. Yes, that is correct. 8 Q. Because obviously, even though we've already discussed 9 how judgment and probity is important, it would be 10 important for him to be imparting accurate clinical 11 knowledge and, to an extent, technical skills in certain 12 spheres, albeit perhaps not in the undergraduate sphere, 13 as you've told us in your surgery? 14 A. Yes, that's correct and the comment about interpersonal 15 skills obviously allude to behavioural issues which 16 would also be very important. 17 Q. Indeed. So there is a broad range of issues that have 18 arisen there across, well, one might say almost a full 19 gamut of qualities that a surgeon has to possess is that 20 fair? 21 A. That is fair. 22 Q. And if, as we discussed earlier, it were demonstrated by 23 other evidence that much of this information was 24 available to NHS Tayside many months before, I think 25 we've already discussed that this would be something Page 131
1 been referred to the GMC. The outcome of that referral 2 is pending. 3 "Subsequent to the decision to suspend and prior to 4 arrangements being made to proceed with an internal 5 investigation Professor Eljamel submitted an application 6 for early retirement and notified NHS Tayside of his 7 intention to leave the service of this Organisation 8 effective from 31 May 2014 and consequently a decision 9 has been made not to pursue the internal investigation. 10 "I hope that the above provides sufficient 11 information in regard to Professor Eljamel's honorary 12 contract status with the University of Dundee. Should 13 you require any further information please do not 14 hesitate to contact Lorraine Fraser, HR Business 15 Lead ..." 16 And just to understand -- because you also, as does 17 Professor Connell, gives an analysis of what was going 18 on over this period. This is, as I understand it -- 19 please correct me if I'm wrong -- Professor Connell 20 being informed by the medical director of NHS Lothian of 21 the outcome of a Royal College of Surgeons review 22 related to Professor Eljamel's clinical knowledge, 23 technical skills and judgment, is that right? 24 A. Yes, that is correct. 25 Q. And this is the first intimation of that, as Page 130	1 that the university would have expected to have been 2 told about at the time when the information came to 3 light, is that right? 4 A. Yes, that is correct. 5 Q. One aspect of this I'd just be quite keen to understand 6 is, whose responsibility do you think it was for you to 7 be told about this? Was it NHS Tayside, or was it 8 Mr Eljamel or some other agency? 9 A. Both. The individual does have responsibility to report 10 to -- both to the various authorities as well as to the 11 university that this has happened, but then I would also 12 have hoped and expected NHS Tayside to have also 13 informed the university about this. 14 Q. Thank you. And we'll look at some of the other details 15 going on around this time with Professor Connell but if 16 we could look at UNID-00136, please. This is a letter 17 to Professor Eljamel from an HR officer within the 18 university; is that correct? 19 A. Yes, that is correct. 20 Q. And effectively this is responding to the information, 21 broadly speaking, that had been imparted. It says: 22 "Honorary status within College of Medicine, 23 Dentistry & Nursing. 24 "I understand that you have indicated that you will 25 retire from NHS Tayside with effect from 31 May 2014. Page 132

1 As your Honorary University of Dundee status with the 2 College of Medicine, Dentistry and Nursing runs 3 concurrent with your NHS Tayside post I am writing to 4 formally advise you that your Honorary University of 5 Dundee status will also end on 31 May 2014. 6 "Please note that all privileges linked to your 7 honorary status will end shortly after your termination 8 date. 9 "May I take this opportunity to thank you for the 10 contribution you have made to the College over the years 11 and to wish you well as you embark on retirement." 12 So that effectively is the university making the 13 decision that, although as we'll find out with 14 Professor Connell, there had been some discussion around 15 this, that in light of the fact that by this stage, in 16 fact, by February, Mr Eljamel had decided that he would 17 effectively leave the employment of the hospital, or the 18 board, that that would also consequently mean that 19 his honorary status with the college would come to 20 an end at that date as well; is that correct? 21 A. That is correct, from that letter. 22 Q. You tell us -- although I'm not going to go into the 23 details of it and we've touched on it to an extent 24 already, you tell us in great detail in your statement 25 about the various research projects that were ongoing at Page 133	1 could go to that, please. If you look at 24.3 as you 2 summarise there, you were able to find out that at that 3 time, Mr Eljamel was the PI, the lead -- is that the 4 lead -- 5 A. Yes, principal investigator. 6 Q. -- for 12 projects in total, is that right? 7 A. Yes. 8 Q. And you have told us in some detail about what they 9 were, but in 24.4, you say: 10 "On 17 January 2014 Professor Belch sent an email to 11 Phillip McLoughlin, Mr Eljamel's line manager at 12 NHS Tayside [UNID-00066]. In the email, she noted to 13 Dr McLoughlin that it was disappointing that the R&D 14 department had not been formally alerted to the concerns 15 regarding Mr Eljamel's professional practice. On 16 23 January 2014, Professor Belch forwarded her email to 17 Dr McLoughlin to Ms Forde, the Governance Manager at 18 TASC, to update her [UNID-00066]." 19 And we'll look at some other aspects of that period 20 with Professor Connell. But Professor Belch is 21 indicating at that stage that it was disappointing that 22 the research department had not been told about the 23 issues. Why was it that she was expressing that 24 disappointment at that time? 25 A. Because there are ongoing clinical trial activity for Page 135
1 the time and there were a number which Mr Eljamel was 2 involved in. I wanted to ask you a couple of high-level 3 questions about that, which is: to what extent can you 4 be confident that the ones you list and describe in your 5 statement are all of the research projects that 6 Mr Eljamel was involved in, which the university had 7 some involvement in itself? 8 A. I can be confident to the extent that they were the 9 clinical trials listed through TASC and NHS R&D, for 10 which we have record. 11 Q. Yes, and so by this stage, just to be clear, we've been 12 through this before, all of the clinical trials he would 13 have been involved in would have been run through TASC; 14 is that right? 15 A. Yes, that is correct. 16 Q. And obviously there may be deficiencies in the records 17 but it does seem that you have quite a lot of 18 information about the actual projects themselves. Does 19 that give you any confidence that these are all of the 20 projects or are we still in the territory that we're 21 subject to the possibility that some files may have gone 22 missing? 23 A. No, that would give me confidence that we have all the 24 information that is available at that time. 25 Q. Thank you. And in paragraph 24.4. your statement, if we Page 134	1 which he was the principal investigator and if he was 2 under investigation and there were issues around probity 3 and practice, they would clearly want to know about 4 that. 5 Q. And obviously that may have implications for the trials 6 continuing? 7 A. Absolutely. 8 Q. And obviously, as you describe elsewhere was the 9 ultimate outcome of this, decisions would have to be 10 made as to whether the trials would have to stop? 11 A. Yes. 12 Q. Or whether someone else might be in a position to take 13 them on? 14 A. Yes, exactly. 15 Q. I think the position was that some came to an end and 16 some were carried on by others, is that right? 17 A. Yes, that is correct. 18 Q. In 24.5, you say: 19 "On 13 February 2014, Ms Forde met with Mr Eljamel 20 to discuss his clinical trials. It was Ms Forde's 21 practice to minute all of her meetings." 22 But as we said, the minute of the meeting has not 23 been found. But at that stage, I think is it correct to 24 say that, as you understand it, that there was 25 a discussion with Mr Eljamel himself as regards where he Page 136

1 was with the clinical trials and what was to happen with 2 them? 3 A. Yes, that's correct. 4 Q. Thank you. One aspect of the letter that we looked at, 5 that was sent by Dr Russell in February of 2014, was 6 that there was an intimation included in it that 7 Mr Eljamel had, by that point, been referred to the GMC? 8 A. Yes. 9 Q. That is, as in accordance with the testimony that you've 10 already given, quite a serious matter? 11 A. Yes, absolutely. 12 Q. And if -- that letter was dated 17 February 2014 we saw 13 from some other evidence that that in fact had been 14 referred to the GMC in prior December on 15 20 December 2013. Would you have expected to have known 16 about that at that stage? 17 A. Yes, they would have expected to know about that -- the 18 university would have expected to know about that. 19 Q. Indeed, and again, would the responsibility about that 20 aspect of things have been on NHS Tayside, Mr Eljamel or 21 both to inform the university? 22 A. Both. 23 Q. During the course of the -- we've already seen 24 information that was transmitted in February saying that 25 there was an ongoing investigation but in light of Page 137	1 would exist and you would expect that line of 2 communication to exist because individuals may go off 3 and may start to practise elsewhere or in other 4 countries. And if they take with titles which they 5 shouldn't be taking with them, again, this is important 6 for everybody to know and so that these days, you can -- 7 you will know what is happening around the rest of the 8 world and you can quickly inform other regulatory 9 authorities who may not be aware of this. 10 Q. So, just to hypothesise. My understanding is the 11 university didn't receive any intimation from the 12 records that you have of that, of the application or 13 applications for Mr Eljamel to have his name voluntarily 14 removed from the register; is that your understanding? 15 A. That's my understanding, yes. 16 Q. So on the hypothesis that the course had been followed, 17 that that had been intimated to you, what is it that you 18 could have done to try to deal with the very issues that 19 you've just described, to deal with the possibility that 20 this might have an effect on somebody practising in 21 another country? What could the university have done 22 had they been contacted? 23 A. It's limited what the university can and cannot have 24 done. But the university is an international body that 25 has people and staff members all around the world and, Page 139
1 Mr Eljamel's intimation that he wished to retire that 2 the investigation would be brought to an end. You may 3 or may not be aware that subsequently there were 4 applications made by Mr Eljamel to the GMC to have his 5 name voluntarily removed from the GMC medical register. 6 Are you aware of that at this moment? 7 A. No, but -- 8 Q. In the event that such an event did take place, would 9 the university have expected to have been informed about 10 it at any point? It may make a difference as to whether 11 it was before he left the university's role or after? 12 A. Yes, particularly if there were any ongoing role within 13 the university, would you absolutely need to know if 14 someone had been removed from the register. 15 Q. Indeed, and in circumstances where we understand there 16 may have been numerous applications, or more than one 17 application, but that one may have taken place in 2015, 18 by which time we know he had left his roles with the 19 university, in accordance with what we've discussed. 20 You say particularly you would expect to be told if 21 there was such an application when he was still in his 22 roles with the university, but would you have also 23 expected that to happen irrespective of whether he was 24 still working for the university or not? 25 A. Yes, you would hope that that line of communication Page 138	1 you know, in a formal way, probably cannot do very much 2 other than to ensure that that evidence is presented on 3 the university website or if anybody were to 4 double-check or to look, if someone had said: I was 5 previous -- I am or were an employee of the University 6 of Dundee, they would make pretty obvious that there 7 were issues raised in the university and somebody had 8 been struck from the register or, you know, there were 9 issues about practice and professionalism. 10 Q. Yes, so as regards the GMC's processes itself, could the 11 university have had any involvement in those? 12 A. If we were asked by the GMC to act as witnesses on 13 a case then we would be involved in that context. 14 Q. Okay, and are you aware, from your own medical practice, 15 as to in those sorts of circumstances what the 16 considerations of the GMC would be in determining 17 an application for a voluntary removal? Because it 18 might seem that if a doctor wishes to remove his name 19 from the medical register, he should be entitled to do 20 so, but from what you're saying it sounds like it's more 21 complex than that? 22 A. In most cases voluntary removal comes when people retire 23 or leave the country. It's not necessarily in this type 24 of context itself. 25 Q. But in the context like this, if an application were put Page 140

