

1 Thursday, 24 September 2026 2 (10.00 am) 3 (Proceedings delayed) 4 (10.07 am) 5 THE CHAIR: Yes, Mr Dawson. 6 Housekeeping 7 MR DAWSON: Good morning, sir. We have two witnesses 8 scheduled for today. Before we start, I have a couple 9 of housekeeping observations just to keep everyone 10 right. The two witnesses whom we have today cover 11 a great deal of important material. They're scheduled 12 to have their evidence completed today. 13 I think it's probably unlikely that they will be, 14 and so some arrangements have been made to try to 15 accommodate that. Can I just point out, sir, just to 16 allow people to understand our processes, that we do 17 give in, through the evidence proposal process, 18 an indication to witnesses as to the estimated time that 19 their evidence will take. 20 We also give a list of the broad topics that we 21 intend to cover with a witness. It's important to 22 understand, however, that it says, in each evidence 23 proposal, that the evidence proposal is an indication of 24 the most important topics which will be examined with 25 a witness and it is not and should not be taken to be Page 1	1 which, of course, must be given to the proposals from 2 the core participants -- is that the witnesses may take 3 slightly longer than had originally been anticipated. 4 In order to try to accommodate that, the solicitor to 5 the Inquiry contacted the agents who are representing 6 Ms Lamb who will appear as the Scottish Government 7 witness this afternoon and I understand that she has 8 indicated that she will be available, albeit only for 9 a relatively short time tomorrow morning, in the event 10 that we spill over and so there may need to be a slight 11 readjustment of our expectations. We only had one 12 witness scheduled for tomorrow anyway so hopefully that 13 will all fall into place and we will, of course, keep 14 the witness Ms Dunning who is due to give evidence, who 15 is one of the NHS Tayside witnesses tomorrow, appraised 16 of progress to make sure that she's not inconvenienced. 17 THE CHAIR: Yes, thank you. 18 MR DAWSON: So, hopefully with that brief introduction to 19 our process and where we find ourselves for the rest of 20 this week, the next witness is Elaine Watson. 21 THE CHAIR: Thank you. Can we have the witness, please. 22 ELAINE WATSON (affirmed) 23 Questions by SENIOR COUNSEL TO THE INQUIRY 24 THE CHAIR: You're obviously going to be asked a number of 25 questions in a room where the proceedings are all Page 3
1 a list of every aspect of the evidence. It will be 2 subject of questioning by me. 3 The reason we do that, sir, is we're trying to 4 strike a balance between the fact that there's no 5 requirement in the rules for us to give any notice of 6 any documents or topics, but that we consider it fair to 7 do so. 8 The fact that there are a number of variables which 9 can occur during the course of preparation for 10 a witness's evidence mean that we can't make 11 a commitment that that will be the time that it takes. 12 One major variable factor is that the time the 13 evidence proposal is completed two weeks before 14 a witness's evidence we have, by that stage, not had any 15 questions contributed by our core participants, and my 16 learned junior and I always, as I said at the beginning, 17 look at those questions and consider them for completion 18 in the questions that are to be put to a witness. 19 For these witnesses today a good deal of material 20 was submitted to us by core participants. As ever, we 21 have been through all of it and incorporated it as we 22 saw fit which has resulted in a good deal of core 23 participant-emanated material coming into our planning 24 for today. 25 The result of that is -- and in light of the respect Page 2	1 recorded. I'm not good at reminding myself that 2 I should remind witnesses of this but there are two 3 microphones in front of you, one of which is 4 illuminated. If you can try to speak into them so 5 everybody can pick up what you have to say. 6 Mr Dawson. 7 MR DAWSON: Thank you, sir. Good morning. You are 8 Mrs Elaine Watson? 9 A. I am. 10 Q. I understand you used to hold the position of Director 11 of People and Culture within NHS Tayside; is that 12 correct? 13 A. I did, yes. 14 Q. And you contributed, I think, to a witness statement in 15 response to a Rule 8 request issued by this Inquiry to 16 NHS Tayside, is that right? 17 A. That's right. 18 Q. Could we have, please, up on the screen NHST-04944. 19 Is that the statement to which you contributed? 20 A. It is. 21 Q. And the statement runs in the name of Dr James Cotton, 22 is that right? 23 A. Yes. Yes. 24 Q. And Dr Cotton, I think, is the executive medical 25 director of NHS Tayside, is that right? Page 4

1 A. That's correct. 2 Q. Could we go to page 273, please. And is it the case 3 that on that page Dr Cotton has signed the statement on 4 behalf of NHS Tayside? 5 A. That's correct. 6 Q. And I think each contributor explains in the statement 7 the bits that you contributed, if that makes sense; is 8 that right? 9 A. That's right. 10 Q. And as far as you're concerned in particular in relation 11 to the points that you answered, the questions you 12 answered, are the contents of the statement true? 13 A. Yes. 14 Q. Thank you. Could I just ask you, first of all, a little 15 bit about the way in which the statement was compiled 16 because you held the role of Director of People and 17 Culture, is that right? 18 A. Yes. 19 Q. And you therefore contributed answers to questions which 20 fell within the broad remit of your role; is that 21 correct? 22 A. That's correct. 23 Q. And others did the same thing? 24 A. Yes. 25 Q. There was a division of labour, if you like, to try to Page 5	1 a document on a team site that we all had access to and 2 we used that channel to update our questions so that we 3 could see the totality of the document as others were 4 answering their questions so we could make sure that 5 there were, as far as we were able, no contradictions or 6 gaps in the answers that were being given. 7 Q. Thank you. And when everyone had contributed their 8 draft part, if you like, was there some effort to try to 9 co-ordinate the final content? 10 A. Yes, so we were all asked to read it and make sure that 11 we had looked at it to ensure that what I have just 12 said -- not to repeat what I have just said, but once 13 the final version or as close to the final version was 14 ready. 15 Q. So does that -- well, it was signed by Dr Cotton 16 obviously. 17 A. Yes. 18 Q. I understand from some previous evidence that he's taken 19 a prominent role in dealing with the response to the 20 Inquiry, is that right? 21 A. Yes, correct. 22 Q. And so effectively can we take this to be everyone to 23 assert to its entire contents or can you only speak to 24 the bits that you contributed? 25 A. Well, I could tell, I could probably answer some of the Page 7
1 make sure that the best person was answering the 2 question that was most properly directed to them, is 3 that fair? 4 A. That's correct, yes. 5 Q. And so you were given, I think, some questions. Who was 6 it that did the distribution? Was that a group effort 7 or was it done by someone in particular? 8 A. It was a group effort. There's a bit of overlap with 9 some of the areas that I took the lead in answering, 10 just by the nature of the questions as it pertains to 11 the oversight of the medical workforce, but for the most 12 part it was a group effort to determine how we could 13 best answer the questions. 14 Q. Thank you. So did you sit down as a group and try and 15 work out -- 16 A. Yes. 17 Q. -- it would be best for this question to be answered by 18 this person and so on; is that fair? 19 A. Correct, yes. 20 Q. And how then did the drafting process proceed? Did 21 everyone just go off and draft the answers to their own 22 questions or was there a degree of collaboration, was 23 there a meeting at the end where you all came together, 24 how did it work? 25 A. So just to be absolutely candid, we put the questions in Page 6	1 other areas, given, you know, my role in the 2 organisation and my level of knowledge of certain 3 things, so I could go beyond what I have specifically 4 answered but it would depend on the question. 5 Q. Yes, understood. And effectively, shall we take the 6 statement as being one that Dr Cotton has assented it to 7 all being correct and you assenting to the bits you did 8 as being correct, is that fair? 9 A. Yes. 10 Q. Because Dr Cotton was overseeing the process, if I can 11 put it that way? 12 A. Yes. 13 Q. Thank you, that's helpful. Your representatives have 14 told me in advance you've brought some notes with you 15 today. 16 A. Yes. 17 Q. Can you tell me what the notes are for? 18 A. So they're an aide-mémoire. In the event that I have 19 a blank in any question that you've asked me, I have 20 used the evidence proposal that I was given. It's just 21 got the headings of the themes that I understand 22 I'm going to be asked about and just some bullet point 23 notes about facts so that if I am able to provide detail 24 then I can refer to my notes to do that. 25 Q. Thank you. Did you make the notes yourself? Page 8

1 A. I did. 2 Q. Thank you very much. If I could ask you a few 3 questions, please, first of all about the broad areas 4 that you contributed to the statement. They all seem 5 logically within the area that you were involved in. 6 A. Yes. 7 Q. But we asked some questions and I think you answered 8 them in relation to general systems relating to human 9 resources matters, if I could put it that way, is that 10 correct? 11 A. Correct. 12 Q. And you were asked questions in particular relating to 13 Mr Eljamel pertaining to his appointments, is that 14 right? 15 A. Yes. 16 Q. You answered questions about the terms and conditions of 17 his employment? 18 A. Yes. 19 Q. You answered questions about his responsibilities within 20 NHS Tayside insofar as they were covered by terms and 21 conditions, employment contracts, internal policies, is 22 that right? 23 A. Correct. Correct. 24 Q. You were asked some questions specifically about the 25 systems relating to clinical suspension, supervision, Page 9	1 structure, started in a role -- I actually started as 2 a PA to the director of HR in a previous iteration of 3 Tayside. Moved into HR proper, through being a business 4 associate, providing front-facing HR services to 5 a client base. Moved into leadership roles, and 6 ultimately was the equivalent of director of HR within 7 the health system in Alberta, Canada. 8 Q. I see, thank you. So effectively from being a PA -- 9 A. Yes. 10 Q. -- you've worked your way up through human resources 11 throughout your entire career, ending upholding very 12 senior positions in that field, is that right? 13 A. Correct. 14 THE CHAIR: Sorry, could I just clarify, was that in 15 healthcare throughout? 16 A. Yes, other than a very small period where I worked in 17 higher education but it was a very small period of time. 18 THE CHAIR: Thank you. 19 MR DAWSON: Thank you. Could we look at the statement, 20 please, at paragraph 2.28. This is where you set out 21 some of the detail of that background. I'm interested, 22 in particular, in the part where you say: 23 "Prior to my time in Canada, I worked in the Human 24 Resources Department of Dundee Teaching Hospitals NHS 25 Trust and Tayside University Hospitals NHS Trust Page 11
1 and resignation of consultants? 2 A. That's correct. 3 Q. And you were asked specific questions, which I think you 4 answered, about Mr Eljamel's clinical suspension in 5 2013, is that right? 6 A. Correct. 7 Q. You answered specific questions relating to his 8 resignation from his position as consultant neurosurgeon 9 in May 2014, is that right? 10 A. That's right. 11 Q. And you also answered some questions about his removal 12 from of his name from the general medical register in 13 2015, is that right? 14 A. That's correct. 15 Q. Thank you very much. I'd just like to ask you a little 16 bit about your background as you set it out helpfully in 17 the statement. You come from a long-standing human 18 resources background, is that right? 19 A. That's right. 20 Q. And I think you spent 20 years in that field in Canada, 21 is that right? 22 A. I did, correct. 23 Q. What was it that you were doing there? 24 A. The same as I was doing when I was in Scotland. So 25 basically working my way up through the ranks of the HR Page 10	1 between 1995 and 2002." 2 As you've told us already: 3 "Initially as a Personal Assistant providing 4 administrative support to the Director of Human 5 Resources, and then as a Human Resources Advisor 6 providing professional human resources support to 7 various departments across the organisation. In my role 8 as HR Advisor I may have been involved in human 9 resources issues with the Neurosurgery department from 10 time to time, however I did not have any dealings with 11 Mr Eljamel. In my current role I am responsible for all 12 workforce practices, policies and governance [issues] 13 across NHS Tayside." 14 We'll get to the currency of the role in a moment 15 but before we do that, I just wanted to use you perhaps 16 as an opportunity to explain some of the background as 17 you've been involved in organisations providing 18 healthcare in Tayside for a long time. We're going to 19 hear tomorrow from one of your former colleagues, 20 Ms Dunning, who I think is responsible for the parts of 21 the statement relating to corporate structure, corporate 22 development, I think she's the board secretary, is that 23 right? 24 A. She is correct. 25 Q. So we'll get into some of that but I think it's helpful Page 12

1 just to set the scene through your career progression. 2 You tell us that you worked, between 1995 and 2002, in 3 two organisations called the Dundee Teaching Hospitals 4 NHS Trust and Tayside University Hospitals NHS Trust. 5 My understanding is that over that period the way in 6 which healthcare services were delivered is slightly 7 different from the way it is today; is that correct? 8 A. That's correct. 9 Q. And at that time, as I understand it, so if we go from 10 the dates of your employment which actually coincide 11 with the dates we're interested in, in this 12 Inquiry, 1995 to 1999 I think, the operational side of 13 healthcare was run, I think, by Dundee Teaching 14 Hospitals NHS Trust, is that right? 15 A. That's correct. 16 Q. So that would be why you're employed by that body 17 because as a personal assistant to an HR director, you 18 were part of the operational side of Tayside healthcare, 19 if I can put it that way? 20 A. That's correct. 21 Q. And then in 1999, as I understand it, there was 22 a different trust who took over that role, is that right? 23 A. So different, yes, but it was an amalgamation of 24 a number of health organisations that had been in place 25 prior to that. Page 13	1 A. Yes, that's correct. 2 Q. Is that broadly your recollection? 3 A. Yes, that's broadly correct. 4 Q. Thank you, that's very helpful. You mentioned, in the 5 role that you held latterly before going to Canada, that 6 you may have been involved in human resources issues 7 with the neurosurgery department but I think your 8 position is that you don't have any particular memory of 9 having any dealings with any issues there, it would just 10 be in the general run-of-the-mill of your work -- 11 A. Yes. 12 Q. -- that you would be drafting and issuing contracts, 13 dealing with HR issues and that could be in the 14 neurosurgery field or any other field, is that right? 15 A. Correct. 16 Q. Thank you. So my understanding as to where we've got to 17 now is you held the role as Director of People and 18 Culture on your return from Canada, is that right? 19 A. Correct. 20 Q. A development, I think, since you contributed to this 21 statement, as you've described, is I think you left that 22 role in June of this year, is that right? 23 A. Yes, I did. 24 Q. And you are, I think, now working still in the same 25 field? Page 15
1 Q. Indeed, so there are a number of other organisations and 2 trusts which, as I understand it, are delivering 3 different aspects of healthcare, is that right? 4 A. That's correct. 5 Q. So these trusts, the ones that you work from, so you 6 worked from the Tayside University Hospitals NHS Trust, 7 I think from 1990 until you went to Canada in 2002; is 8 that right? 9 A. Yes. 10 Q. These trusts, as I understand it, were the ones 11 responsible for the operation of hospital-type care 12 rather than primary care; is that right? 13 A. So you're really testing my knowledge now. So Dundee 14 Teaching Hospitals was acute care, Tayside University -- 15 yes, that's correct, because there was a separate -- 16 Q. I think that's right -- 17 A. Yes, you're right. 18 Q. -- broadly speaking, without in any way -- I'm sure 19 Ms Dunning will know this inside out, but just to get 20 a broad picture there were, at different times, 21 different trusts. Some of the trusts were responsible 22 for what you've called acute care that was delivered 23 through hospitals and there were, I think, other trusts 24 that were in charge of primary care, so general 25 practice. Page 14	1 A. Yes. 2 Q. Although in a different role? 3 A. Correct. 4 Q. Could you tell us a little bit about that? 5 A. So I retired from the role with NHS Tayside, as you say, 6 at the end of June. I have now taken on a part-time 7 role which is a national role supporting a national 8 committee which is called the Management Steering Group, 9 MSG which is the employer group. So it's representing 10 the 21 employers in the NHS in Scotland from 11 an employment perspective to support pay and terms and 12 conditions, working alongside Scottish Government 13 colleagues and union colleagues. So I am the secretary 14 of that committee. 15 Q. Thank you. So you no longer work for NHS Tayside? 16 A. No. 17 Q. Thank you. I'm obviously primarily interested in 18 roles -- as you didn't have anything to do historically 19 between 1995 and 2002 with anything the Inquiry is 20 interested in, although that is a time period we are 21 interested in -- 22 A. Yes. 23 Q. -- I'm interested primarily today in discussing your 24 role as the director of human resources effectively, 25 people and culture and indeed your responsibilities in Page 16

1 that role in responding to the Inquiry's Rule 8 2 statement. So if I slip into asking you questions about 3 "your role", that's what I'm talking about rather than 4 the one you now hold. 5 A. Yes. 6 Q. You've provided us with a helpful breakdown, as you were 7 asked to do, in some of the questions to which you 8 responded of the identity of a number of people who 9 held, first of all, senior roles within what I could 10 broadly call human resources within NHS Tayside, is that 11 right? 12 A. Yes, correct. 13 Q. And then you've also -- we'll look at this in a bit more 14 detail -- helpfully provided with us a list of other 15 people not in the senior role but in other roles that 16 you think may have something to tell us about what we're 17 looking at, is that right? 18 A. Yes, correct. 19 Q. And I'm interested in particular in the way in which the 20 names of the different roles have evolved over 21 the years. Now, if I can start with your role which is 22 Director of People and Culture. What's your 23 understanding of why your role was given that title? 24 A. So it was actually "Director of Workforce" when I first 25 came back in September of 2023 and it was really around Page 17	1 and represented what the job was doing as opposed to 2 a change in the duties of the role. 3 Q. So from what you've said, would it be fair to say that 4 what the job was doing, as you put it, was not just -- 5 I think you said acting as the gatekeeper, dealing with 6 contracts and formal things which might be seen kind of 7 as off to one side of the rest of the operation but was, 8 in fact, trying to engage itself more in the day-to-day 9 operations of the health board and influence its 10 culture; is that correct? 11 A. Yes, correct. 12 Q. Can you tell us of any -- we've heard some evidence of 13 the importance of culture in healthcare -- 14 A. Yes. 15 Q. -- do you think it is important to set a particular 16 culture within an organisation like NHS Tayside? 17 A. Absolutely, critical. 18 Q. Can you tell us, broadly speaking, what sort of 19 initiatives you think have taken place in NHS Tayside to 20 focus on that aspect of things? 21 A. Yes, so one of the first things that I introduced 22 working with the executive team and with the team that 23 I was responsible for was to develop a people and 24 culture plan which laid out different areas that we were 25 going to focus on that were beyond, just as I've said, Page 19
1 discussion of the breadth of the role and what we were 2 trying to do in terms of, you know, creating the 3 conditions and the culture within the organisation to 4 really allow people to work in the best way possible. 5 Director of Workforce is actually quite a legacy title. 6 Across the NHS in Scotland many boards are changing or 7 have changed the title of this role to "people and 8 culture". 9 I think historically it was seen to be a procedural 10 role that was really the gatekeeper of HR policies and 11 procedures, as opposed to being a more strategic role 12 that would contribute to how we do business within the 13 organisation, and how we create the conditions for that. 14 Q. So did that development from a workforce-based role 15 based on historic legacy considerations of what the role 16 held might be, the role held by people you list in the 17 statement, did that development expand the range of 18 responsibilities that your role had, or did it just mean 19 that you now became part of the executive strategic 20 leadership of the NHS Tayside? 21 A. So the role was always a member of the executive team of 22 the board and its predecessors and so it didn't change 23 the responsibilities, although corporate equalities was 24 moved into my portfolio actually from the board 25 secretary's portfolio. It really just more described Page 18	1 the policies and procedures. So in my mind the policies 2 and procedures were the foundation, they have to be in 3 place, but what we were going to do beyond that. So 4 in the time I was with Tayside, as an example, we 5 introduced a well-being framework, and we were working 6 on other initiatives such as leadership development 7 programmes which we had started to roll out which 8 focused -- as well as what I would call the bread and 9 butter, things that leaders need to know but how leaders 10 in an organisation can create the right culture within 11 their teams to, as I've said a few times, you know, 12 create the conditions for people to do their best. 13 THE CHAIR: This may seem a very basic question, and 14 I apologise in advance but these initiatives that you've 15 just described, do they or did they apply to both 16 medical and administrative staff? 17 A. Yes. 18 THE CHAIR: One envisages that there is a difference, that 19 there's a huge intermingling of various duties but 20 I have in my mind medical initiatives but it's across 21 the whole thing? 22 A. Yes, all staff. 23 MR DAWSON: But that might be a manifestation of what you 24 described earlier as your department or role trying to 25 integrate itself in the services that are provided. Page 20

1 It's not just dealing with the back-room contracts, it's 2 actually trying to influence the culture of its 3 public-facing individuals; is that correct? 4 A. Yes, correct. 5 Q. Just to be clear, you arrived back in NHS Tayside by 6 this point in 2022? 7 A. 2023. 8 Q. 2023, and these were initiatives that you launched -- 9 A. Yes. 10 Q. -- to try to improve that cultural aspect, if you like? 11 A. Yes, correct. 12 Q. Could I just ask you, Mrs Watson, one thing which I'm 13 going to get in trouble for and it's my responsibility, 14 when I'm asking you a question the stenographer will get 15 very upset with me if you answer the question before 16 I finish my question. It's entirely my fault but it's 17 just to be clear as to what your answer to the question 18 is. It's easy to do that as if we're having 19 a conversation but the stenographer needs to write down 20 what it is that you're saying, so if you could try and 21 do that, that would be very much appreciated. Thank 22 you. 23 A. Understood. 24 Q. You explain a little bit about your role in the 25 statement as well, as you've done today. In the time Page 21	1 been able to find an organisational structure from that 2 time, but from what I have read I think it's broadly 3 similar -- that there's a team called the HR business 4 team -- that's what it's called now -- that are assigned 5 to separate client groups within the organisation, and 6 they are effectively the go-to person for that client to 7 get HR advice. 8 So, as with anything, you can have whatever policies 9 and procedures you like in place in an organisation but 10 a lot of how things work is based on relationships. And 11 HR doesn't actually have any authority, what it has is 12 its credibility and its relationships in order to 13 support managers to make decisions. So at the different 14 levels within HR, there will be an assignment to clients 15 to provide HR advice, and it can be on a daily basis. 16 Certainly, if there's any issues that are arising with 17 any staff, whether it's medical or otherwise, my 18 expectation would be that HR is consulted at every step. 19 Q. Thank you. And my impression is that that sort of basic 20 rule has been one that's existed really in all the 21 historic documents. 22 A. Yes. 23 Q. It will always say: when you get to this stage remember 24 to get HR involved, to put it crudely, is that broadly 25 what you would expect? Page 23
1 that you were involved in the role from 2023, in what 2 circumstances and to what extent would, broadly 3 speaking, a human resources and culture director like 4 you have expected to have become involved in issues 5 relating to the sorts of matters we're looking at here, 6 such as where there are problems with a consultant? 7 What would the HR role in that be? 8 A. So my expectation would be that if it's something that 9 has been escalated to the medical director, that I would 10 know about it and be involved in it. 11 Q. Because, as we may come on to see, over the years 12 there are lots of different policies, disciplinary 13 policies for example, which refer to the imperative to 14 get the HR department involved. 15 A. Yes. 16 Q. And I think you also tell us -- we'll come to it in 17 a minute, but you tell us that in the period that 18 I mentioned a moment ago to do with 2013, to 2014 when 19 we're dealing with Mr Eljamel's clinical suspension, 20 suspension and resignation, you actually give us the 21 name of someone who actually did that HR function, 22 I think. So I'm just interested in understanding what 23 are the respective responsibilities? What does the HR 24 department contribute to those sorts of situations? 25 A. So the structure that's in place now -- and I haven't Page 22	1 A. Well, I would -- yes. My preference would be that any 2 conversation that's happening, that HR is involved in 3 it. 4 Q. Yes, so when you use the word "client" there, are you 5 talking about the HR department is looking at one of the 6 other groups or departments within the health board 7 structure, like acute services or something like that? 8 A. Yes. 9 Q. That would be a client for you? 10 A. Yes. 11 Q. And if an issue arose within acute services, you would 12 expect the acute services team, at whatever level was 13 appropriate, to involve HR to provide support, is that 14 right? 15 A. Correct. 16 Q. Because it seems that the sort of escalation mechanisms 17 seem to be through the particular client department but 18 what I think the documentation recognises is that in 19 these sorts of situations there will always be an HR 20 component and what the documents are trying to do is to 21 remind people: you need to avail yourself of that 22 department to help you, is that right? 23 A. That's right. 24 Q. Thank you very much. I wanted to ask you some questions 25 about the executive structure as well. Again, I'm using Page 24