1 in, is it just assumed that someone is stopping their 2 practice or is there some sort of investigation around 3 it? 4 A. I'm not aware of any investigation around that from the 5 GMC itself. 6 Q. In this case? 7 A. I am not aware that they would investigate in any case. 8 I'm afraid, I don't know their policy in detail, for 9 what happens when someone withdraws. 10 Q. I see, thank you. I suppose from the point of view of 11 the university are you aware of this sort of thing 12 having happened in relation to other individuals who 13 have an association with the university, an intimation 14 from the GMC that someone is doing this? Presumably 15 people come to the end of their medical careers and they 16 want to stop their roles because they're just retiring, 17 and then you would -- I think you've told us you would 18 expect the GMC to intimate to the university that that 19 is what somebody is doing? 20 A. Yes, they will do and they do write in that context but 21 that is the only context in which I've ever been made 22 aware of someone withdrawing from the GMC, was through 23 retirement. 24 Q. Yes, thank you. 25 A. And then as the employer, that would be for clinical Page 141	1 [university] are in the process of considering 2 amendments to the current MOU ... so that the 3 description of processes more accurately reflects the 4 shared understanding and position between the two 5 organisations in respect of the definition of 'Clinical 6 Academic' and the procedures in place where there are 7 concerns raised in a clinical setting regarding 8 a [University of Dundee] employee with an honorary role 9 at NHS Tayside. These amendments will formalise the 10 operational arrangements between the [University of 11 Dundee] and NHS Tayside. 12 "The [University of Dundee] have updated the 13 honorary process as set out in response to question 3." 14 Just to understand where we got to with this, that 15 was the matter we discussed earlier in relation to the 16 possible moves that might be made to formalise not only 17 the clinical academic position, which was where someone 18 was primarily employed by the university but worked in 19 the hospital, if you like, but that that should also 20 include a formalisation of the position the other way 21 round and a clearer structure as to when information 22 should be shared about that individual; is that correct? 23 A. Yes, in my -- 24 Q. Sorry, the only thing I was just trying to understand 25 here, but please feel free to explain your views on it Page 143
1 academics. 2 Q. Sorry, could you say that again? 3 A. It was when there was a clinical academic who was 4 employed by the university and that's why they would be 5 reaching out to me in that context. 6 Q. I see, because you would be the principal point of 7 contact? 8 A. Yes. 9 Q. We've touched on aspects of this already, professor, but 10 there are some helpful matters which you bring up in the 11 conclusions of your statement which I'd just like to 12 address with you. In particular, could we go, please, 13 to paragraph 32.1, page 47. We've touched on aspects of 14 this already but we asked you whether there were some 15 challenges and reflections that you might be able to 16 bring to our attention. You say: 17 "The care of patients at NHS Tayside are not within 18 the remit of the [university]. Although the 19 [university] and NHS Tayside have a [memorandum of 20 understanding] in place now, the process could be 21 further enhanced by the introduction of a formal 22 committee between the organisations to ensure that there 23 is clear communication of any issues, even in 24 circumstances where there is no direct line management 25 relationship. As mentioned in paragraphs 6.2-6.3 the Page 142	1 as well, was you mentioned there being -- efforts being 2 made in that regard at the moment? 3 A. Yes. 4 Q. How far along that process have we got? 5 A. I think we're in -- we are in regular communication with 6 the medical director of NHS Tayside with the chief 7 executive and the team about how we might move on and 8 further develop this process, as well as their HR 9 department. I think we will have to wait until the 10 learnings of this tribunal, which I think will be very 11 important for us, to assess on what the committee should 12 and how it's best constructed to ensure the safety of 13 patient but also obviously of student in other areas 14 under our care. 15 Q. Thank you. 16 THE CHAIR: Just on that, perhaps my reading of the 17 paragraph was slightly different but my impression of it 18 was that although there were developments afoot that you 19 describe there, they, again, had a concentration on one 20 side of the fence, if you like. Namely, the position of 21 the clinical academic with a role to play in the NHS 22 rather than the other way around. But perhaps 23 I misunderstood that and you're saying that the exercise 24 that's currently underway is broader than that and 25 reflects some of the concerns that you described to us Page 144

1 this morning? 2 A. Yes. I think the exercise will be broader than that 3 because it is too focused on the clinical academic and 4 situations like this have arisen because there's lack of 5 communication within this area, I think. 6 THE CHAIR: All right, that's helpful. Thank you. 7 MR DAWSON: You refer there to the fact that the process 8 could be further enhanced by the introduction of 9 a formal committee between the organisations. Is that 10 a conception that you think might solve these problems 11 in order to police the principles, the Follett 12 Principles working in that honorary situation, or are 13 steps actually being taken for such a committee to 14 either be formed or another committee perform that role? 15 A. I think it is a first step. I think there are many, 16 many steps to take place and you are always learning and 17 trying to ensure the best ways to ensure patient safety. 18 So I think this is one step that would help within the 19 process because what it does do is improve 20 communications between two very large but intertwined 21 organisations. 22 Q. And would that be a function which you think could be 23 done by an existing committee or would it require 24 a separate committee to do that, just in terms of the 25 practicalities? Page 145	1 I think -- that these positions are often perceived as 2 equivalent and that it's important that there should be 3 recognition of the differences between the two. 4 What practical steps could promote the recognition 5 of the differences, in particular amongst patients, 6 which I think, as we discussed earlier, would perhaps be 7 important to them? 8 A. I think the most important step is actually to get the 9 opinion of people, of patients, as to what the 10 distinction of these different titles means and then 11 see -- and how we best reflect that to improve 12 understanding. In this case, it may not necessarily be 13 the role of the university or the NHS to make this 14 decision because confusion is not with the university or 15 the NHS; it's with the patients. And in that case, 16 I think we should look very, very carefully or listen 17 very carefully to patients and understand what are the 18 implications of these different titles and how we may 19 clarify between the different roles. 20 Q. We heard evidence last week from the Patient Safety 21 Commissioner for Scotland who talked to us about the 22 strategic role in relation to systemic matters which her 23 remit allows her to play. I don't know how much you 24 know about that role but is that the sort of thing that 25 might facilitate such a process because she has Page 147
1 A. There is no existing committee and that's why I think 2 there needs to be one. There used to be a committee 3 called the Academic Health Science Partnership but that 4 related more to strategy than it did to people. And 5 I think there needs to be a group that meets formally 6 that really is looking at any issues that happen to be 7 arising. Now, there are multiple committees around 8 fitness to practise for students, around how we manage 9 staff, but there is no formalised way of bringing all of 10 these together at present. 11 Q. I see, thank you. Bear with me. Yes, there is 12 something mentioned -- I just wondered if this is -- in 13 this area, called the University Strategic Liaison 14 Committee. Is that a committee you're aware of? 15 A. It is not one that has met regularly. 16 Q. Right, okay. So this is in Professor Connell's 17 statement. He refers to it in a historic sense -- 18 A. Historic sense, yes. 19 Q. So it may not be a committee that could do that now? 20 A. Not now. 21 Q. I understand. Thank you. You also helpfully suggest, 22 in the final paragraph something we've also discussed, 23 you say -- this is to do with the distinction between 24 an honorary professor and a professor employed by the 25 university. You say that it would be important, Page 146	1 an advocacy and listening role with patient groups? 2 A. I think that would be very valuable, yes. 3 Q. Thank you very much indeed. Sir, those are my questions 4 for the professor. Professor, at this stage I ask all 5 of the witnesses whether there is anything you would 6 like to add? 7 A. No, there is nothing I would like to add other than to 8 express my sympathy for everything that has happened in 9 the past. I think it's been an awful situation for the 10 families involved. 11 MR DAWSON: Thank you. Sir, the usual short break. 12 THE CHAIR: Yes, professor, we take one final short break. 13 That's just to check whether there are any further 14 questions that parties wish to raise with you. So if 15 you bear with us a few moments longer, we'll be ready to 16 resume again very shortly. Thank you. 17 (2.19 pm) 18 (A short break) 19 (2.32 pm) 20 THE CHAIR: Yes. 21 MR DAWSON: Thank you, sir. Professor, I have a couple of 22 questions for you around a matter we addressed earlier 23 which was to do with research. I asked you some 24 questions about the financial aspect of research and 25 money being brought in to an institution. You've looked Page 148