1 you as a little bit of creating the background as you're 2 one of the first witnesses to come from NHS Tayside, and 3 your statement is helpful in this regard. 4 So, I was keen to understand, first of all, we've 5 heard evidence from one individual who used to be the 6 Chair of the Tayside Health Board, effectively. 7 A. Yes. 8 Q. And we've heard evidence from the current chief 9 executive of NHS Tayside. I'm interested just in 10 teasing out whether NHS Tayside is different from 11 Tayside Health Board, or are they synonymous? 12 A. In my mind they're synonymous. 13 Q. I wondered whether it might be the case, and I may be 14 wrong about this, that "NHS Tayside" is used as a means 15 of referring to the sort of operational side, the side 16 that Ms Connor is head of. Would that be fair or is 17 that not right? 18 A. That's not the way I would see it, but that would be 19 a question for Mrs Dunning tomorrow. She would be clear 20 about that. 21 Q. Yes, I'm just trying to put it in context. We will, of 22 course, come back to the details with her tomorrow but 23 just to make sure we're referring to the right thing as 24 we go along because there is a chair of the board, is 25 that correct? Page 25	1 organisation. They all form part of the Chief Executive 2 Team (CET), which is the group of employees who directly 3 report to the Chief Executive and assist them in the 4 strategic leadership of NHS Tayside." 5 So that's describing all of the people who 6 contributed to the compilation of the statement. Is it 7 correct to say there are there more people in that chief 8 executive team who contributed to the statement or are 9 all the people who contributed to the statement the 10 chief executive team? 11 A. All of the people who contributed to the statement are 12 members of the chief executive team but there are more 13 members of the chief executive team than those that 14 contributed to the statement. 15 Q. Understood, based on the various different questions 16 that we asked and their responsibilities, as you've 17 explained? 18 A. Correct. 19 Q. Thank you. And as I understand it in that structure, 20 the chief executive team with these senior leaders, they 21 report effectively to the chief executive; is that 22 correct? 23 A. Correct. 24 Q. And the chief executive effectively reports to the 25 board, is that right? Page 27
1 A. Correct. 2 Q. And there is an executive team which is led by the chief 3 executive? 4 A. That's correct. 5 Q. Do all or some of the executives sit on the board? 6 A. No. So we all attend the board meeting but there's only 7 certain roles within the chief executive team that are 8 deemed executive board members. 9 Q. Okay, so, as far as the area that you are responsible 10 for, in whose name do employment contracts with 11 employees of this organisation run? 12 A. Do you mean the individual? 13 Q. Yes. 14 A. I actually don't know the answer to that. 15 Q. Okay. 16 A. I can certainly find out and let you know. 17 Q. Thank you. But it will either be: Tayside Health Board 18 or NHS Tayside contracts with Mr Smith to provide these 19 services? 20 A. Yes. 21 Q. Thank you. And it says in the statement if we can look 22 at paragraph 1.2, please. It says there: 23 "The individuals listed in response to Question 2 24 are all senior leaders witness NHS Tayside who 25 contribute to the strategic leadership of the Page 26	1 A. Yes. 2 Q. Right, understood. Your responsibilities, as 3 I understood it, would have included, as well as the 4 cultural aspects you've told me about, the more 5 traditional, if you like, aspects of human resources 6 management, including employment contracts? 7 A. Correct. 8 Q. And that would mean negotiation of employment contracts 9 but also issues arising from them, is that right? 10 A. Yes. 11 Q. I'm interested in understanding some aspects of broadly 12 how employment contracts work within NHS Tayside. In 13 particular I'm interested in understanding, first of 14 all, if people are doing things which they say are in 15 the name of NHS Tayside, are they personally responsible 16 for those actions? 17 A. It would depend on what that action is. 18 Q. Could you elaborate on that? 19 A. So, if they are acting -- if they have done something 20 that is contrary to their contract and also could 21 potentially be contrary to their regulatory body and the 22 professional standards to which they're being held, then 23 they could be personally. 24 Q. Yes, so it's the concept to lawyers of vicarious 25 liability, is that right? Page 28

1 A. Yes. 2 Q. So even if someone is saying: I'm acting on behalf of 3 the NHS Tayside doing my job or whatever, as long as 4 it's within their contract they're personal responsible, 5 is that right? 6 A. Correct. 7 Q. Thank you. And that would be the case in all employment 8 contracts that NHS Tayside have with any of their 9 employees, is that right? 10 A. Correct. 11 Q. So a sort of standard rule that you have to bear 12 responsibility for what you do in the name of 13 NHS Tayside? 14 A. Correct. 15 Q. That would just be an efficient way of running 16 an organisation, is that fair? 17 A. Yes. 18 Q. I'm wondering, there are some aspects of the conduct, if 19 I can put it that way, of people who have either 20 represented or been acting on behalf of NHS Tayside, 21 that people have reported to us, patients in particular. 22 A. Yes. 23 Q. I'm wondering if you could help us with understanding, 24 in broad terms, whether these sorts of things would be 25 acceptable under someone's general employment contract Page 29	1 A. Yes. 2 Q. Could you tell me whether there are circumstances that 3 you can envisage in which the terms of employment would 4 permit an employee of NHS Tayside to describe a patient 5 as "aggressive and vulgar" or something of that nature? 6 A. No. 7 Q. That would not be permitted under the employment 8 contract? 9 A. No. 10 Q. Thank you. The reality is you might think that as 11 an employee because an employment contract can't control 12 what you think, can they? 13 A. Yes. 14 Q. They can't? 15 A. No, they can't control your behaviour, they just give 16 you guidance on what's expected of you. 17 Q. Yes, well, they certainly can't control what you think, 18 can they? 19 A. No. 20 Q. But they should control what you do in the name of 21 NHS Tayside? 22 A. I think that's very fair. 23 Q. Thank you. Do you know what "gaslighting" is? 24 A. Yes. 25 Q. Can you imagine any circumstances in which it would be Page 31
1 or not. I'm going to ask you a few of them but I'm just 2 setting the scene, but do you understand what I'm asking 3 you? 4 A. If I understand your question correctly, if patients 5 brought forward concerns about the conduct -- sorry, do 6 you mind -- 7 Q. What I'm saying is -- it's my fault. Some people have 8 said to the Inquiry that they've had some experiences or 9 dealings with people who have been acting on behalf of 10 NHS Tayside. I'd like to put some of these things to 11 you because we may hear evidence that these things have 12 happened and people have reported to us that they have. 13 And from an employment perspective, given you held the 14 role as the head of this department, I'm just interested 15 in trying to understand whether these things are things 16 that are permitted under the employment contracts or 17 not? And I will go on to list them. 18 A. So I think it would depend on what the behaviour was or 19 what the conduct was. 20 Q. Yes, well, I'm going to put some things to you. I am 21 just explaining what I'm going to do. 22 A. Okay. 23 Q. Presumably it is the case that all employees, including 24 members of the executive team, require to abide by their 25 contracts of employment? Page 30	1 permissible, under the NHS Tayside general contract 2 terms, for any person employed by the board to gaslight 3 a patient in the course of their work? 4 A. So I would -- so my answer will be very general, without 5 there being any example given of what is meant by 6 gaslighting, but I would say, no. 7 Q. Thank you. Would it ever be permissible, in terms of 8 the contracts which NHS Tayside employees are expected 9 to adhere to, for employees to blacklist patients 10 because they had made a complaint? 11 A. Absolutely not. 12 Q. It's quite important that patients wouldn't be treated 13 like that, in fact? 14 A. Absolutely. 15 Q. Why do you think that is? 16 A. Because everybody is entitled to the highest level of 17 patient care irrespective of people's personal views of 18 those patients and anything that they bring forward. 19 Q. Thank you. Could you imagine any circumstances in which 20 the contracts of employment would permit employees of 21 NHS Tayside to act in a way towards a patient which was 22 evasive, arrogant or chauvinist? 23 A. No. 24 Q. We heard some evidence from one of your now former 25 colleagues about an important aspect of the systems that Page 32

1 exist, not for which you were responsible, but systems 2 to do with the reporting and investigation of adverse 3 incidents. 4 A. Yes. 5 Q. That was from Mr Dunn who has a responsibility in that 6 regard as I understand it now. Is it the case that 7 under the contracts of employment, employees are 8 expected to comply with those adverse incident 9 management policies? 10 A. Correct, yes. 11 Q. And again, that's important, isn't it? 12 A. Yes. 13 Q. Because those adverse incident management policies, 14 they're not optional, they're key, aren't they? 15 A. Correct. 16 Q. And if people don't comply with them then that can put 17 patients at risk? 18 A. Yes. 19 Q. And if people don't comply with them that can undermine 20 the commitment which I understand NHS Tayside makes to 21 being a learning organisation? 22 A. Yes. 23 Q. In your culture role, I'm interested in asking you 24 a little bit about that learning organisation. We've 25 heard that from a lot of different witnesses that that's Page 33	1 Q. Understood. The point you make is a very important one 2 if I may say so and in fact your suggestion that often 3 when things go wrong it's not because people aren't 4 trying their best it's because of systemic issues -- 5 A. Yes. 6 Q. -- is something which features in the adverse incident 7 management policy; is that something you're aware of? 8 A. Sorry, can you repeat that? 9 Q. The very thing that you just said which is it's often 10 the case that people are trying their best but the 11 reason why things go wrong is because of issues with 12 systems features in the adverse management policy. Is 13 that something you're aware of, whether it's from that 14 policy or more generally? 15 A. Yes, I am. Yes. 16 Q. So as a former executive member of NHS Tayside's top 17 team, if you like, it would have been something that you 18 were conscious of that systemic failures can give rise 19 to individuals not being able, I think you said "perform 20 at their best" or something? 21 A. Yes. 22 Q. And indeed it is therefore important, perhaps something 23 that you might have thought about yourself in your role 24 in culture, that the organisation provides mechanisms to 25 enable people to live up to their obligations and give Page 35
1 an important part of the culture, I think, at 2 NHS Tayside, is that right? 3 A. Yes. Yes. 4 Q. And what obligations exist under the contractual 5 relationships between NHS Tayside and its employees to 6 try to ensure that individuals contribute to that 7 organisational learning? 8 A. You know, that's a difficult question to give 9 a straightforward, or you know, a simple answer to. To 10 me a learning organisation is cultural. It's 11 an organisation that is open, and learns from its 12 mistakes and is continually trying to improve how 13 services are delivered. And in my mind, as I've said, 14 creating the conditions for people to do their best work 15 is a key to meeting that obligation of being a learning 16 organisation. 17 In my view, the vast majority of people -- and 18 I have been, you know as you've said, around HR for 19 a long time in healthcare. The vast majority of people 20 come to work to do their best and the circumstances in 21 which they don't are usually systematic. So it's not 22 a straight answer to say that you can uphold someone's 23 lack of contributing to a learning organisation to be 24 contractual because it would depend on the circumstances 25 in which that happened. Page 34	1 their best, is that right? 2 A. That's fair, yes. 3 Q. Thank you. I have one question now which is a little 4 bit out of the run of this but it was something 5 I thought you might be able to help us with. One thing 6 which our core participants did when we had our opening 7 statements last year is we asked them to provide lists 8 of people we thought, like yourself, who might be 9 witnesses who could tell us something of value to our 10 investigation. And there was one role that a certain 11 group suggested that they thought this person might be 12 of interest and it's a role which I don't know whether 13 you may be able to tell us what this role actually does. 14 I won't name the individual person that they named 15 but the role was someone who acted in the capacity of 16 a "personal secretary to a consultant surgeon"? 17 A. Yes. 18 Q. Now, is that a role with which you were familiar or are 19 familiar? 20 A. Yes. 21 Q. I'm just interested in knowing what sort of things that 22 person would do? It's in order to try to inform us as 23 to whether it would be worth us trying to investigate 24 with that person what they know of certain things that 25 are of relevance to us? Page 36

1 A. So there's the art and the science of all of these 2 things. A consultant would have a personal secretary 3 but what that personal secretary did for that consultant 4 is very relational. 5 Q. Right. 6 A. It would depend on what that consultant, if we just use 7 a consultant, wanted that person to do. My experience 8 is that they tend to be the right-hand person of the 9 consultant, they will manage their diary, they will 10 support their work and maybe become a bit of 11 a confidante for that consultant, anybody that has a PA 12 or a personal assistant. So they are the ones that 13 often know the detail that others don't but that is 14 really dependent on the relationship and how that person 15 uses their personal assistant. 16 Q. Thank you, that's very helpful. And just to understand 17 in a sort of strict employment context you're obviously 18 aware of that sort of role. One of the things that 19 you've helped us with in the answers that you gave is 20 trying to explain the ways in which a consultant may 21 have various different roles all going on at the same 22 time. There would be theatre obligations, ward round 23 obligations, there would be things contained in a job 24 plan, you've told us. In a teaching hospital like 25 Ninewells, we've learned about the fact that every Page 37	1 trying to find out in Mr Eljamel's case, whether that 2 was a factor in issues that arose in his practice. 3 So it is possible, then, that his secretary may have 4 been someone who had a role in organising all these 5 various commitments, could we put it at least like that? 6 A. She or he may have. 7 Q. Yes, but that would be a matter more of, I think you 8 told us, of a sort of personal decision or relationship 9 with the actual individual consultant? 10 A. Correct. 11 Q. So some secretaries might just organise the 12 in-hospital tasks and not the others but some might take 13 a wider role? 14 A. I think that's fair. 15 Q. In the interest of trying to assist with all of these 16 things, NHS Tayside wouldn't have an issue with that in 17 a sense of, if that's what the consultant wants, then 18 that's the best way for the consultant to get the 19 service from the NHS Tayside secretary; is that correct? 20 A. Correct. 21 Q. Thank you very much. I wanted to ask you a little bit, 22 specifically in your case but also in a general sense, 23 about the way in which you went about answering the 24 questions in the statement that you answered. What 25 I would particularly be interested in -- and you've Page 39
1 doctor has some level of teaching responsibility, many 2 are involved in research and some in private practice, 3 as well, as many other things, including committees and 4 external professional commitments. 5 When there is a personal assistant or secretary, is 6 that person usually employed by NHS Tayside? 7 A. Yes. 8 Q. Is it the case that those secretaries or assistants are 9 free to offer services in the organisation of the 10 consultant's time pertaining to matters which 11 effectively happen beyond the doors of the hospital? 12 A. Possibly. I can get an explicit answer for you if it 13 would be helpful. I don't know the exact answer to 14 that. 15 Q. I'm not in any way trying to get a secretary in trouble 16 or anything like that. 17 A. No, no. I understand. 18 Q. I'm simply trying to work out whether -- because 19 obviously one of things you've helped us with a great 20 deal in your responses is trying to work out how 21 consultants go about managing these various commitments 22 and it's something which falls squarely within the Terms 23 of Reference of the Inquiry. And for some consultants 24 I think that can become difficult and sometimes 25 overwhelming and that's something we're interested in Page 38	1 explained already the process that you all went through, 2 you contributed to certain questions, you did it on 3 a shared portal I think and Dr Cotton took an overall 4 lead, is that fair? 5 A. Correct. 6 Q. And the thing I was interested in asking you about is 7 that there are various places in your responses where 8 you tell us that you have access to certain documents 9 but you don't have access to others. I'm wondering who 10 was it that undertook the searches for documents? If we 11 just focus on your areas, did you do them, did you have 12 people help you do them, was it someone who did that 13 for everyone? How did that work? 14 A. So when I became involved in this, when I joined at the 15 beginning of September, there was already a body of 16 information that had been gathered because of the work 17 that had been done on the due diligence report. 18 I worked particularly with the deputy director of people 19 and culture and the leadership team within my portfolio 20 to ensure that there was further searches into any 21 files, any material files that may be held, any 22 information that may be held on any drives, and any 23 documentation that was held outside of the HR team 24 because, as you'll have seen from some of the 25 documentation, there's mention, which would make sense, Page 40

1 of information being held within the medical director's 2 office or other leaders who were in the neurosurgery 3 team. So we did a further process of looking to see 4 what other information may be available beyond what was 5 already gathered when I joined in September. 6 Q. Understood. I think I've seen the phrase relating to 7 the due diligence report, of having created something 8 they called "an information log", is that right? 9 A. Yes, correct. 10 Q. Is that what you still call it, the information log 11 relating to Eljamel? 12 A. Yes. 13 Q. So as I understand what you're saying, please correct me 14 if I'm wrong, there was an information log already there 15 at the beginning. Was it the case that someone took 16 that information log and effectively allocated to you 17 the sorts of documents that they thought would be 18 relevant to you, or did you look at all of it? 19 A. No, I looked at all of it, me and the team. 20 Q. And your team, yes. And obviously in doing that you 21 would be able to identify the sorts of things that would 22 be useful to you in answering the questions that were 23 allocated to you? 24 A. Correct. 25 Q. For example, you've provided us with a 460-page HR file Page 41	1 I've already said, we had an initial discussion about 2 how we were going to divvy up -- for want -- I can't 3 think of another expression -- the questions and then 4 there was regular discussions on how we were progressing 5 with the completion of the questions. And so there will 6 have been discussions about information that was 7 available and whether, as I've already said, we were 8 making sure that we were cross-referencing as far as we 9 were able. 10 Q. Thank you. So that might broadly be described as there 11 being -- not simply all went off into your own corners, 12 but there was an extent of information exchange. So, 13 for example, if your researches meant that you found 14 something you thought might be interesting to one of the 15 other contributors, you would have brought that to their 16 attention, is that right? 17 A. Correct. 18 Q. So it's not everyone does their own bits and there's no 19 co-ordination, there is a degree of co-ordination and 20 mutual assistance? 21 A. Correct. 22 Q. Thank you. The HR file, as I say, is 460 pages long, is 23 that right? 24 A. Yes. 25 Q. And it contains a lot of helpful information but Page 43
1 for Mr Eljamel. 2 A. Correct. 3 Q. Which I think you've relied on heavily, quite 4 understandably, in answering some of the questions you 5 were asked? 6 A. Yes. 7 Q. Did everybody get access? Did all of the contributors 8 get access to all of the information log in the way that 9 you did? 10 A. I believe so. 11 Q. And did everybody undertake that same process that you 12 undertook of looking in and finding what you thought 13 would be relevant and then undertaking further searches 14 elsewhere in places you thought where things might be 15 found, might still exist, that could add to that log? 16 A. I can't speak to what others did. 17 Q. Right. But there wasn't an instruction given to you to 18 do that? 19 A. Not that I can recall. 20 Q. So effectively, you divided up the questions amongst 21 yourselves and then the way in which you went about 22 answering them allowed you access to the information log 23 but anything else that you did was a matter for you and 24 your team? 25 A. So it wasn't as black and white as that. I think, as Page 42	1 equally, there are areas where it doesn't contain 2 information which would have assisted you to answer 3 questions, is that right? 4 A. I agree. 5 Q. So we'll get into looking at some of the documents from 6 it in other places in due course but I was just 7 interested in what an HR file is for, and in particular 8 the sorts of things that one would expect it to contain, 9 if you like in real time, rather than many years later. 10 So what's the purpose of an HR file? 11 A. So, I suppose "HR file" is the colloquial language that 12 we use in HR. It's really the file that contains the 13 history of an employee's journey from the point of 14 appointment until the end of their career with the 15 organisation. So all relevant documents that pertain to 16 that employment should be contained within the HR file. 17 Q. Okay. So when you say -- it's really, I suppose, 18 teasing out what you mean by "relevant to the 19 employment" but let's try to and do that. So would it 20 contain, as you say, all material relating to the 21 employment but not relating to the person's operational 22 activities during that employment? 23 A. Correct, other than the job description. 24 Q. Yes, absolutely. 25 A. That would -- yes. Page 44

1 Q. You've provided us, from I think the file, the number of 2 job plans -- 3 A. Yes. 4 Q. -- that set out, I think annually, you don't have them 5 all, but it looks like they're annually, setting out 6 what Mr Eljamel had agreed he would do every year, is 7 that broadly right? 8 A. That's broadly right. 9 Q. Yes, so it doesn't have documents relating to how you 10 went about doing those activities but it does have 11 a plan what it is it was agreed he would do? 12 A. That's exactly right. 13 Q. And so it wouldn't contain the sorts of things that one 14 would find in medical records, for example, the 15 interactions with patients, or the surgeries he carried 16 out, or meetings with colleagues in the neurosurgical 17 department; you wouldn't expect to find that in an HR 18 file? 19 A. Not generally, unless there was an investigation or some 20 kind of process under a policy relating to the 21 performance or practice, conduct of that individual. 22 That information should be in the HR file. 23 Q. Understood. So in certain circumstances where 24 an investigation were undertaken, and I know there are 25 policies relating to investigations -- Page 45	1 the years that you've helpfully provided to us relating 2 to the way -- and indeed, some which existed all at the 3 same time I think, relating to how disciplinary 4 investigations and processes require to be carried out. 5 Those take place within the HR bubble, if I could say it 6 that way; is that right? 7 A. Yes, but with the caveat that for medical staff that 8 would be done very much in concurrence with the medical 9 director and the processes that pertain to medical 10 staff. 11 Q. Right. But would you expect, as someone who was 12 formerly in charge of this department, the material 13 related to that to be comprehensively stored within the 14 HR file? 15 A. Yes. 16 Q. Because, as we said earlier, all of the policies say, 17 perhaps reminding people: you need to get HR involved in 18 these things and therefore HR needs to have access to 19 all of the information pertaining to the investigation 20 to be able to do its job properly? 21 A. Correct. 22 Q. Thank you. Would it ordinarily contain some of the 23 following information. Does it contain information 24 relating to training or continued professional 25 development of an individual? Page 47
1 A. Yes. 2 Q. -- it might be that some of the material that would 3 ordinarily find its home in a medical record or some 4 sort of file of minutes of meetings or something like 5 that, it might need to be incorporated into the HR file 6 because it would be of relevance to the investigation? 7 A. Correct. 8 Q. As far as what ordinarily or routinely be found, one 9 would ordinarily find information relating to someone's 10 application for employment? 11 A. Correct. 12 Q. Terms and conditions of their employment? 13 A. Correct. 14 Q. Which might change over the years, yes? 15 A. Yes. 16 Q. Any information relating to interviews they had to have? 17 A. Correct. 18 Q. For their initial employment and any promotions? 19 A. Correct. 20 Q. Does it contain disciplinary-related information, 21 ordinarily? 22 A. Yes. 23 Q. You talked about -- yes? 24 A. Yes. 25 Q. So there are a number of policies relating over Page 46	1 A. Not -- no. 2 Q. No. What part of the system would one find that in? 3 A. So, we have an electronic system called -- there's two 4 actually. One is called Turas, T-U-R-A-S, which is 5 a national system. We also have a system called 6 learnPro, L-E-A-R-N-P-R-O, which is also a somewhat 7 national system, that training and development 8 information is contained for employees. 9 Q. I suppose what it sounds like you're telling me, but it 10 might be wider than this, is that that's sort of 11 information training resources. So it might be: here's 12 a guidebook as to how one does a particular type of 13 surgery. Would those systems contain the details of 14 someone's participation in development? 15 A. Yes. 16 Q. So like a certificate or something like that, to say: 17 you attended this course? 18 A. Yes. So, there would be records of the courses that 19 were undertaken and whether those courses were 20 completed. There's also -- I'm sure this will be -- 21 I would suggest this is a question for the medical 22 director, there's also records and processes within the 23 department of medical education that would not 24 necessarily cross-reference with HR. 25 Q. The medical education department, is that within Page 48