1 at research, insofar as information was available to you 2 about it, that was undertaken by Mr Eljamel, and my 3 understanding is that they are exclusively clinical 4 trials; is that right? 5 A. Yes. 6 Q. Would it be fair, based on your experience of looking at 7 research in no doubt lots of different areas, to 8 describe that as "pioneering research"? 9 A. Not from what I have seen, in terms of research that's 10 actually been done. 11 Q. And would it be contrary to your expectations of what 12 the normal financial benefits would be of getting 13 involved in research projects, is there anything to 14 suggest that the research projects in which Mr Eljamel 15 was involved might have been ones that attracted higher 16 levels of financial benefit than the norm? 17 A. Not that I can see from the applications that were 18 provided. 19 Q. Is it the case that if others took the view that the 20 research that Mr Eljamel was involved in was important, 21 pioneering, etc, is there a value to an institution like 22 a university to have someone conducting research there 23 that is pioneering, even if it is not financially 24 beneficial to the organisation? 25 A. I think that's a challenging question. I would guess Page 149	1 there's nothing that you've seen that looks pioneering 2 in that nature? 3 A. Not that I have seen, no. 4 Q. Thank you. Sir, those are all my questions. Thank you 5 very much, professor. 6 THE CHAIR: Thank you. Professor McCrimmon, that, as you'll 7 have gathered, brings your session to an end and you 8 have, of course, been answering questions, giving 9 evidence and offering a number of insights and 10 reflections over quite a number of hours now. I'm also 11 very conscious of your contribution to what is a lengthy 12 statement that was prepared in advance of these hearings 13 by the university and the associated documents that 14 required to be looked out and looked at for that 15 purpose. So that's the context in which, as I'm sure 16 you will appreciate, I'd like to extend to you the 17 thanks of the Inquiry and also my personal thanks for 18 all of that work which is greatly appreciated. You are 19 now free to go, thank you. 20 A. Thank you very much. 21 (Witness withdrew) 22 MR DAWSON: Sir, we have another witness this afternoon, as 23 previously advertised. I think we need to have a short 24 break just to work out -- 25 THE CHAIR: Just to get the arrangements in place, yes. Page 151
1 that if individuals within Ninewells Hospital were 2 conducting pioneering research that made the area 3 attractive, that might attract medical students, it 4 might attract other academics or other clinicians 5 wanting to work within that field. I think that would 6 be the only context I can see in which that would have 7 an influence. 8 Q. I suppose there could be prestige associated with it and 9 media attention or something like that? 10 A. That's what I meant really, essentially prestige. 11 Q. This is a question I have been asked to ask you. So 12 I think what it's getting at is the possibility that 13 this is not your impression of the research but if 14 somebody were, hypothetically, to be undertaking 15 research of a particularly impressive or pioneering 16 nature, there could be sort of secondary benefits to 17 an organisation like a university, or indeed a hospital, 18 to have someone like that as part of the staff or 19 providing a service not part of their staff, as we've 20 discussed? 21 A. Yes, there might be some intangible benefits to the 22 organisation from having figure heads who are very 23 important in a given field. 24 Q. But in this case, as far as you're concerned based on 25 your significant experience of looking at research, Page 150	1 MR DAWSON: Indeed. Thank you, sir. 2 THE CHAIR: Thank you. 3 (2.37 pm) 4 (A short break) 5 (2.46 pm) 6 THE CHAIR: Yes. 7 MR DAWSON: Sir, the next witness is John Connell. 8 THE CHAIR: Thank you. 9 PROFESSOR JOHN CONNELL (sworn) 10 Questions by SENIOR COUNSEL TO THE INQUIRY 11 MR DAWSON: Thank you, sir. You are John Connell? 12 A. I am. 13 Q. You provided a witness statement, I think, on behalf of 14 Dundee University to the Inquiry, is that right? 15 A. I did. 16 Q. Could we have, please, up on the screen document number 17 UNID-01435: is that your statement? 18 A. It is. 19 Q. Could we go to page 20, please. Does your signature 20 appear on that last page of the statement? 21 A. I presume it's below "CAT C". 22 Q. Yes, you signed that last week? 23 A. I did sign it, yes. 24 Q. And the statement is dated 7 May 2026, is that right? 25 A. That's correct. Page 152

1 Q. And as far as you're concerned, you consider the facts 2 stated in your statement to be true? 3 A. Yes. 4 Q. Thank you. You tell us, if we go to page 1, please, of 5 the statement, you provide helpfully some background 6 about your training and the positions you've held. You 7 say that you trained in medicine at the University of 8 Glasgow, graduating with commendation in 1977. You 9 gained membership of the Royal College of Physicians 10 (UK) in 1979. In 1986 you completed your postgraduate 11 research degree, MD, at the University of Glasgow. In 12 1990 you became a fellow of the Royal College of 13 Physicians and Surgeons of Glasgow. In 1999 you became 14 a fellow of the Academy of Medical Sciences and in 2002, 15 a fellow of the Royal Society of Edinburgh. 16 We have, in evidence we've already heard, 17 Professor Connell, heard a number of pieces of 18 information about medical training and also about Royal 19 Colleges and fellowships and the like. Yours throws up 20 the fact that you completed a postgraduate research 21 degree, MD, at the University of Glasgow in 1986. 22 I wonder if you could tell us, both with regard to the 23 specific matters you addressed in that degree but also 24 generally, what that degree entails? 25 A. I did that degree while I was involved in clinical Page 153	1 with you was when you talk about clinical and research 2 training, obviously we're familiar with what clinical 3 training is, but is there some training in research to 4 which you're referring to? 5 A. Yes. I spent a year and a half in Australia training in 6 laboratory research practice. 7 Q. I see. Is it -- we've heard about the fact that, in 8 particular in the context of the University of Dundee 9 and Ninewells Hospital which is a teaching hospital, 10 that there's a lot of teaching and research goes on 11 there. 12 A. Yes. 13 Q. Is it normal for doctors who are involved in research to 14 have training in research? 15 A. Not formally, no. Some doctors like myself elect to 16 spend a period of time elsewhere, often overseas. Many 17 go to Australia or America and do something that's 18 focused for a period of time on a particular topic. 19 Q. I see and so what are the advantages of training and 20 research in that way? 21 A. I think it probably gives one an enhanced understanding 22 of the topic in question, better understanding of 23 research practice are the main benefits, I would 24 suspect. 25 Q. Thank you. You tell us that you were the Dean of the Page 155
1 training. I was, at that time, training in 2 endocrinology and diabetes and the research subject was 3 the treatment of patients with overactive thyroid 4 disease. 5 Q. Is that postgraduate degree a normal part of medical 6 training or is it something that one can take 7 voluntarily in addition to the training? 8 A. Voluntarily in addition. 9 Q. What sort of proportion of doctors do a postgraduate 10 degree while training like that; is it common? 11 A. I can't give you the exact figure, but less than 10%. 12 Q. Right. You tell us that you are a fellow of the Academy 13 of Medical Sciences which is not an academy we've come 14 across. Could you tell us something about that 15 organisation? 16 A. Academy of Medical Sciences is a UK-based academy. It 17 was set up around 1999 to promote excellence and 18 scientific research across the UK. Fellowship is by 19 election and is generally seen as a mark of 20 international recognition. 21 Q. Thank you. You tell us at paragraph 2.1, if we just 22 scroll down a little bit, that your clinical and 23 research training and professional academic clinical and 24 research practice from 1977 to 2009 was in the west of 25 Scotland. An aspect of that I just wanted to explore Page 154	1 School of Medicine and Professor of Endocrinology at the 2 University of Dundee between October 2009 and 3 January 2012; is that correct? 4 A. Yes. 5 Q. What were your responsibilities as dean? 6 A. I was overall in charge of the medical school. So I was 7 responsible for ensuring that undergraduate medical 8 teaching was being delivered appropriately, that 9 research was being carried out in the appropriate manner 10 by the university staff and that the university medical 11 school had appropriate relationships with other medical 12 schools and regulatory bodies across the United Kingdom. 13 Q. Thank you. You go on to say that you were the "Head of 14 the College of Medicine, Dentistry and Nursing and 15 Vice Principal for Research" at the University of Dundee 16 between 2012 and 2015. What did that role involve? 17 A. At that stage, the university still was divided into 18 a college structure, so there was a college of medicine, 19 dentistry and nursing. All various schools had their 20 own deans. So I was no longer dean of medicine, but I 21 was head of college. So I had overall responsibility 22 for ensuring the schools delivered on their purpose. In 23 addition to that, I was head of research for the 24 university. The university at that stage was involved 25 in a national research assessment process called the Page 156

1 research assessment framework. And my role was to guide 2 the university through that process. 3 Q. Right. So you mentioned there the schools. As 4 I understand it, would medicine be one of the schools? 5 A. Medicine was a school. 6 Q. What would the other schools be, are they dentistry ...? 7 A. Dentistry and nursing. 8 Q. Understood. You also tell us in your statement that you 9 were the "Chair of NHS Tayside between 2016 and 2018 and 10 have since been retired" and you explain that was 11 a non-executive role providing leadership to the board. 12 We heard earlier from one of your former colleagues, 13 I think Professor McCrimmon, that he held a role within 14 the board of NHS Tayside which he described as being one 15 which, since he has been involved in the university, 16 it's been occupied by someone from the university. And 17 that that was a role which he understood would be filled 18 by a university representative because of the close 19 relationship between the university and NHS Tayside. As 20 I understand it, the role that you had was not so much 21 that but it was quite a different role, is that right? 22 A. It was. 23 Q. And what were the responsibilities, then, of the chair 24 of NHS Tayside? 25 A. The chair of a health board was responsible for, Page 157	1 Q. Thank you. You tell -- we've had some discussion with 2 Professor McCrimmon about various circumstances in which 3 it might or might not be appropriate to use the title 4 "professor" but your current position, as I understand 5 it, is something called an emeritus professorship from 6 the University of Dundee. Could you tell us what that 7 is? 8 A. Generally speaking, when academic members of staff 9 retire, they retain association with the academic body 10 in which they were working, so in my case the University 11 of Dundee. But I'm no longer an active professor in the 12 university, I have no role in the university. So 13 "emeritus" is really an honorary title to indicate that 14 I was a professor in the university, but I'm now 15 retired. 16 Q. As I understand your evidence that you've just given, 17 that would tend to involve, but not necessarily involve, 18 some ongoing connection in the activities of the 19 university, is that right? 20 A. It can vary from person to person. I still have some 21 involvement in supervising or leading Tenovus, the 22 medical research charity, for example, which is located 23 within the medical school. 24 Q. Thank you. In response to the question you were asked 25 at paragraph 2.3, if we scroll down a little bit. You Page 159
1 I guess, providing overall leadership to the board, 2 providing scrutiny and support for the executive team on 3 the board, and liaising with other non-executive board 4 members to ensure that the public and other 5 representatives were appropriately heard and listened 6 to. 7 Q. I think we'll hear evidence from some people who are 8 currently involved in that system but it would be useful 9 just to understand, from your perspective, how that 10 works. So you described your role as a non-executive 11 role. Does that mean that the executive -- perhaps the 12 chief executive reported to you? 13 A. Reported to the board and as I was chair of the board, 14 yes, I led that scrutiny. 15 Q. So the role of the board, if I can put it broadly, is 16 that the executive arm would be involved in running 17 NHS Tayside, whereas the board is involved in 18 scrutinising that function, broadly? 19 A. Yes. Yes. 20 Q. With all sorts of other activities, particular 21 activities, but that's the broad relationship. How did 22 you become the chair of NHS Tayside? 23 A. I applied and had a selection process carried out by, at 24 that stage, Paul Gray who was the chief executive of NHS 25 Scotland. Page 158	1 tell us you can confirm that there was no crossover 2 within your professional roles or responsibilities with 3 the neurosurgical department at Ninewells Hospital or to 4 Mr Eljamel: 5 "In [particular], there was no crossover between 6 2016 and 2018 when I was Chair of NHS Tayside." 7 You were asked to confirm whether the neurosurgical 8 service, or Mr Eljamel were services or an individual 9 with whom you had some connection. You confirmed, 10 I think, that you did not; is that right? 11 A. That's correct. 12 Q. Do I take it from that to mean that issues related to 13 Mr Eljamel or the neurosurgical service pertaining to 14 his practice were not raised in the period between 15 2016-2018 while you were chair of the board, or at least 16 not raised with you? 17 A. They were not raised with me. 18 Q. So for example, we've heard evidence already that in 19 2018 a report about, I think it would be fair to say 20 governance issues or structural issues pertaining to 21 Mr Eljamel's practice, was commissioned by the executive 22 medical director of NHS Lothian in 2018, Ms Tracy 23 Gillies. Was that something then that wasn't brought to 24 your attention? 25 A. I have no recollection of it. Page 160