1 NHS Tayside or the hospital? 2 A. Yes. 3 Q. So they might have information relating to whether 4 someone had attended certain courses or whatever, the 5 CPD-type thing? 6 A. Yes. 7 Q. And you are telling me also that the medical director 8 might also have that? 9 A. Yes. 10 Q. So I think what you're saying to me is that ordinarily, 11 that doesn't find its home in the HR file? 12 A. No, that would be administratively impossible. 13 Q. Understood. It might, however -- I suppose it applies 14 to all these things -- if there were some sort of 15 investigation, a disciplinary matter which, in some way, 16 turned on the issue whether someone attended a course or 17 not, then it would find its way into the file, is that 18 right? 19 A. Yes. 20 Q. Thank you. What about information relating to a process 21 we've heard about called "revalidation and appraisal"? 22 Does that feature in the HR file or is that somewhere 23 else? 24 A. No, that would be within the department of medical 25 education. Page 49	1 colleagues have tried to explain to us why certain 2 documents might not exist at this remove, is that they 3 talked to us about document retention policies. 4 A. Yes. 5 Q. And they've told us that there are policies, I think 6 perhaps different policies that relate to different 7 types of documents which will mean that there is, after 8 the expiry of a certain passage of time, it then becomes 9 open for something to be destroyed? 10 A. Yes. 11 Q. There's a minimum amount of time that you keep something 12 for, is that right? 13 A. Yes. 14 Q. So let's just say hypothetically -- because we know 15 there's stuff from 1995, so let's say hypothetically 16 there was something, completely hypothetically, I wanted 17 to know about from 2000 and you had looked through the 18 file and you say: well, I couldn't find anything to help 19 with that. That's very helpful that you've done that 20 for us. But it might seem odd that there are gaps like 21 that, on the assumption that the thing from 2000 22 actually existed in the file in the first place. 23 Because if someone had destroyed -- if someone had come 24 along in 2010 or something, looked at the file and 25 thought: oh, there's a whole load of stuff here that we Page 51
1 Q. Thank you. And as far as the HR file, this 460-page 2 document that you helpfully provided to us, as we will 3 see in due course, it contains some very historic 4 information. It contains quite a lot of information 5 relating to the Mr Eljamel's application for his 6 original consultant neurosurgery post, doesn't it? 7 A. It does. 8 Q. So around about 1995, I think his position started on 9 9 October 1995, is that your recollection? 10 A. Yes. 11 Q. And there are, as I've said, other places where you have 12 helpfully attempted to answer questions we've asked you 13 but you've said that the documentation does not appear. 14 Now, can you help us with understanding why, in the 15 file, there might be something as historic as before he 16 even started the job but there might not be something 17 from many years later. How could that happen? 18 A. I can't answer that question. I would have expected 19 there to be -- while it's a thick file, there's lots of 20 information in it that I wouldn't necessarily have 21 expected to see in the file, but there are some -- 22 I don't know that we can absolutely see the journey of 23 his time with Tayside just looking at the HR file. 24 Q. Because one of the things that we heard about I think 25 from other witnesses, or certainly appears where your Page 50	1 don't need any more, it's historic, it's past the 2 deadline for the document retention, would it not have 3 been normal for them to have destroyed everything before 4 that point, and not retained other documents? 5 A. So for records pertaining to employees, there's nothing 6 that's taken from the file while the employee is still 7 in the employment of the organisation. The retention of 8 documents is beyond the end of the employee's tenure. 9 And it does range, depending on what the information is, 10 it depends. If it's health and safety records, it's one 11 retention, if it's tribunal records, they are never 12 destroyed, employment records, in general, it's 13 six years beyond the date that the employee leaves the 14 organisation. 15 Q. So for our purposes that's 31 May 2014? 16 A. Yes. 17 Q. That's the date on which Mr Eljamel's resignation came 18 into effect, I think, is that right? 19 A. Yes. 20 Q. So if that's the case, the entire file should have been 21 kept for six years after that? 22 A. Yes. 23 Q. Minimum, is that right? 24 A. Yes. 25 Q. But imagine oneself six years after that, looking at the Page 52

1 file. 2 A. Yes. 3 Q. And is there any reason why someone would retain stuff 4 from 1995, six years later, but not other material? 5 A. I can't think of any reason. 6 Q. Right. So does that mean that it would be fair to 7 assume that everything that appears in the file now is 8 what always appeared in the file? 9 A. So that's the assumption that I have made. 10 Q. So I think that's fair, actually. The way in which 11 you've gone about answering your questions has been, 12 I think on the basis that if you couldn't answer 13 a question, you've assumed that that's never been in the 14 file -- 15 A. Yes. 16 Q. -- even if it's something that should have been in the 17 file, based on what you've told us about what have been 18 in files? 19 A. Yes. 20 Q. And that would be a logical explanation, I think, as to 21 why it is that documents have been retained all the way 22 back to 1995, that the answer is this is the whole file, 23 is that fair? 24 A. Yes. 25 Q. A fair interpretation? Page 53	1 A. I think that's less likely. 2 MR DAWSON: Thank you for that. Sir, that would be 3 a convenient moment for a break. 4 THE CHAIR: Yes, very well. Mrs Watson, we're going to have 5 a 15-minute break now. Just before Ms Miller takes you 6 back to the witness room, can I just mention something 7 that I do to any witness in your situation. You've 8 started giving evidence but not finished it, so to keep 9 matters regular we ask that you don't discuss your 10 evidence during the break. 11 A. Understood. 12 THE CHAIR: Okay. 15 minutes, thank you. 13 (11.13 am) 14 (A short break) 15 (11.31 am) 16 THE CHAIR: Right, thank you, Mrs Watson. I think we're 17 ready to resume. Mr Dawson. 18 MR DAWSON: Sir, just before we start with Mrs Watson there 19 is one other housekeeping matter. There is no 20 difficulty her being in the room for this. Just in 21 addition to what I said earlier about the timings for 22 today, one matter that I omitted to mention is there are 23 a number of documents which are still going through our 24 processing system which have emanated from the Scottish 25 Government that have been subject to various discussions Page 55
1 A. Yes. 2 Q. Because the alternative to that would have to be that 3 someone had removed certain documents from the file and 4 not others, is that right? Just logically, I'm saying. 5 A. Yes. Yeah, that could be a conclusion that is reached. 6 But what I would say is, and -- is that there's been 7 quite a lot of work done about how we ensure that 8 concurrent employment records are managed appropriately 9 and that we are ensuring that the right information is 10 in the file. I'm not sure that that was quite as 11 fastidious in the past. 12 Q. Understood, understood, but I'm just trying to work out 13 which side of the line we're on because either the 14 position is -- and you, I think, are candidly accepting 15 that in the past, sometimes documents one would have 16 expected to be on the file didn't make their way on the 17 file; is that what you're saying? 18 A. Yes. 19 Q. And you think that's the likely explanation as to why 20 there's gaps in the file? 21 A. Yes. 22 Q. Rather than the alternative which would be all of those 23 things were on the file, or some of them were on the 24 file, but someone's removed them. You think that's less 25 likely? Page 54	1 about their completion, their passage through that 2 system. Those documents, I'm told, will be able to be 3 disclosed at the end of today. 4 As it appears to be the case that we're unlikely to 5 finish Ms Lamb this afternoon anyway, that will give 6 people some opportunity to be able to look at those in 7 the event that they wish to try to raise questions about 8 them with her. Obviously that's a much more limited 9 opportunity than we would normally give core 10 participants, but in order to give them some, the 11 Scottish Government lawyers and the Inquiry solicitor 12 have been trying to get those completed to make sure 13 that there is the full disclosure of documents that 14 there have been for other witnesses. 15 THE CHAIR: All right. That's noted, thank you. 16 MR DAWSON: Those who are sitting in the room may wish to 17 take note of the fact that there may be some documents 18 they wish to look at this evening and if they wish to 19 propose questions, there is the usual opportunity in the 20 morning with Ms Lamb. 21 THE CHAIR: All right, thank you. 22 MR DAWSON: Thank you, sir. Sorry about that, Ms Watson, it 23 was just a housekeeping matter. 24 We were talking earlier about your helpful list of 25 various professionals who work within effectively the Page 56

1 predecessor to your department that we asked you to 2 provide. I wonder if we could look, please, at the 3 statement at page 25. This is basically the broad 4 question that you were asked in this area and I think 5 different people took different components because there 6 was a big list of all the different people we were 7 interested in knowing about and you, inevitably, took 8 the sections relating to people who had worked in HR 9 before. 10 So the question asked: 11 "Please set out the identity and roles of key 12 individuals within those bodies over the relevant period 13 and the nature and remit of their roles, including but 14 not limited to the following (with equivalents where the 15 designation of particular roles or groups have changed 16 over the years) with particular regard to the matters 17 covered by the Inquiry's Terms of Reference and 18 provisional List of Issues ..." 19 So, if one could particularise that to HR, you 20 understood, I think, that what we were asking for here 21 was a list of people who held the key roles in the HR 22 department in the period we were looking at, which was 23 broadly from 1995 to 2015, is that right? 24 A. Correct. 25 Q. In particular, one thing which we'll come to that you Page 57	1 a question for Ms Dunning tomorrow but one aspect I was 2 interested in was the one at the top there, which you've 3 listed as being someone who works within the board, 4 that's from 2001 to 2005. Is that suggesting that 5 there's someone working on the board side who was 6 dealing with human resources, or has human resources 7 always been within the operational side of the Tayside 8 healthcare provision? 9 A. So that definitely is a question for Ms Dunning because 10 what happened at that time was quite confusing, I would 11 say. 12 Q. Yes, I think that's fair to say and she knows the 13 details of it so we'll deal with that with her. I think 14 you said earlier -- and this would be our understanding 15 as well -- that effectively, human resources was always 16 delivered throughout operational side of the board, if 17 you like. That would make sense, is that fair? 18 A. Yes. 19 Q. Thank you. If we just scroll a little bit further past 20 this, please. So you provided us a list, up to very 21 recently in fact, of all of the different people who 22 held the various different positions in charge of the 23 department but then in the next box, you also provided 24 to us, helpfully, individuals who appear to have played 25 a role relating to matters that are actually within the Page 59
1 obviously picked up on was we were looking for 2 an explanation as to -- we wanted to know what their 3 roles were, so the titles, which you gave us. 4 A. Yes. 5 Q. We wanted to know what their roles comprised, ie what 6 their responsibilities were, broadly; did you understand 7 that? 8 A. Yes. 9 Q. And in particular we wanted to know if there were people 10 that you could draw our attention to who played 11 a particular role relating to matters that were set out 12 in our Terms of Reference or List of Issues; was this 13 your understanding? 14 A. It was my understanding. 15 Q. Thank you. If we could go then, please, to page 52. 16 This is the question that you answered. Others have 17 answered for various other departments but this is the 18 one that was obviously within your remit. So, if we 19 scroll through this slowly, you can see there that what 20 you've set out, if we just stop there. We talked 21 earlier about the two trusts that existed. You've told 22 us who -- effectively I think these are the heads of the 23 HR department in the trusts and if we scroll past that, 24 you can see that you're providing that for people that 25 work within the board as well. Now, in may be Page 58	1 Terms of Reference explicitly; is that right? 2 A. That's right. 3 Q. In fact, what you did in fact was, you provided, I think 4 for Mrs Ingram, a sort of full CV for her because she 5 worked in HR at one point and if we scroll on further, 6 I think the reason you've done that -- because you've 7 helpfully, as you can see there, included a "reason for 8 inclusion" box, is that right? 9 A. Correct. 10 Q. I think you've given that whole background for 11 Mrs Ingram because she did something important actually 12 in a different role, is that right? 13 A. Correct. 14 Q. But for the sake of completeness, you've told us she was 15 an HR person at one point, she then moved on to being 16 the deputy chief executive in 2018 and she was the one 17 who commissioned the report from Tracy Gillies from 18 NHS Lothian in 2019, is that correct? 19 A. Correct, along with the chief executive at the time. 20 Q. Absolutely, that's very helpful. And you've been very 21 thorough in providing that because technically, when she 22 did that, she wasn't in the HR department, I think? 23 A. Correct. 24 Q. But she was at one point. That's very helpful. If we 25 scroll a little further down, please. You've told us, Page 60

1 I think, that Mrs Blair is the person who led the 2 recruitment and appointment process for Mr Eljamel. 3 A. Yes. 4 Q. Now, just to be clear about that, we've discussed this 5 a couple of times already. What that meant was she 6 provided the HR function in relation to that? 7 A. Yes. 8 Q. Is that right? 9 A. Yes. 10 Q. Because there's actually quite a complicated process 11 involving quite a lot of people and a panel or 12 a committee to employ consultants. So this would be 13 an example of the thing we talked about earlier whereby 14 there may be operations that are required, including 15 employing consultants, that need to be done by a panel 16 of people, but there will always be an HR function 17 related to that, and was that what Mrs Blair was doing? 18 A. Yes, and there's a specific medical staffing team that 19 specialises in the recruitment of medical staff and 20 Mrs Blair led the recruitment of consultants in 21 particular. 22 Q. Yes, and you can see her name on some of the 23 documentation in the HR file from that time? 24 A. Yes. 25 Q. Yes, and similarly, Mrs Fraser you told us played Page 61	1 find out whether individuals might be able to tell us 2 more than you have been able to because of the obvious 3 limitations, the fact that you weren't directly involved 4 at the time, whereas these people were. Is it the case 5 that NHS Tayside would routinely hold contact details 6 for people when they leave or would that be a more 7 recent phenomenon; could you help us with that at all? 8 A. I don't know we would routinely officially hold details 9 because we wouldn't keep up with people beyond their 10 retirement or leaving the organisation, the contact 11 details would be based on what we have at the time of 12 them leaving the organisation. 13 Q. I just wondered whether that might be right because you 14 mentioned earlier, I think in relation to Mr Eljamel's 15 HR file, that that would tend to come to an end when the 16 employment comes to an end but we know from Mr Eljamel's 17 HR file that's not the case. There's actually quite a lot 18 of documentation that postdates the 31 May 2014, isn't 19 that right? 20 A. Yes. 21 Q. But I'm assuming that's because there were particular 22 things happening including, for example, correspondence 23 with the police -- 24 A. Yes. 25 Q. -- that had to have somewhere to go in the system, is Page 63
1 a particular role in the period around about Mr Eljamel 2 going into clinical supervision and suspension, so in 3 2013 probably into '14. Again, she is not controlling 4 that process, if you like. Others are making the 5 decisions but she's providing the HR function, is that 6 right? 7 A. Yes, so she was a senior HR practitioner. She was the 8 HR business lead for surgery, she was then the associate 9 director of workforce and it's clear from the 10 documentation that she was providing HR support through 11 the process. 12 Q. That's very helpful indeed and very helpful that you've 13 provided the column on the right-hand side setting out 14 what they've done, so we appreciate that. 15 Do you happen to know, without talking about any 16 individual, whether these are people whom NHS Tayside 17 are likely still to have contact details for or is that 18 beyond your remit? 19 A. I don't know about Mrs Blair but I believe that we would 20 for Mrs Fraser because she retired in the not too 21 distant past. 22 Q. Thank you. And as a broader question, probably based on 23 your experience of running the department more recently, 24 is it -- because, of course, the reason why we're asking 25 these questions is because we're interested in trying to Page 62	1 that right? 2 A. Yes. Yes. 3 Q. Whereas ordinarily, one wouldn't have that sort of thing 4 happening that would involve NHS Tayside after someone 5 had left the employment? 6 A. Correct. 7 Q. So the answer I think is that you might hold it, but you 8 might not? 9 A. We might, yes. 10 Q. But no doubt, if you do, we'll get in contact with your 11 successor to it and try to find out the details? 12 A. Yes. 13 Q. Thank you for that. I'd like to ask you some questions 14 now about some more specific matters relating to 15 Mr Eljamel that you've helpfully been able to find for 16 us, starting with his appointment as a consultant 17 neurosurgeon which I think you've confirmed already from 18 your understanding was the post started on 19 9 October 1995? 20 A. Correct. 21 Q. Could we look, please, at paragraph 21.1 of the 22 statement. You tell us here: 23 "Based on information from Mr Eljamel's original 24 application for the role of consultant neurosurgeon 25 [NHST-01544] with Dundee Teaching Hospitals NHS Trust, Page 64

1 and other information available in Mr Eljamel's HR file, 2 Mr Eljamel's career history is as follows: 3 "January 1983-December 1983: Pre-registration 4 training in Libya ... 5 "January 1984-August 1985: General Professional 6 Training in Tripoli, Libya ... 7 "September 1985-August 1987: General Professional 8 Training, Dublin and Airdrie ... 9 "Sept[ember] 1987-Sept[ember] 1991: Senior House 10 Officer/Registrar, Walton Centre for Neurology and 11 Neurosurgery, Liverpool ... 12 "Oct[ober] 1991-Sept[ember] 1994: Senior Registrar, 13 Beaumont Hospital, Dublin ... 14 "December 1994-Sept[ember] 1995: Clinical 15 Neurosurgical Fellow, University of Connecticut ..." 16 And you have put in an asterisk there, which says: 17 "This information is from a handwritten annotation 18 within ..." 19 One of the documents. And: 20 "October 1995-May 2014: Consultant Neurosurgeon [at] 21 NHS Tayside ..." 22 And then you say, below that, that: 23 "Mr Eljamel's employment from September 1987 24 to September 1994 was verified by references." 25 So we'll come back to some aspects of that in due Page 65	1 post which Mr Eljamel eventually got, the neurosurgery 2 service was offered through Dundee Royal Infirmary, is 3 that right? 4 A. That's right. 5 Q. And I think we can see that even at this stage, there 6 was a plan that the service would move to a new facility 7 in Ninewells, is that right? 8 A. That's right. 9 Q. And that eventually happened some years later in 1998, 10 I think, is that right? 11 A. That's my understanding. 12 Q. So for the first three years of his consultant career, 13 Mr Eljamel was doing his work from Dundee Royal 14 Infirmary and then there was a moved to Ninewells in 15 1998? 16 A. Correct. 17 Q. Is it the case, I think this is right, that Mr Varma, 18 the consultant who was in charge of this advert, if you 19 like, he was the lead consultant in neurosurgery at the 20 time? 21 A. I believe so, but I can check that. 22 Q. Yes, it appears in one of the answers that one of your 23 colleagues has given, but I think that's the case. It 24 would presumably be normal that the lead consultant in 25 a department would lead a recruitment like this? Page 67
1 course, but if we can look at, please, NHST-01544. Just 2 go to page 12, please. Just zoom in on that, please. 3 I think this is the advert, is that right -- 4 A. That's right. 5 Q. -- for the post. It says: 6 "Dundee Teaching Hospitals NHS Trust. 7 "Consultant neurosurgeon. 8 "Applications are invited for this replacement post 9 based at Dundee Royal Infirmary. This is small but 10 busy, forward-looking and friendly Unit which offers the 11 ability to develop a variety of special interests. The 12 department is exceptionally well equipped and plans are 13 well advanced for the transfer to a purpose-built 14 integrated Neurosciences facility at Ninewells Hospital. 15 "Informal visits are encouraged and applicants 16 should contact Mr TRK Varma, Consultant Neurosurgeon 17 [at] Dundee Royal Infirmary. 18 "Applications in the form of a curriculum vitae, 19 with names and addresses of three referees should be 20 submitted to the Medical Staffing Department, Level 9, 21 Ninewells Hospital, Dundee from which further 22 particulars might be obtained." 23 And there's various information there and then 24 a closing date of 18 March 1995. 25 So my understanding is that at the beginning of the Page 66	1 A. Correct. 2 Q. Because the lead consultant, probably with other people 3 in the executive of the hospital, would be in charge 4 I think of trying to work out how many consultants were 5 needed to offer the service that they wished to offer in 6 the area, is that right? 7 A. That's fair, yes. 8 Q. Yes. 9 THE CHAIR: Just out of interest, where would this advert 10 have been placed, do you know? 11 A. So definitely the BMJ, the British Medical Journal. 12 Maybe others. It was actually specified within the 13 process where it had to be. 14 MR DAWSON: Yes, my recollection is it's in two medical 15 journals. One is the Lancet and possibly the British 16 Medical Journal. 17 A. Yes. 18 THE CHAIR: Okay, thank you. 19 MR DAWSON: I was just interested in it being said that it 20 was a unit which would offer the ability to develop 21 a variety of special interests. That's something that's 22 come up in the evidence before, that there would be -- 23 I think one can maybe see this from some of the 24 subsequent documentation relating to Mr Eljamel's actual 25 position when he got it -- that there would be a sort of Page 68

1 core requirement for someone to offer certain services 2 that would be required of a neurosurgical service but 3 then the opportunity to offer perhaps more unusual 4 services would be something that would depend on the 5 consultants themselves as to whether they wished to 6 offer that service or whether there was a demand for it 7 in that area. Is that your broadly your understanding 8 of -- 9 A. (Overspeaking) Yes, that's broad -- I mean, the medical 10 director would be able to provide -- my understanding is 11 because it was such a small unit, there was 12 an expectation, I think at the time that Mr Eljamel was 13 appointed, there were only three neurosurgeons. So 14 looking at what the breadth of service is that the 15 population were requiring, there would be that 16 opportunity. As I say, the medical director would be 17 able to give you. 18 Q. Thank you. The other aspect of this that I just wanted 19 to ask you about if you have any observations. It says 20 that the department is exceptionally well equipped but 21 obviously plans being well advanced to move somewhere 22 else might suggest that it has ambitions to be something 23 other than it was at that point; do you think that's 24 fair? 25 A. Yes, that's how I would read that. Page 69	1 with, given your previous role, is there was -- 2 an invitation for a job went out. There was a brief 3 description of the job. And what you had to do was you 4 had to submit a letter of application plus a CV and 5 three references, is that right? 6 A. Correct. 7 Q. And I think what was anticipated and what did happen is 8 that certain people would be invited for an interview, 9 is that right? 10 A. Yes. 11 Q. And is it the case, when you're carrying out application 12 processes like this, that especially if you ask for 13 a CV, it might be the case that not all of the 14 information that the interviewers need is on the CV and 15 it's part of the purpose of the interview to elicit any 16 further information that you think might be important in 17 making the decision? 18 A. Yes, and what may also happen and what I have made 19 an assumption has happened here, there's a reach-out to, 20 a sort of shortlisting, based on the CVs as to whether 21 the individuals meet the criteria for the role, that 22 medical staffing will reach out to each of the 23 shortlisted candidates, will have a discussion with them 24 about their application and I think what -- the 25 assumption I'm making is that the handwritten comments Page 71
1 Q. Excellent, thank you. If we could go, then, to page 8 2 of this document. Just go to page 7, please. It's said 3 there, of course, that there was a requirement for there 4 to be a CV submitted I think and three referees, is that 5 what it said? 6 A. Correct. 7 Q. So I think this is the CV that was submitted by 8 Mr Eljamel in connection with the application, is that 9 right? 10 A. Yes. 11 Q. One thing that slightly baffled me is that this set of 12 documents is produced separately from the HR file. Did 13 this come from somewhere different or was it part of the 14 HR file? I think some of the documents in this 15 bundle were in the HR file and some were not? 16 A. Sorry, I didn't mean to -- 17 Q. Some were in the HR file and some were not. I wondered 18 if this had come from a different place? 19 A. So my understanding is that it comes from the HR file. 20 Q. Okay, understood. That's fine. It's just it isn't in 21 the 460 pages, but produced as something separate. But 22 that may just be a sort of administrative anomaly? 23 A. I'm sure that's where I saw it for the first time. 24 Q. Thank you. So, one, I think the process that we've gone 25 through is a process with which you're very familiar Page 70	1 that you're seeing on this CV have come from that 2 initial conversation with Mr Eljamel and then any 3 additional information that's required will be gleaned 4 at that time. And as you say, there's the opportunity 5 in the interview process to probe any areas. 6 Q. Yes, absolutely. It would be, as well as trying to work 7 out interpersonally and get further explanation, that's 8 kind of what the interview is for? 9 A. Yes. 10 Q. As well as, I suppose, for the candidate to ask more 11 questions about the job and get more information as 12 well? 13 A. Yes. 14 Q. Okay, thank you. Can we please have a look at -- we'll 15 come back to this document, but could we have a look at 16 paragraph 52(f).1, please, of the statement. You were 17 asked there some questions about whether the application 18 had included any reference to the Royal College of 19 Surgeons and the possibility that he received 20 an intercollegiate fellowship in neurosurgery from them 21 in 1992. And you told us: 22 "There was no claim within Mr Eljamel's CV ... 23 submitted as part of his application for the post of 24 consultant neurosurgeon that he had received an 25 Intercollegiate Fellowship in Neurosurgery." Page 72