1 Q. Thank you. As far as the way in which the statements 2 were generated, the Inquiry sent a single request to the 3 University of Dundee. We've been already, with 4 Professor McCrimmon, through aspects of his statement 5 which he explained to us have been contributed to by 6 numerous individuals. Did you contribute to his 7 statement? 8 A. I had a telephone discussion with him on two occasions. 9 I didn't help him write the statement though. 10 Q. Yes. And you were -- were you contacted by the 11 university to provide some evidence in response to the 12 request? 13 A. Contacted by the university's legal department, or legal 14 officers. 15 Q. Right, do you know why they did that? 16 A. No. Well, I assume because I was dean of medicine from 17 2009 to 2012. 18 Q. Yes and in particular, I suspect as we'll come on to, 19 you had some factual involvement -- 20 A. Yes. 21 Q. -- in certain matters that perhaps they thought you 22 would be able to provide some useful testimony to the 23 Inquiry about. 24 A. Yes. 25 Q. I think your position, if we could just scroll down to Page 161	1 to the University of Glasgow. So Mr Eljamel's name 2 cropped up in the context of that. 3 Q. What was the nature of that research, to the best of 4 your recollection? 5 A. Sandy Cochran did research into developing technologies 6 for very fine ultrasound probes to detect tumours etc 7 within body cavities. Eljamel, as far as I know, was 8 advising him on that. 9 Q. Right, and we've heard some information already from 10 Professor McCrimmon about different types of research. 11 Is that sort of research a clinical trial? 12 A. I don't think it got to the stage of a clinical trial. 13 I think it was device development and trying it out in 14 a laboratory setting, not in patients. 15 Q. I see. So, as I understand it, if -- this is at a sort 16 of conceptual level, one is trying to work out whether 17 it would be possible to conceive of and devise and 18 develop a tool for this particular function; is that 19 right? 20 A. That's right. 21 Q. And I suppose had the project progressed, someone might 22 actually have created one and tried it out. And would 23 that be a clinical trial? 24 A. That would be, yes. 25 Q. Thank you. Was that research particularly important or Page 163
1 paragraph 3.1, you were asked in particular -- you've 2 given a general response about your association with 3 Mr Eljamel when you were on the Tayside board, but in 4 relation to the particular issue of his teaching and 5 involvement at the university, you tell us that you: 6 "... have no recollection of Mr Eljamel's teaching. 7 [But that] at the time, Mr Eljamel was an employee of 8 NHS Tayside, and he held an honorary contract with the 9 [University of Dundee]. All consultants at NHS Tayside 10 had honorary contracts with the [University of Dundee] 11 as lecturer, senior lecturer or reader/professor. This 12 was routine practice for any consultant that worked at 13 NHS Tayside, and it would allow them access to the 14 [University of Dundee] medical school teaching resources 15 and emails." 16 So first of all, you have no recollection of his 17 teaching? 18 A. No. 19 Q. No recollection of his research? 20 A. I was aware that he was carrying out research. 21 Q. Yes, but how far did that go? Was it beyond that mere 22 fact, did you know anything about it? 23 A. I was aware he was involved in some collaborative 24 studies with Professor Sandy Cochran who was a professor 25 of medical technology at the time, who has since moved Page 162	1 pioneering research? 2 A. It was pioneering. Sandy Cochran is an international 3 expert in the field of fine-needle ultrasound detection 4 of tumours etc. So the university was pleased it was 5 being carried out. 6 Q. Do you recall the time period over which it was being 7 delivered, or being done? 8 A. From recollection, it must have been around 2010 and 9 2012-13. 10 Q. If we could just understand a little bit more about the 11 concept, I don't know how much of the detail you can 12 remember, but if the idea here were that they -- you had 13 these -- you had this, in particular, eminent individual 14 who was involved in trying to conceive of and develop 15 something that might ultimately become a product -- 16 A. Yes. 17 Q. -- is that something that might attract attention from 18 companies that might be interested in manufacturing such 19 a product? 20 A. Eventually, yes. This research was funded by the EPSRC, 21 the Engineering and Science Research Council. 22 Q. Right, is that a public body? 23 A. It's a public body, similar to the MRC, but focusing on 24 engineering and allied topics. 25 Q. Understood. We've heard some evidence about that. And Page 164

1 so, it wasn't funded by a pharmaceutical company or 2 anything at that stage? 3 A. No. 4 Q. But might it have become something of interest to 5 a company? 6 A. It might have had potential. 7 Q. Thank you. You mentioned, in the passages that I have 8 read out, you tell us some information in connection 9 with which we've already heard evidence about the system 10 in place at the university at the time for awarding 11 honorary positions to medics working in the hospital, in 12 particular consultants. And we know, because we've been 13 through the details of the documentation with 14 Professor McCrimmon, that Mr Eljamel held a number of 15 these positions and that shortly after his appointment 16 he was offered the position of honorary senior lecturer 17 and at some point later, exactly when it's slightly 18 unclear, he became an honorary reader and then 19 ultimately an honorary professor. I was interested in 20 your recollection, in particular of the process that was 21 undertaken by the university, in order for these 22 appointments to be ratified, I suppose. 23 My understanding, from the evidence so far, is that 24 when one starts off at the bottom level, if you like, it 25 would be normal for a consultant, in particular, as Page 165	1 A. By and large the senate would take advice of the 2 recommending medical school board or other school board 3 or college board. 4 Q. Does that mean that there was not a lot of scrutiny, if 5 you like, of the applications? 6 A. I think it's fair to say that. 7 Q. Would that apply equally to all of the different levels. 8 So for example, as one goes up the scale up to honorary 9 professor, would it perhaps be the case that a greater 10 degree of scrutiny would be applied in relation to 11 progress to a professorship application? 12 A. I think so. 13 Q. We've heard some evidence already that one of the key 14 components in an application like this, from a factual 15 point of view, was to assess the eggs tonight which 16 an applicant actually, in fact, played a role in 17 university life by offering teaching and/or research. 18 Would that have been part of the consideration? 19 A. It should have been, yes. 20 Q. Yes, and would there have been consideration in 21 a professorship application -- honorary professorship 22 application of what one might describe as the probity of 23 the individual involved, or would that be assumed from 24 the fact that they already held a consultant post in the 25 hospital? Page 167
1 Mr Eljamel was a consultant, to be offered either 2 a lecturer or a senior lecturer post relatively 3 automatically, is that right? 4 A. That's correct. 5 Q. And you mention in the statement that there is some part 6 of the process in which the application passes through 7 various different bodies for their approval to be 8 accorded to it; is that right? 9 A. Yes. 10 Q. In particular, you mention the senate as being a body. 11 Now, what is the senate of the university? 12 A. Senate is a senior regulatory body of the university, so 13 it had the ultimate say-so in deciding whether or not 14 honorary contracts would be awarded. Senate members 15 were comprised of heads of college, university 16 vice-chancellor and some staff representatives and some 17 student representatives. 18 Q. And by the time an application for an honorary post had 19 got to the senate, it would already have been through 20 earlier stages in the process, is that right? 21 A. Yes. 22 Q. So if we can focus on what would the senate's role have 23 been in particular, would their role have been simply to 24 rubber-stamp an application, or would it be more 25 complicated than that? Page 166	1 A. I suspect that certainly it would work on the basis that 2 no one would come to their notice unless probity had 3 been assured. 4 Q. Okay. Can we have a long at paragraph 3.4, please, and 5 in this regard you give us some information about 6 circumstances in which issues may arise. You say: 7 "If there were concerns about Mr Eljamel's clinical 8 competence, NHS Tayside would have managed these. The 9 [University of Dundee] would have only been notified of 10 any concerns if they pertained to Mr Eljamel's link to 11 the [university]. If any action were taken to address 12 any concerns, for example an employee with an honorary 13 contract was suspended, dismissed or resigned from NHS 14 Tayside then I believe the Senate would be notified." 15 So, is it only in those circumstances of suspension, 16 dismissal or resignation, that information about 17 someone's clinical practice would come to the senate's 18 attention, in the normal course? 19 A. I think in terms of the senate, that's correct. I would 20 have hoped before that period the medical school dean or 21 the whatever school dean involved would have been 22 notified and discussed the matter with NHS Tayside. 23 Q. Yes, because we've heard some evidence to this extent 24 already, that it is an important part of awarding, 25 albeit honorary positions, to consider the fact that by Page 168