1 That's correct? 2 A. Yes. 3 Q. I think it is correct -- 4 A. Yes. 5 Q. -- that there wasn't that claim. 6 A. Yes. 7 Q. Would it seem unusual if a claim was made subsequently 8 that he did hold that at the time of the application, 9 that he wouldn't have included it within his application 10 for the job? 11 A. Yes, I think that's a fair comment. 12 Q. So there is quite a full list of his various background 13 and qualifications and experience. 14 A. Yes. 15 Q. But if he had made a claim subsequently, some years 16 later, that he had at this time held it, you'd expect 17 that to be in the application for the job -- 18 A. Yes. 19 Q. -- because it's relevant information. Sorry, could we 20 can go back, please, to -- 21 THE CHAIR: Sorry, can I just clarify one thing. 22 Mrs Watson, you looked a little perplexed when you were 23 initially asked that question and the reference to the 24 response to it in 52(f).1. I just wanted to clarify 25 because I may have miss-noted which parts of the Page 73	1 probably go to the statement again. 52(g).1, apologies. 2 This is immediately after where we just were. You were 3 asked whether there was reference here to a position 4 which he had held within the University of Connecticut: 5 "Hartford Hospital in Connecticut, USA, at which he 6 claimed to have undertaken a fellowship ..." 7 And you said: 8 "The CV submitted by Mr Eljamel in 1995 in 9 application for the position of Consultant Neurosurgeon 10 in Tayside did not claim that he had undertaken a 11 fellowship at Hartford Hospital in Connecticut, USA. 12 There is a handwritten annotation on the CV referencing 13 a fellowship with the University of Connecticut. This 14 note was not authored by Mr Eljamel and there is no 15 evidence within Mr Eljamel's file as to when or why this 16 annotation was added. It is notable that information 17 relating to Mr Eljamel's fellowship in Connecticut, USA 18 was included in the Staff Engagement Form ... signed by 19 Mr Eljamel in October 1995 and within his visa 20 application to the Overseas Labour Service 21 in June 1995 ... There is no evidence in Mr Eljamel's 22 HR file ... held by NHS Tayside of further investigation 23 into his time in Connecticut, USA. References were 24 obtained from the three referees provided by Mr Eljamel 25 in his application, all of which were very Page 75
1 statement you were responsible for and whether that was 2 in fact part of what you were responsive -- 3 A. So, my perplexed look was -- I wondered if I had 4 answered this question incorrectly and it was referring 5 to the Connecticut contact -- it was -- that's -- 6 MR DAWSON: Yes. Perhaps I just clarify for Mrs Watson, 7 that it is slightly confusing this, because there are 8 two fellowships. We'll get on to the second one in 9 a moment -- 10 A. Yes. 11 Q. -- but there is a subsequent claim in another document 12 that suggests that in 1992, he held a Royal College of 13 Surgeons intercollegiate fellowship in neurosurgery 14 which he had from 1992, so pre-dating this. 15 A. Yes. 16 Q. There is a separate question, sir, which we'll address 17 right now to do with a different fellowship -- was that 18 the cause of your confusion, Mrs Watson? 19 A. Yes, I actually just thought I may have answered the 20 question incorrectly, that was why. 21 Q. For what it's worth, that's what it seems to show on the 22 document, so that's in agreement. So if we could go 23 back, please, to the previous CV which is NHST-01544 at 24 page 7. So, I think you told us -- we can go to it if 25 you want -- in fact, sorry, I think we should actually Page 74	1 supportive ..." 2 Now, you've put an asterisk next to this because you 3 wanted to draw attention in the statement to the fact 4 that that was not part of the typed CV but that there 5 is, as we'll see in a moment, a handwritten annotation 6 on it. Now, the conclusion, I think, that you have put 7 forward in the statement is that that was not part of 8 the application because it wasn't on the typed form and 9 I think there remains a mystery as to whether that was 10 available at the time when the application was made as 11 a piece of information which could have been taken into 12 account in the application or not, is that fair? 13 A. That's correct. 14 Q. Yes, and I think you've helpfully told us that it is 15 notable you say, in the passage I just read, that 16 information relating to Mr Eljamel's fellowship in 17 Connecticut USA was included in a staff engagement form 18 that was signed by Mr Eljamel in October 1995, so just 19 after he got the job, if you like. And also within 20 a visa application which was completed in June 1995, so 21 shortly before he took the post, is that right? 22 A. Correct. 23 Q. So therefore I think you're trying to draw our attention 24 to that as being relevant pieces of information that 25 suggest that around that time in other places he had Page 76

1 been putting forward that he had a fellowship from 2 Hartford Hospital, Connecticut, is that right? 3 A. I think what I'm just noting is that -- not to repeat 4 what you've just said -- it wasn't there in the original 5 application. There must have been a conversation about 6 it for it to have been noted on his CV and then, for 7 a reason that I can't obviously explain, it was noted in 8 these other documents. 9 Q. Yes, there have been, I think, at least two places where 10 this question about whether the information about the 11 fellowship at Hartford University was available at the 12 time when he got the job, whether he represented 13 effectively to the interviewers or those deciding or 14 not. Is that right? There was one in 2018 and it was 15 also part of the due diligence review in 2023, is that 16 right? 17 A. Yes. 18 Q. And I think, broadly speaking, those investigations 19 concluded that it couldn't be said whether it was part 20 of the application or not because effectively it wasn't 21 part of the typed CV, is that right? 22 A. Yes. Yes. 23 Q. So that's what I'd like to investigate with you just now 24 from an HR perspective. Could we go back then, please, 25 to NHST-01544, at page 7. So this is the CV from the Page 77	1 worked at the Beaumont Hospital in Dublin, is that 2 right? 3 A. Yes. 4 Q. And then someone has written under that: 5 "Dec[ember] 1994, Clinical neurosurgical fellow, 6 University of Connecticut, USA for a year." 7 And that's the sort of controversial entry that we 8 don't know who made that, is that right? 9 A. So, I do know who made that. That's the writing of the 10 medical staffing officer, Elizabeth Blair. 11 Q. How do you know that? 12 A. Because her writing is elsewhere. It's quite 13 distinctive writing and it's elsewhere in his file. 14 Q. And so is your position, as you explained earlier, that 15 that information has been inserted by someone, 16 Mrs Blair, who was the HR representative working within 17 the application process, if I can put it that way? 18 A. Correct. 19 Q. I think you said earlier that the HR department may 20 liaise with a candidate in order to elicit further 21 information from them as part of the application 22 process, is that right? 23 A. Correct. 24 Q. This is, I think Mrs Watson, evidence of precisely the 25 sort of information that people conducting an interview Page 79
1 previous bundle where it appears this is what he put 2 forward in support of his application. You see there 3 are various handwritten annotations on it. The first 4 says, in the top right-hand corner "House in Dublin". 5 There is some other handwritten information just below 6 his name which gives some information about his family, 7 is that right? 8 A. Yes. 9 Q. And then below that someone has written, in relation to 10 his original undergraduate medical degree, MBChB, that 11 that came from Libya, is that right? 12 A. Yes, yes. 13 Q. And below that, the word "Libya" is written again in 14 connection with some of his early training, if you like? 15 A. Yes. 16 Q. All of that is information that doesn't appear in the 17 typed version, isn't that right? It's been handwritten 18 on there? 19 A. Correct. 20 Q. So if we scroll down a little bit further. Further 21 still, thank you. In the section relating to "Higher 22 neurosurgical training", there are various pieces of 23 information about the more advanced stages of his 24 medical career, which set out his positions at the 25 Walton Centre in Liverpool, and the fact that he had Page 78	1 would want to know in addition to the information which 2 is on the printed form, isn't it? 3 A. So yes. Yes. Yes. 4 Q. Because for a start, as we've seen, it looks like 5 Mrs Blair perhaps, or someone else around that time, has 6 asked Mr Eljamel, "What are your living arrangements?" 7 Is that right? Because it says "House in Dublin". 8 A. I would -- and I obviously don't know this because it's 9 someone else would need to explain it, how I have 10 interpreted this is there has been a conversation with 11 Mr Eljamel, he was living in America at the time and 12 just thinking about it from my perspective as an HR 13 practitioner of many years, you get in contact with 14 someone and say: we're interested in your application 15 for this job, what are you doing currently in America? 16 And just getting information about what he was currently 17 doing and going through his CV with him, which is why, 18 I think, we're seeing those annotations. 19 Q. Thank you. It would be perfectly natural, if you're 20 interviewing someone for a post which is based at Dundee 21 Royal Infirmary, to know: are you going to come and live 22 in the area, where do you live at the moment? 23 A. Absolutely, yes. 24 Q. Perfectly reasonable questions? 25 A. Yes. Page 80

1 Q. And in the same way as when someone produces a detailed 2 CV going back to undergraduate education right up to 3 effectively the year before this application is being 4 made, it would be perfectly natural to ask them as part 5 of the interview or the application process: you have 6 got a gap in the last year, what have you been doing? 7 A. Yes. 8 Q. Yes. So what that looks like is someone, perhaps 9 Mrs Blair, as part of the application process has 10 elicited from Mr Eljamel what he's been doing in the 11 last year and what he has said is that he has been 12 a clinical neurosurgical fellow at the University of 13 Connecticut, USA, for a year, is that right? 14 A. Yes. 15 Q. And so that information is important information because 16 it's part of the totality of his history, isn't it? 17 A. Agree. 18 Q. It would be probably quite an important piece of 19 information, if you are going to take on a consultant in 20 particular, with the freedom that a consultant is given, 21 to know: have you been doing this sort of thing for the 22 last year? That would be important, wouldn't it? 23 A. Yes. 24 Q. I wonder if we could have a look, please, at another 25 document. This is from the HR file. The HR file is Page 81	1 what includes a CV. You don't know the answer? 2 A. No, I can't give an explanation. I certainly saw this 3 in the HR file but happy to check that outside of this. 4 THE CHAIR: Okay, thank you. 5 MR DAWSON: Thank you. What I could work out, for what it's 6 worth, is I thought some of these documents were in the 7 file and some were not. But it might be useful to know, 8 if we could find out, whether this bundle exists 9 separately for some particular reason -- 10 A. Certainly. 11 Q. -- which would be very helpful, thank you. They can 12 pass that on to your former colleagues, who can no 13 doubt -- 14 A. I will. 15 Q. -- work that out for us. I wonder if we could go to the 16 HR file, which is NHST-04741, please, and I'm looking at 17 page 46. This is a document which appears amongst other 18 documents, as I say, it's a haphazard order. If you 19 could look at the top there, there's a date which is 20 printed on it. It's September 29, 1995, is that right? 21 A. Yes. 22 Q. If we scroll down a little bit further, sorry, further 23 than that, to where the signatures are, it looks like 24 something which has been signed by a programme director, 25 dated 29 September, 1995, is that right? Page 83
1 a difficult document to navigate -- 2 A. Yes, it is. 3 Q. -- because it is massive and also, it's in no 4 discernible order. So we may have to jump about it. 5 THE CHAIR: Can I just double-check, I'm not sure if 6 I noted -- the provenance of these documents, as 7 I recall it, there were 14 pages in number. Is this 8 simply part of the material -- 9 MR DAWSON: (Overspeaking) Well, that was one of the things 10 I have canvassed with Mrs Watson. It's not part of 11 what's described -- 12 THE CHAIR: (Overspeaking) I follow that, but we don't know 13 anything more than the fact that it's a bundle of -- 14 MR DAWSON: Well, Mrs Watson may be able to help us with -- 15 A. Sorry, I didn't catch your question. 16 THE CHAIR: Let me put it this way. You've already been 17 asked by Mr Dawson about the existence and provenance of 18 an HR file extending to some 460 pages. What we're 19 looking at here, as I understand it, although your 20 evidence is that you saw the CV in the HR file -- 21 A. Yes. 22 THE CHAIR: -- it doesn't appear to be part of the file that 23 we have in electronic form and I was just wondering what 24 we're looking at, beyond the fact that I have gleaned, 25 from the screens, that there are 14 pages attached to Page 82	1 A. Yes. 2 Q. If you scroll back up to the top, please, obviously it's 3 called a "Final summary report", is that right? 4 A. Yes. 5 Q. And it relates to Mr Eljamel, correct? 6 A. Yes. 7 Q. I think he occasionally uses the sort of American 8 formulation "MD" in certain documentation which I'm sure 9 is because of the fact he's in America. There's 10 a reference there to his total appointment dates which 11 look like -- there are two dates that appear very close 12 to each other, one which may be sort of overwritten at 13 the top. The bottom one is very difficult to read. The 14 top one suggests that the dates of the appointment are 15 from 20 March 1995 to 30 September 1995, making 16 allowances for the inverted use of the dates in American 17 writing, yes? 18 A. Yes. 19 Q. And do you think it's fair to say that this appears to 20 be some sort of report from the time he spent in 21 America? 22 A. Yes, that's what I thought it was. 23 Q. Thank you, and if we could just look through. So the 24 person has given some information about this. It says, 25 under 1, you can see: Page 84