1 awarding these positions that the individual who 2 receives the role would be working with students, 3 working in research, working therefore with undergrad, 4 possibly graduate students and also staff of the 5 university, is that right? 6 A. Correct. 7 Q. And so both from a point of view of the way that they 8 interact with other people, but also from the point of 9 view of the quality of the education they would be 10 imparting to students or others, one should, I would 11 imagine, have some level of assurance that they will do 12 so in a manner that would be commensurate with the 13 university's expectations? 14 A. Yes. 15 Q. Could we have a look at paragraph 3.7, please. You 16 mention there, professor, that: 17 "In addition, there was a formal University 18 Strategic Liaison Committee ('the Committee') that was 19 made up of individuals from NHS Tayside, usually the NHS 20 Medical Director and/or the Chief Executive, the Deans 21 of Medical, Nursing and Midwifery, Dentistry and 22 Postgraduate from the [University of Dundee], University 23 of St Andrews, Abertay University and Fife NHS Board. 24 The Committee would meet three or four times a year. 25 The purpose of the meeting was to discuss high level Page 169	1 the undergraduates rather than managing his delivery of 2 the teaching per se? 3 A. Yes, both. There would be bodies this would decide what 4 the structure of the curriculum looked like and what the 5 content should be and a committee tasked with ensuring 6 how that would be delivered. 7 Q. Yes, because the latter part, presumably, is also 8 important to make sure that the students are getting the 9 sort of education that the university would expect? 10 A. Quite. 11 Q. Could we have a look at paragraph 7.2, please. You tell 12 us there you were asked some -- this is a general 13 section which you're giving some responses in connection 14 with matters within the Inquiry's Terms of Reference to 15 the extent you can recall. And you say: 16 "In respect of 7(b), any complaints of bullying or 17 intimidation of junior medical staff in training should 18 have been formally raised with the Postgraduate Medical 19 Dean who at the time was Professor Philip Cachia, who 20 was an employee of NHS Education for Scotland. 21 Professor Cachia held this position throughout the 22 relevant period." 23 I wanted to, in that regard -- so far, what we've 24 been talking about in terms of training and teaching is 25 of university students; isn't that right? Page 171
1 policies. It would have been unlikely that we would 2 have discussed any clinical competency issues of an NHS 3 employee." 4 Could you describe -- obviously that involves quite 5 a wide variety of different bodies from the geographical 6 area. What sort of high-level matters would be 7 discussed on that board? 8 A. I think the clue is in the name; it was broader 9 strategy, often to do with joint teaching approaches, 10 sometimes common research goals between the universities 11 and how it might best relate to health boards across 12 Fife and Tayside. 13 Q. Do you recall what time period that was an active 14 committee? 15 A. It was in place when I arrived in Dundee in 2009 -- at 16 the latter part of 2009 and continued to meet until 17 I stopped being dean in 2012. 18 Q. Thank you. In the next paragraph, you say that: 19 "As I understand, within the structure of the 20 Undergraduate teaching there would have been formal 21 bodies in place for the management and clinical teaching 22 that would detail Mr Eljamel's involvement in 23 neurosurgical teaching." 24 Does that mean that there would have been bodies 25 that would have worked out what it is he needed to teach Page 170	1 A. Yes, correct. 2 Q. But this is a different type of training, as 3 I understand it. This is training being delivered to 4 what I think you tell us in the statement would have 5 been known a junior doctors at the time, now resident 6 doctors in training; is that right? 7 A. Correct. 8 Q. And you help us throughout your statement with 9 identifying the appropriate body that would be contacted 10 if issues arose in different circumstances. In this 11 particular circumstance, if there were considerations of 12 bullying and intimidation you say that that's a matter 13 that would be raised with the postgraduate medical dean 14 and you tell us that that was Professor Philip Cachia. 15 A. Yes. 16 Q. And Professor Cachia, did he work for NHS Education for 17 Scotland or did he work for the university or the 18 hospital? 19 A. NHS Education for Scotland. 20 Q. Right. Did he also have a role in the hospital? 21 A. He was a consultant haematologist. 22 Q. I see. Could we go, please, to paragraph 13.3. You 23 were asked about, in relation to the honorary roles that 24 we've discussed, whether there were any inductions 25 involved in the roles. That's something that the Page 172

1 Inquiry is specifically tasked with looking at and you 2 understand, as I think you indicate there, that there 3 that were there no inductions involved in any of the 4 honorary roles, is that right? 5 A. Formally yes, although I think all consultants involved 6 in teaching would take part in training opportunities to 7 understand the university's medical curriculum and how 8 best to deliver it. 9 Q. Yes. I was going to say there would be presumably some 10 level of information that would have to be imparted? 11 A. Yes. 12 Q. You know, even how does one access the university emails 13 and things like that? 14 A. Quite. 15 Q. But beyond that, there was, you think, some level of 16 informal system of educating someone about what it is 17 that they should be teaching? 18 A. Absolutely. For example, we wouldn't allow people to 19 examine students in terms of final exams or term exams 20 without understanding how the examination system worked, 21 how students should be treated, etc. 22 Q. Right, and would that be the responsibility of 23 an honorary individual such as Mr Eljamel, undertaking 24 exams? 25 A. We wouldn't allow anyone to take part in exams if they Page 173	1 Mr Eljamel. In the exchange, Mr Mowle explained that 2 Mr Eljamel had been suspended by NHS Tayside pending 3 referral to the General Medical Council ... which was a 4 drawn-out process likely to take 1-2 years. Mr Mowle 5 explained that it was unlikely Mr Eljamel would be 6 returning to work within the timeframe of Mr Mahboob's 7 research project. Professor Cochran's email to myself 8 and Jill Belch explained that Mr Eljamel held a formal, 9 paid consultant position on his Engineering and Physical 10 Sciences Research Council ('EPSRC') grant on Ultrasound 11 in a Needle and was the MD Supervisor of Mr Mahboob, in 12 the Clinical Research Facility on the grant. 13 Professor Cochran was seeking advice in relation to how 14 to deal with the situation concerning Mr Eljamel in the 15 context of the EPSRC grant." 16 So could we just have a quick look at that, please? 17 A. Sure. 18 Q. That's UNID-00115. Just zoom in please and go further 19 down, thank you. And further down again. Further down, 20 please. We're going to the entry on 19 December. 21 Further down, please. Just go right down to the bottom, 22 thanks. Okay. So, we see the exchange there. There's 23 an email from Sandy Cochran to Mr Mowle. I think that 24 email is following up, just saying that Mr Mahboob had 25 obviously spoken to him and that he should contact Page 175
1 had not been through the proper training process. 2 Q. Okay, could we go, please, to paragraph 16.2. I'd like 3 to ask you questions now, professor, about the process 4 through which Mr Eljamel's connection with the 5 University of Dundee came to an end. This is a matter 6 in which you had some personal involvement as 7 I understand it; correct? 8 A. Yes. 9 Q. You say, at paragraph 16.2, that: 10 "On 19 December 2013 Professor Sandy Cochran [who 11 you've mentioned already] (Professor and Senior Research 12 Scientist) forwarded an email exchange between 13 themselves and ..." 14 You say "David Mowle", is that possibly David Mowle? 15 A. I think it's Mowle, yes. 16 Q. Mowle, yes: 17 "... Consultant Neurosurgeon and Clinical Leader, at 18 the Hospital, NHS Tayside, to myself and Jill Belch 19 ([who is the] Head of the Medical Research Institute ... 20 The email exchange indicated that Professor Cochran had 21 been invited to contact Mr Mowle by [a] Mr Mahboob 22 regarding confidential information concerning 23 Mr Eljamel. I am not aware of who Mr Mahboob is, but 24 from the content of the email, it appears that he may 25 have been a clinical research trainee working with Page 174	1 Mr Mowle about the situation with Mr Eljamel. The 2 position then, as I understand it, is that this 3 individual, who is involved in the research project that 4 we've talked about already, had approached 5 Professor Cochran with a concern about what was going on 6 with Mr Eljamel, is that right? 7 A. That's correct. 8 Q. And the concern appears to have related to the fact that 9 Mr Eljamel was supervising in some way related to his -- 10 that individual's involvement in the project; is that 11 correct? 12 A. Correct. 13 Q. And can one deduce from this correspondence that the 14 concern was as to whether or not Mr Eljamel would be 15 able to continue to provide that supervision? 16 A. Correct. 17 Q. And the outcome was that -- as you explained in the 18 statement, was that you had contact from 19 Professor Sandy Cochran effectively seeking your advice 20 as to what to do and whether you knew anything about 21 this; is that right? 22 A. Correct. 23 Q. Did you know anything about it at that stage? 24 A. This was the first I'd heard of any problems with 25 Eljamel. Page 176

1 Q. Right. Would you -- if there had been problems with 2 Mr Eljamel, and we'll come back to what they might have 3 been before this point, was it the person in your role 4 that should have known? 5 A. I think Sandy Cochran approached me because of my role 6 as vice principal for research, but he should probably 7 have approached, first of all, the dean of medicine at 8 that time who was Andrew Morris. 9 Q. But what he was trying to ascertain was whether people 10 in senior positions knew something about this in order 11 to help the individual who'd approached them? 12 A. Yes. 13 Q. And you've told us already that you didn't know? 14 A. No. 15 Q. So you didn't know, for example, that there had been 16 numerous complaints about Mr Eljamel's practice, 17 including allegations of wrong-site surgery and 18 allegations about his probity that had arisen between 19 2011 and 2013? 20 A. I had no knowledge of that. 21 Q. You didn't know that, as a result of those concerns and 22 complaints by patients, the NHS Tayside had launched 23 a Royal College of Surgeons invited review about 24 Mr Eljamel as an individual? 25 A. Again, no knowledge. And no one at the university had Page 177	1 Q. Yes. So you say in that -- this is to Jill Belch, whom 2 we've heard about already who was heavily involved in 3 the research side of the operation, I think. And to 4 Professor Cochran, who we've already discussed. It 5 says: 6 "Dear Jill and Sandy. 7 "This is a great pity. As far as I'm aware, Sam is 8 an NHS employee so the NHS are fully responsible for his 9 line management. Normally, suspension will prevent him 10 having any form of clinical contact, but it is possible 11 that he could carry out consultancy for a research 12 project while suspended. I have cc'd Gillian in HR for 13 advice here. 14 "In terms of the MD, he could supervise the academic 15 element, but clearly not any clinical study that 16 involved him in patient contact. 17 "I am not aware of the reason for the suspension. 18 It is a pity that the NHS management has not kept us 19 informed as Sam is an honorary professor who has been 20 important in teaching etc. Gillian may have more 21 information here, and can contact NHS HR." 22 Is it fair to say that you've only just learned this 23 information and these are immediate thoughts off the top 24 of your head? 25 A. I think that's fair, from 19 December, yes. Page 179
1 been told. 2 Q. Yes, I was going to ask you. Did anybody else, as far 3 as you understand it, know anything about this? 4 A. No. 5 Q. For example, you have mentioned Andrew Morris. As far 6 as you understand, did he know anything about it? 7 A. He did not know. 8 Q. Right. So therefore, would you have expected to have 9 known these things? 10 A. We should have been told. 11 Q. Yes. Why? 12 A. Because Mr Eljamel had an honorary appointment with us, 13 he was involved in and exposed to students, involved in 14 research projects, would be affected by issues of 15 probity and certainly affected by his inability to be 16 involved in clinical work. 17 Q. I see. So armed with that information, the university 18 would have required to take some decisions about 19 Mr Eljamel's ongoing involvement with his activities? 20 A. Yes. 21 Q. Could we go to page 2 of this document, please. Further 22 up. This is an email from you to Jill Belch and 23 Sandy Cochran of the 19th. Is this your response to 24 this being raised with you? 25 A. This was my initial response, yes. Page 178	1 Q. Yes and obviously, you've identified that the issue, as 2 we've discussed, is whether Mr Eljamel will be able to 3 continue his involvement in the research project and 4 supervising the individual who had raised the issue; is 5 that right? 6 A. That's correct. At that stage, we had no understanding 7 of the concerns that had been raised by Mr Eljamel were. 8 So I was working on the basis we should perhaps assume 9 that he was not necessarily innocent until proven 10 guilty, but we should not jump to conclusions. 11 Q. Understood. And on the subject, you say: 12 "Normally, suspension will prevent him from having 13 any form of clinical contact, but it is possible that he 14 could carry out consultancy for a research project while 15 suspended." 16 Is that thought off the top of your head related to 17 the nature of this particular project, in the sense that 18 if he were suspended he couldn't have clinical contact 19 with patients but because, as we discussed, this was not 20 a clinical trial, that might not be necessary; was that 21 the thinking? 22 A. I think that was correct. I expected if he was being 23 asked his opinion on the design of a needle or his 24 opinion on how to test something, he might be able to 25 advise on that. Page 180

1 Q. Obviously, at this stage, as you say you're innocent 2 until proven guilty, you're keeping an open mind, but 3 you were advancing a theoretical possibility in those 4 circumstances. He could be suspended from clinical 5 practice but continue in a research project, in theory? 6 A. In theory. 7 Q. Yes. Could we go to 16.5, please, of the statement. 8 You say there: 9 "On 20 December 2013 Gillian ..." 10 I think Gillian is the person within the HR 11 department, is that right? 12 A. Gillian Boyd, who I think is now Gillian Stott. 13 Q. Right, indeed. She contributed, I think, to the other 14 statement: 15 "... contacted NHS Tayside's HR who ultimately 16 returned her call. Due to the passage of time, I have 17 no knowledge of who Gillian spoke with. I do not know 18 whether Gillian kept a record of the call. Gillian 19 suggested a call with me but explained in the email that 20 NHS Tayside would not disclose any information to us at 21 this stage, but that Mr Eljamel should have disclosed 22 his suspension to us ... Due to the passage of time, 23 I cannot recall the details of the discussion with 24 Gillian." 25 And if we could go back to the other document, Page 181	1 contact, either with me or with the dean of medicine, 2 Andrew Morris at the time. 3 Q. For the reasons that we've discussed? 4 A. Yes. 5 Q. And also, despite the fact that she was calling 6 effectively on behalf of yourself and other senior 7 members of the university staff, they wouldn't disclose 8 any information to her about what was going on. 9 A. I was surprised. 10 Q. What would you expect them to have told her? 11 A. At the very least, I think they could have given her 12 an outline of where the main areas of concern were, 13 outlined what processes had been undertaken and offered 14 an immediate meeting. 15 Q. This was on 20 December 2013? 16 A. Yes. 17 Q. You weren't informed -- or your colleague Gillian wasn't 18 informed on your behalf that that was the day on which 19 Dr Russell, the medical director, had referred the 20 matter to the GMC? 21 A. No. 22 Q. Would that have been an important piece of information 23 to have communicated to the university? 24 A. Yes. 25 Q. Why? Page 183
1 please, at UNID-00115, this time page 1. At the bottom 2 there, at 10.22, Gillian says to you: 3 "Dear All ..." 4 This is Gillian Boyd to Jill Belch herself, and 5 Professor Cochran: 6 "Dear All. 7 "I contacted the NHS this morning and await a call 8 back. Will keep you posted!" 9 And then informs you that: 10 "In confidence I have spoken to the NHS [today]. 11 Perhaps [can you] give me a call ... I am around until 12 2.30pm. 13 "Basically they will not disclose information at 14 this stage but have indicated that [Professor] Eljamel 15 should have disclosed his suspension to us. Perhaps we 16 will have to write to him or ask him to attend 17 a meeting." 18 Now, there are some interesting aspects of that 19 which is, first of all, despite the fact that 20 NHS Tayside suspended him, they're suggesting that it's 21 Mr Eljamel who should have told you about this. Do you 22 agree with that, as a matter of process? 23 A. No. 24 Q. Whom do you think should have told you about this? 25 A. I would have expected the medical director to have made Page 182	1 A. Because a GMC referral would -- were it on the basis, 2 for example, of probity, or concerns about probity, then 3 the university would have been concerned about having 4 someone in that -- honorary staff involved in student 5 contact or research. 6 Q. Because in fact, which you may know now, the reasons for 7 the referral to the GMC were for a multiplicity of 8 different aspects of concerns related to Mr Eljamel's 9 practice, including interpersonal skills and what one 10 might describe as probity. 11 A. Yes. 12 Q. As well as -- technical skills as well. Is that your 13 understanding now? 14 A. Yes. 15 Q. So, back to the statement, please. Sorry to jump 16 around. Paragraph 16.6, you then tell us that: 17 "On 28 January 2014 I was contacted by Gillian to 18 see whether I had received any updates in relation to 19 Mr Eljamel. I confirmed the same day that I had not and 20 that I would clarify with NHS Tayside." 21 That's UNID-00130. We don't need to go to that. 22 And you say, at 16.7, if we just scroll down a little, 23 please: 24 "I sent an email to NHS Tayside's Medical Director, 25 Dr Andrew Russell and Alan Cook, Associate Medical Page 184

1 Director dated 4 February 2014 [UNID-00033]. In this 2 email I explain that I have become aware that 3 NHS Tayside had suspended Mr Eljamel pending an inquiry 4 into his clinical practice and questioning whether 5 notification had been provided to the [University of 6 Dundee] as I did not recall seeing information in 7 relation to this. Dr Russell responded to confirm that 8 it was an oversight and that he would ensure that there 9 was formal notification in the usual way ..." 10 Now, if we could go to UNID-00033, please. Just to 11 orientate ourselves, we're now in February and the 12 original request by Gillian on your behalf had been back 13 in the December; that's right, isn't it? 14 A. Yes. 15 THE CHAIR: 20 December, I think. 16 MR DAWSON: Indeed. Thank you, sir. So if we scroll down 17 a bit, this is an email from you dated 4 February, 18 saying: 19 "Dear Andy and Alan ..." 20 Just to be clear, "Andy" was Andrew Russell who was 21 the medical director of NHS Tayside? 22 A. Yes. 23 Q. And the other individual who I think was Alan Cook, 24 associate medical director; is that correct? 25 A. That's correct. Page 185	1 would you characterise that response? 2 A. Brusque. 3 Q. Yes. Do you think it would be fair to say that it 4 perhaps doesn't pick up on the fact that you're 5 irritated and that you consider this to be quite 6 an important matter? 7 A. That's one interpretation. 8 Q. Would it be an interpretation that you would have? 9 A. Possibly, yes. 10 Q. If we could then go to UNID-00027. This is a letter 11 we've seen already which is a letter dated 17 February 12 to you. Is this the formal contact that Dr Russell had 13 referred to in the previous email? 14 A. This is the first formal notification. 15 Q. Yes. So the suggestion that the oversight would be 16 remedied was on 4 February and this is on the 17th, is 17 that right? 18 A. Yes, correct. 19 Q. And he says -- sorry, just scroll down a little bit so 20 we can see who this is from. This is, I think we can 21 see, from Dr Andrew Russell, medical director. And if 22 we go back to the top, thank you, please. It says: 23 "Dear Professor Connell. 24 "Suspension from duty, Professor Eljamel. 25 "Following a review report commissioned by the Royal Page 187
1 Q. So just to understand, that would be kind of a level 2 below the medical director, who would assist him with 3 exercising his medical director's functions; would that 4 be broadly -- 5 A. Yes. 6 Q. "I'm aware that the Trust has suspended Sam Eljamel 7 pending an inquiry into his clinical practise; our own 8 HR officers have queried whether we have had formal 9 notification of this, as he does hold an honorary 10 contract and we should ensure that our processes are 11 aligned. 12 "It may that be that this has occurred, but I cannot 13 recall seeing any information on this." 14 And scroll up to the top, it says: 15 "John. 16 "Apologies -- an oversight on our part. 17 "Will ensure formal notification in [the] usual 18 way." 19 Now, I suppose it's a matter of interpretation, but 20 that's quite a short response. What was the intention 21 when you sent the email of 4 February? 22 A. I think I was trying to be polite, but indicate that 23 I was irritated. 24 Q. Yes, it rather reads like that, if I may say so, 25 professor. And as far as the response is concerned, how Page 186	1 College of Surgeons in regard to Professor Eljamel's 2 clinical knowledge, technical skills and judgement as 3 well as his interpersonal skills a decision was made to 4 suspend him from duties with NHS Tayside on 5 10 December 2013. In addition Professor Eljamel has 6 been referred to the GMC. The outcome of that referral 7 is pending. 8 "Subsequent to the decision to suspend and prior to 9 arrangements being made to proceed with an internal 10 investigation Professor Eljamel submitted an application 11 for early retirement and notified NHS Tayside of his 12 intention to leave the service of this Organisation 13 effective from 31 May 2014 and consequently a decision 14 has been made not to pursue the internal investigation." 15 So that contains quite a lot of information about 16 the background and the GMC referral which Dr Russell 17 hadn't given you in his email of 4 February, is that 18 right? 19 A. Correct. 20 Q. And this is an aspect of what I was referring to earlier 21 when I was looking back into the past but just to get 22 your impression, as far as the report is concerned, 23 how -- would you agree with the characterisation I made 24 earlier that this is an extensive report into a wide 25 range of aspects that you would consider to be important Page 188

1 in a surgeon's practice? 2 A. Pretty comprehensive. 3 Q. Yes. One might say that's a list, really, of the 4 qualities that a surgeon would have to have to be 5 an effective surgeon, is that fair? 6 A. Yes. 7 Q. Thank you. And if I could go, please, to UNID-00022. 8 Thank you very much. This is a letter dated 9 25 February 2014. If we just scroll down a little bit 10 more, we can see this is letter from you, is that right? 11 A. Correct. 12 Q. This is to Dr Russell and you are saying: 13 "Thank you for your letter outlining the outcome of 14 Professor Eljamel's application for retirement. This 15 seems to me to resolve the situation and it certainly 16 makes management of any joint contract issues much 17 easier. 18 "There are some residual research studies where he 19 has been an investigator and I have let Jill Belch know 20 in order that she can now set up appropriate governance 21 arrangements for this." 22 What did you mean when you said that the outcome 23 involving his application for retirement seemed to 24 resolve the situation and made management of any joint 25 contract issues much easier? Page 189	1 abandoned which I was surprised about at the time. 2 Q. Why were you surprised about that? 3 A. I felt that NHS Tayside needed to understand what had 4 gone on and needed to understand what remedial steps it 5 should have taken. 6 Q. Are you familiar with the Royal College of Surgeons 7 Invited Review Mechanism? 8 A. In general terms, yes. 9 Q. Well, if you can take it from me that we've heard 10 evidence already that there are different kinds of 11 reviews that can be commissioned from the Royal College 12 of Surgeons. The two main categories being 13 an individual review or a review into the systems that 14 exist within the hospital pertaining to individual 15 issues. Is your understanding enough to understand that 16 those are the broad categories? 17 A. Yes. 18 Q. And we've already heard evidence from a professor from 19 the Royal College of Surgeons who is now in charge of 20 that mechanism to tell us that the review that was 21 requested and is referred to in the correspondence sent 22 to you was an individual review but that it also asked 23 for any comments on clinical governance or wider 24 systemic issues that happened to come up during the 25 course of it. It wasn't a formal review into systems. Page 191
1 A. I think at the time I was of the view that had he not 2 applied to retire but was staying on NHS Tayside books, 3 the university would then have had to start dealing with 4 him as an individual and sort out a separate process for 5 managing whatever was going to happen to him. The fact 6 he had retired made it much easier from our point of 7 view. 8 Q. I suppose I'd ask you why is that the case? 9 A. Because it then became very clear that we could simply 10 terminate his honorary contracts and say that we had no 11 further contact with him. 12 Q. I see, rather than it being more specifically to do with 13 the fact, for example, that he didn't have any contact 14 with patients from that point on, would mean he couldn't 15 really be involved in any university activities. It's 16 simply a question of if one relationship comes to an 17 end, the other would automatically, is that right? 18 A. Yes. 19 Q. Understood. So your understanding, I think at this 20 stage, just to be clear, was that an investigation -- 21 an intimation had been made to the GMC -- 22 A. Yes. 23 Q. -- and that an investigation was underway but that that 24 investigation had been abandoned, is that right? 25 A. The internal investigation appeared to have been Page 190	1 Take it from me we've heard evidence to that effect. 2 He also told us that it would be open to NHS Tayside 3 at any stage to have commissioned a systems review. Is 4 that the sort of investigation, whether it be via the 5 Royal College of Surgeons, or internally, or via another 6 agency, that you think should have been undertaken at 7 this stage? 8 A. Yes. 9 Q. Why? 10 A. Because clearly there had within major issues in terms 11 of Mr Eljamel's clinical practice carrying on, in 12 retrospect, for some years and I thought it was 13 important that NHS Tayside understood why these had not 14 been addressed properly, what impact it had on patients 15 and how they might be avoided in the future. 16 Q. Did you have any insight into why it was that such 17 an investigation, which as you've explained to us you 18 considered would be important, was not undertaken with 19 NHS Tayside and that the investigation was brought to 20 an end at that stage? 21 A. I think someone was trying to close the book on the 22 matter. 23 Q. And that someone would be someone within NHS Tayside? 24 A. Yes. 25 Q. Could we go to paragraph 16.8, please, of the statement. Page 192

1 You tell us there -- you carry on through the narrative. 2 You say: 3 "On 3 April 2014 Gillian emailed me regarding 4 Mr Eljamel's retirement with effect from 31 May 2014 and 5 asking whether to end his honorary contract with the 6 [University of Dundee] at this point ... I responded 7 the same day to explain that I had discussed it with 8 Gary Mires (Head of the Medical Education Institute and 9 Deputy Dean) and Andrew Morris (Dean of Medicine), and 10 the feeling was that the honorary appointment would 11 terminate on his retiral from NHS Tayside ... Whilst 12 I do not have a full recollection of this, I believe 13 that the default position favoured by Professor Morris 14 at the time would be to remove the honorary contract 15 when the individual ceased NHS employment. At this 16 stage NHS Tayside were formally treating details of the 17 concerns in relation to Mr Eljamel as a confidential 18 matter and had not divulged full details to the 19 [University of Dundee]." 20 At this stage it appears that that there was some 21 internal discussion within the university as to what all 22 this meant and whether there would, in fact, 23 necessarily, as you've suggested, be an automatic 24 termination of the honorary contract and what course 25 should be taken. Was your ability to make decisions Page 193	1 A. Yes. 2 Q. Could we look, please, at UNID-01435. Sorry, that's the 3 wrong reference, it's UNID-00067. My apologies. 4 Page 10, I think, of this document. Scroll down. This 5 is Jill Belch, I think, writing to you, Andrew Morris, 6 Gary Mires and Roland Wolf; who is that? 7 A. Yes. 8 Q. Who is Roland Wolf? 9 A. He was the joint head of the Medical Research Institute, 10 a non-clinical scientist. 11 Q. Thank you. So this correspondence, I think, is to do 12 with what the research consequences are of this 13 situation, is that right? 14 A. Yes. 15 Q. It says there: 16 "Dear John. 17 "Further to discussion about Sam with the MRI 18 Directors ..." 19 We have heard about the MRI this morning: 20 "... i.e. Keith, John, Roland and myself, as you 21 requested, regarding the question of continued 22 University work, we now have an agreed opinion from MRI. 23 "Because there is a question of probity in the GMC 24 investigation, which we believe will still proceed 25 despite his retiral, we feel that he should not have any Page 195
1 about what the proper course was with your colleagues, 2 I think it's Mr Mires and Professor Morris, hampered by 3 the fact that you still didn't have, you felt, all of 4 the information? 5 A. I think we were concerned that we still had not been 6 fully informed. 7 Q. You mentioned earlier the need to try to take someone as 8 innocent until proven guilty. Was it fair to say at 9 this stage that there was more information that you 10 think you could have been provided with by NHS Tayside 11 that would have made that process easier? 12 A. Yes. 13 THE CHAIR: Did you have any insight at all as to why this 14 approach appeared to be taken? 15 A. I was puzzled by it. 16 MR DAWSON: And the discussion at this stage -- I suppose 17 the fact that there was a discussion, which you accept 18 but you don't have full recollection of it, suggests 19 that other options might have been feasible for the 20 university but that the discussion led to the conclusion 21 that you've already described, that it would be the most 22 appropriate course in the circumstances to terminate the 23 honorary contract as well? 24 A. Yes. 25 Q. For the reasons you've already explained to us? Page 194	1 role in research until after the GMC result is 2 available. This is very distressing for Sam however, 3 the probity issue is a key one for us in terms of 4 research integrity and we feel that we cannot continue 5 research access until this is clarified. 6 "I hope this opinion is [helpful]." 7 So this is Jill Belch explaining to you, given what 8 information she has got about the nature of the GMC 9 investigation, that the probity aspect of it would mean 10 that she would not be comfortable with him continuing in 11 any of the research he was involved in at all, is that 12 right? 13 A. Quite. 14 Q. And just scrolling up a little bit further, please, to 15 the next email response, you say: 16 "Dear Jill. 17 "Agreed -- I had assumed that given the 18 circumstances we ought not to renew his honorary status 19 at present. This is also the view of Andrew and Gary." 20 That's what we saw in the other correspondence, 21 I think. And one aspect of this discussion is that 22 Jill Belch is under the impression, I think, that the 23 investigation by the GMC would continue at this stage? 24 A. Yes. 25 Q. But effectively, for her purposes, she knew enough about Page 196

1 the allegations to be able to say that she didn't think 2 it was appropriate for there to be a continuation? 3 A. Yes. 4 Q. And indeed, separately in relation to the honorary 5 appointment, yourself and your colleagues had reached 6 that conclusion as well? 7 A. True. 8 Q. Could we have a look, please, at -- sorry, 16.10 of the 9 statement, please. You tell us that: 10 "On 18 April ... Gillian from HR emailed me 11 a proposed letter to send to Mr Eljamel confirming the 12 termination of his honorary appointment [UNID-00135]. 13 The letter, dated 16 April 2014, explained that as 14 a result of the resignation from NHS Tayside with effect 15 from 31 May 2014, his honorary post would also end on 16 the same date [UNID-00137]. I confirmed my approval of 17 the letter by email the same date (19 April 2014) 18 [UNID-00034]." 19 And you say: 20 "I assume that the letter was then sent to 21 Mr Eljamel." 22 And if we could go, please, to UNID-00136. There's 23 a slight incongruity in the dates here. It purports to 24 be dated 16 April which is before the discussions you 25 had, but around this period, this appears to be Page 197	1 A. Yes. 2 Q. It's an email being sent directly to Mr Eljamel, is that 3 right? 4 A. Yes. 5 Q. And copying in the two colleagues, Gary Mires and 6 Andrew Morris, whom you mentioned earlier; is that 7 right? 8 A. Yes. 9 Q. It says: 10 "Dear Sam. 11 "Thank you for your email about your current status. 12 I was aware of your retirement from NHS practice. Given 13 this circumstance, and after discussion with colleagues, 14 I do not believe that it would be appropriate to 15 continue your Honorary contract to allow teaching or 16 other activity at present. 17 "I am aware of the very close involvement you have 18 had, over a significant number of years with 19 neuroscience research at Ninewells and I am very 20 grateful to you for this support. I think that 21 maintaining an informal link in relation to some of this 22 activity would, of course, remain appropriate without 23 sustaining an Honorary contract. 24 "With best wishes. 25 "John." Page 199
1 a letter, I think -- if we just scroll down to see who 2 it's from, please. Thank you. It's from Gillian Boyd, 3 HR Officer. It says: 4 "Dear Professor Eljamel ..." 5 On 16 April 2014: 6 "I understand that you have indicated that you will 7 retire from NHS Tayside with effect from 31 May 2014. 8 As your Honorary University of Dundee status with the 9 College of Medicine, Dentistry and Nursing runs 10 concurrent with your NHS Tayside post I am writing to 11 formally advise you that your Honorary University of 12 Dundee status will also end on 31 May 2014. 13 "Please note that all privileges linked to your 14 Honorary status will end shortly after your termination 15 date. 16 "May I take this opportunity to thank you for the 17 contribution you have made to the College over the years 18 and to with you well as you embark on retirement." 19 So this is a letter that she has sent out but it is 20 effectively saying that that's the decision which has 21 been reached by the staff, including yourself? 22 A. Yes. 23 Q. Could we have a look, please, at UNID-00042. This is 24 an email that you had sent, I think, at an earlier stage 25 in the process on 21 March 2014, is that right? Page 198	1 So at an earlier stage in your decision-making 2 journey, if I can put it that way, you had decided that 3 it would be appropriate to contact Mr Eljamel directly; 4 is that right? 5 A. I think in response to an email he'd sent me. 6 Q. Right. I don't think we have the email that he sent to 7 you. 8 A. I couldn't find it, no. 9 Q. Can you recall, or can you deduce from what you've said 10 here, what it was that he will have been saying to you? 11 A. I assume he must have told me that he had been -- 12 decided to retire from NHS practice and I don't know 13 whether he told me he'd been subject to GMC referral. 14 Q. Yes, which was information that had, by that point 15 I think, already been communicated to you by Dr Russell 16 already? 17 A. Yes. 18 Q. Yes, but he obviously felt that it was important that he 19 should tell you that directly. So you have replied to 20 that email. I'm interested in the aspect that says -- 21 you explain the decision you've already outlined, but: 22 I think that maintaining an informal link in relation to 23 some of the previous activity would, of course, remain 24 appropriate without sustaining an honorary contract. 25 What sort of link did you contemplate might be possible, Page 200

1 given the restrictions that you've already set out? 2 A. I think at the time, this is before we'd had the review 3 of Jill Belch, Roland Wolf and Keith Matthews. 4 Q. Yes. 5 A. And I think because we weren't aware of the – 6 necessarily the probity issues at that stage, we thought 7 it might be possible for him to have ongoing discussions 8 with Sandy Cochran, for example about technical matters. 9 Q. Yes, because as we discussed earlier, on that particular 10 research project it wouldn't necessarily be the case 11 that one would need to have clinical contact? 12 A. True. 13 Q. And therefore this is a theoretical possibility, as 14 I understand? 15 A. Absolutely. 16 Q. And as you have described, when you first got intimation 17 of this -- and we've gone through the process -- you 18 started off with your innocent until proven guilty 19 assumption and then the information you've had available 20 to you as we've gone along has increased and the 21 severity of the situation has become increasingly 22 apparent to you; is that right? 23 A. Correct. 24 Q. And when you refer to the report from Jill Belch and her 25 colleagues it was the documentation we just looked at in Page 201	1 Do I take it, from the evidence that you've already 2 given, that the "better information sharing" that you 3 contemplate here would have been sharing of information 4 from NHS Tayside to the university? 5 A. Yes. 6 Q. And you've already given us your reasons as to why you 7 think that was important? 8 A. Yes. 9 Q. And going forward, although you're not involved in the 10 university, you have a long-standing association with 11 both of these bodies. How important in the interests as 12 you point out yourself of patients is it that 13 information is shared in a candid way of this nature 14 going forward? 15 A. I think it's absolutely essential. Good patient 16 outcomes depend on good cooperation across 17 university/NHS interface, and if that doesn't occur then 18 patient outcomes will suffer. 19 Q. Thank you very much indeed. Sir, those are my 20 questions. Those are the questions that I have for you, 21 professor. There's just one question I ask of all of 22 the witnesses at this stage: is there anything you'd 23 like to add? 24 A. Perhaps on a personal level I should express my sympathy 25 to all those who have been impacted by Mr Eljamel's Page 203
1 which she, as the head of research, as I understand 2 it -- I have put it broadly -- had taken a view as to 3 whether it would be possible to continue with the 4 research and she had thought even if it might 5 theoretically be possible, it would not be appropriate 6 because of the probity issues? 7 A. Correct. 8 Q. And that was after this date, if I remember? 9 A. Yes. 10 Q. Could I just come to what, given the evidence you've 11 given, Professor Connell, might in fact be an entirely 12 understandable conclusion that you helpfully express to 13 us in your report, it's at paragraph 33.1. You were 14 asked -- or the university was asked and you gave 15 a view -- to reflect on this correspondence and to try 16 to work out, given this episode, whether there were 17 learnings that could come from it. And as I say, 18 perhaps not entirely surprising given your evidence to 19 the Chair today, you say, at paragraph 33.1: 20 "It is my belief that better information sharing 21 between the [University of Dundee] and NHS Tayside would 22 have promoted the best interests of Mr Eljamel's 23 patients. As I have not worked at the [university] for 24 some time, I am not aware as to the current processes 25 and procedures relating to information sharing." Page 202	1 actions and inactions over the years. 2 MR DAWSON: Thank you very much. 3 THE CHAIR: Thank you. Professor, we usually take another 4 point at this point in time just in case there are other 5 questions that parties wish to put. So if you can bear 6 with us for a few minutes. I'm sure I needn't remind 7 you not to discuss your evidence during the break, but 8 we'll be ready to resume shortly. 9 A. Thank you. 10 (3.49 pm) 11 (A short break) 12 (3.56 pm) 13 THE CHAIR: Yes, please have a seat. Mr Dawson. 14 MR DAWSON: Thank you, sir. Professor, there's one further 15 matter to raise with you. Could we go please to 16 document UNID-00112. 17 We can see here that this is a report of a meeting 18 on 20 September 2013 of the College of Medicine, 19 Dentistry and Nursing Board senate, is that right? 20 A. Yes. 21 Q. And is this a meeting that you attended? 22 A. I think so. 23 Q. If we just scroll down -- 24 A. I set of meetings to the college to submit a paper to 25 the senate in advance. Page 204

1 Q. If we just scroll down to the bottom, please. Just go 2 to 6.1, please. So there's a decision I think being 3 taken at this senate meeting relating to the senate 4 approving the college board's recommendations of certain 5 honorary professorships, is that right? 6 A. Yes, correct. 7 Q. And at this meeting, as I understand it, Mr Eljamel's 8 application for a renewal of his honorary professorship 9 was granted; is that correct? 10 A. Correct. 11 Q. As I said to you earlier, we've heard some evidence 12 about emerging concerns about professor -- or 13 Mr Eljamel's practice, and in particular and as a result 14 of three complaints about his practice in 2011, four in 15 2012 and eight in 2013. As I've told you before, 16 NHS Tayside instigated an Invited Review Mechanism 17 review from the Royal College of Surgeons in 2013. 18 A. Yes. 19 Q. And in fact at this time we've heard evidence that 20 a two-day visit had taken place earlier that month by 21 those who were involved in conducting the review. And 22 a verbal report had been given to the NHS Tayside which 23 we were told was likely to have included concerns about 24 Mr Eljamel's practice and probity? 25 A. Yes. Page 205	1 THE CHAIR: Thank you. 10 o'clock tomorrow. Thank you. 2 (4.00 pm) 3 (The hearing adjourned until 10.00 am on Thursday, 4 17 September 2026) 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 207
1 Q. Was that information available to you at the time when 2 decisions were being taken about the renewal of 3 Mr Eljamel's application for honorary professorship 4 in September of 2013? 5 A. No. 6 Q. Would that information have been material to 7 decision-making around that issue? 8 A. Very much so. 9 MR DAWSON: Sir, I have no further questions. 10 THE CHAIR: Thank you. 11 MR DAWSON: Thank you, professor. 12 THE CHAIR: Professor, as you'll have gathered, that's all 13 the questions you're going to be asked at this session 14 this afternoon. And just before I invite you to step 15 down from the witness stand, can I express on the 16 Inquiry's behalf and indeed on my own behalf the thanks 17 from the Inquiry for your evidence this afternoon, the 18 insights and reflections you've offered to us during the 19 session this afternoon, but also your work in preparing 20 the statement to which you have spoken in generated the 21 associated documents, all of which is very much 22 appreciated. Thank you, you're free to go. 23 A. Thank you, sir. 24 (Witness withdrew) 25 MR DAWSON: Sir, there are no further witnesses. Page 206	1 INDEX 2 PAGE 3 PROFESSOR RORY MCCRIMMON 1 4 (affirmed) 5 Questions by SENIOR COUNSEL 1 6 TO THE INQUIRY 7 PROFESSOR JOHN CONNELL 152 8 (sworn) 9 Questions by SENIOR COUNSEL 152 10 TO THE INQUIRY 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 208

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