1 "Performance is satisfactory, yes ... 2 A. Yes. 3 Q. It says: 4 "Resident should receive credit for the entire 5 time." 6 Now, it's not ticked there but it says "if no" and 7 then it's filled in. So presumably the answer to that 8 is "no", is that right? 9 A. That's what I would assume given the "5 months". 10 Q. Yes: 11 "If no, how many credits should be given? 12 5 months ..." 13 Is that right? 14 A. Yes. 15 Q. And then it says: 16 "Has the resident/fellow completed the entire 17 programme for board eligibility at this institution?" 18 What's circled is "no", is that right? 19 A. That's right. 20 Q. And then it says -- the reasons, options given as to why 21 "no" is circled and the one that's ticked is: 22 "He/she is transferring to another institution to 23 complete this program ..." 24 Is that right? 25 A. Yes. Page 85	1 programme director at the bottom, is that right? 2 A. Yes. 3 Q. Then, if we go over to page 47, please. I think that 4 appears to be simply some of the questions extracted, is 5 that right? Is that question -- it's question 3, 6 somehow extracted again, but I think it's the same as 7 the question 3 answer we've looked at a moment ago, is 8 that right? 9 A. Yes. 10 Q. So what that appears to me to be saying is that he had 11 not completed the entire programme for board eligibility 12 at this institution and had been there between March 13 and September of 1995, is that right? 14 A. That's how I read it. 15 Q. Right. That's not the same as what is in the 16 handwritten annotation on the document, is it? 17 A. No. 18 Q. Because on it's handwritten annotation of the document 19 it says that the fellowship is over, if you like, is 20 completed? 21 A. Well, that's how it can be interpreted. 22 Q. Thank you. And it also says for a year? 23 A. Yes. 24 Q. Thank you. In the investigations I referred to a moment 25 ago in 2018 and the due diligence report, as I think we Page 87
1 Q. And then there's a list of other questions: 2 "Is there [a] record of disciplinary action ...?" 3 "No". 4 Is that right? 5 A. Yes. 6 Q. "Are you aware of any formal claims ...?" 7 "No". 8 Is that right? 9 A. Correct. 10 Q. And then the following questions are also answered "no": 11 "... any concerns about professional competence?" 12 "No ..." 13 "... any concerns about ethical behaviour?" 14 "No ..." 15 "... any concerns about interpersonal skills?" 16 "No ..." 17 Is that right? 18 A. Yes. 19 Q. And then there appears to be a shorthand written 20 comment, which says: 21 "An excellent house officer -- we will miss him, 22 would be delighted if he were to stay." 23 Is that right? 24 A. Yes. 25 Q. And then it's signed by someone who appears to be the Page 86	1 established, the view was taken of the accumulative 2 documentation, that this had not been part of the 3 application process, is that right? 4 A. Yes. 5 Q. And was that view taken based on an interpretation of 6 this documentation? 7 A. Yes. 8 Q. And I know that you've looked at both of those for us 9 and is your interpretation that that's because of the 10 fact that the references here, the materials here, are 11 not in the typed CV but are written on the document? 12 A. So how I have understood it, from the diligence I have 13 done, is that Mr Eljamel did not present this as part of 14 his original application for the job. It has been 15 discerned through a process that it would appear the 16 medical staffing officer has undertaken with Mr Eljamel 17 and has written it on his CV. What intent there was 18 around that to present it as being completed, I don't 19 know. I agree with you that it should have been noted 20 that it wasn't going to be completed, but the intent of 21 that, I can't give any view on. 22 Q. That will ultimately, I suspect, be a matter for the 23 Chair of the Inquiry to determine. 24 A. Yes. Yes. 25 Q. But we've seen, through various other evidence, over Page 88

1 the years that for various reasons Mr Eljamel produces 2 CVs for various different things. He's applying for 3 jobs in the university, he's applying for promotions and 4 things. That would be normal, wouldn't it, you put 5 together a CV for a particular purpose when you're 6 applying for a post that gives a snapshot in time as to 7 what your relevant qualifications are for the job; isn't 8 that right? 9 A. Yes, and what it is that you're applying for and what 10 you think that the people who are reviewing the CV might 11 want to see. 12 Q. Indeed. So it would seem odd, would it not, that the 13 annotation that's been made here would not have been 14 made as part of the application process, because what 15 would be the point in putting it on effectively 16 historical CV after the job had already been determined? 17 A. I can't give a view on that because I don't know what 18 the conversation was with him about it. 19 Q. But would it not, based on your experience, seem odd 20 that someone would, after the event, annotate a CV that 21 was relevant to a particular application? What would be 22 the purpose of that? 23 A. You mean in the future applications? 24 Q. No, I mean after the event in connection with which the 25 CV had been presented? Page 89	1 A. Yes. 2 Q. A recent witness said a sort of modern translation of 3 the word might be "integrity"; would that be fair? 4 A. Yes. 5 Q. And if he had effectively misrepresented what experience 6 he had had and what qualification he had received or -- 7 in his period in America, that would cast serious doubt 8 on his integrity, wouldn't it? 9 A. Yes. 10 Q. And in your experience of, no doubt dealing with many 11 consultant applications, would that be a significant 12 factor in the decision-making process? 13 A. Yes. 14 Q. Thank you. You have provided us with a very helpful 15 breakdown of lots of aspects relating to the interview 16 process that was undertaken and I think we can follow 17 all of that through in the written evidence already. 18 One aspect I wanted to ask you about in relation to that 19 was you mentioned something called an "Advisory 20 Appointment Committee"? 21 A. Yes. 22 Q. My understanding is that, at the time when this 23 interview was taking place in 1995, there were various 24 regulations in place relating to how consultant 25 appointments needed to work, is that right? Page 91
1 A. You mean the 1995 CV? 2 Q. Correct. 3 A. So he didn't write it. The medical staffing officer 4 wrote it. I think it's now created confusion, looking 5 back on it, and I appreciate the interpretation that's 6 being made around it. 7 Q. Thank you. Bear with me two seconds. You've provided 8 us with some information about other aspects of the 9 process which we'll get on to in one second. But if the 10 position is that Mr Eljamel did suggest that he had done 11 this for a year and suggested he had a clinical 12 fellowship which he didn't, that would be quite 13 a significant thing for him to have done in the process 14 of applying for a job as a consultant neurosurgeon, if 15 it weren't true? 16 A. Yes. 17 Q. We've heard a lot of evidence from many, many sources 18 about the importance -- there's a word that comes up 19 a lot which is called "probity" -- 20 A. Yes. 21 Q. -- in relation to consultant neurosurgeons. Is that 22 a concept that you're familiar with? 23 A. Yes. 24 Q. And it's an important professional quality of 25 consultants, isn't it? Page 90	1 A. That's right. 2 Q. And that's because when you're appointing a consultant, 3 what effectively you're doing is appointing someone to 4 a very important role, is that right? 5 A. Yes. 6 Q. With, importantly, quite a lot of freedom to be able to 7 exercise that role? 8 A. Correct. 9 Q. And I'm sure, given your long history in healthcare, you 10 will be aware that there have been, over the years, 11 circumstances in which doctors have been put in 12 positions of medical responsibility with a great deal of 13 freedom and they've abused that? 14 A. Yes. 15 Q. Like Harold Shipman, for example? 16 A. Yes. 17 Q. And therefore it's very important, when applications are 18 being conducted in a health board such as the ones for 19 which you have been responsible for many years, that 20 they are conducted in a way which realises what the 21 consequences will be if the person gets the job? 22 A. Yes. 23 Q. And I think, just to understand the context, that's one 24 of the reasons why these regulations existed about the 25 Advisory Appointment Committee. It wasn't just any old Page 92

1 job, this. This was a seriously important job and there 2 needed to be a stringent process overseen by a number of 3 individuals on a specially appointed committee? 4 A. That's correct. 5 Q. And you tell us, I think, who was on the committee and 6 the various people and I think it included, for example, 7 Mr Varma the consultant we saw earlier who we think was 8 the clinical lead at the time, is that right? 9 A. Yes. 10 Q. One aspect -- we looked at this and we can look back at 11 it if you want -- that I wanted to ask you about. We 12 saw it in the background to the various jobs that he 13 claimed to have. On the printed CV there was 14 a suggestion that between September 1985 and August 1987 15 Mr Eljamel had done general professional training in 16 Dublin and Airdrie? 17 A. Yes. 18 Q. That has been something of interest to us because you've 19 looked into that question and I think -- because 20 obviously I'm interested to know whether there was 21 a suggestion that he had previously worked in Scotland? 22 A. So I think the reason we'd highlighted that was because 23 initially we had let the Inquiry know he hadn't worked 24 in Scotland but when we were preparing and going, you 25 know, through everything in detail we found the Page 93	1 that up, in the sense of there's no evidence of anyone 2 contacting anyone at Monklands Hospital and saying: 3 there's this guy applying for this very important job, 4 he says he worked with you, do you know him? 5 A. There's no evidence of that. 6 Q. No. You also say, in the passage that we read out from 7 the statement, that Mr Eljamel's employment 8 from September 1987 to September 1994 was verified by 9 references. 10 A. Yes. 11 Q. We can look back at it if you need to -- 12 A. It's okay. 13 Q. -- but my understanding is I think that covers basically 14 the time he was in Liverpool and Dublin, is that right? 15 A. Yes. 16 Q. And so the references that came from -- the references 17 are on the file? 18 A. Yes. 19 Q. There are three references? 20 A. Yes. 21 Q. They come from two consultants in Liverpool and one 22 consultant in Dublin, as I understand it? 23 A. Yes. 24 Q. So I'm assuming what that means is these are the 25 references provided in support of the application, is Page 95
1 reference to Airdrie which is why we highlighted it to 2 the Inquiry. 3 Q. Yes, and -- just because I know you've looked through 4 all the documents in detail, is the reference on the CV 5 the only reference to Airdrie? 6 A. Yes. 7 Q. I mean, there is a hospital in Airdrie, there's 8 Monklands Hospital in Airdrie. 9 A. Yes. 10 Q. And the training which Mr Eljamel describes that he was 11 doing at that time is "general professional training", 12 is that right? 13 A. Mm-hmm. 14 Q. So, for example, Monklands Hospital doesn't have 15 a neurosurgical unit, does it? 16 A. Right, no. 17 Q. But he's not claiming that he was doing neurosurgery at 18 that time, it was a more general part of his training as 19 I understand it, is that right? 20 A. That's what I understand. 21 Q. And so it's possible that he could have spent a period 22 at Monklands Hospital, is that right? 23 A. Yes. 24 Q. And is it correct to say that there's nothing in the 25 documentation that would suggest that anybody followed Page 94	1 that right? 2 A. That's correct. 3 Q. And as you fairly say in the statement, they are very 4 positive statements about him? 5 A. Yes. 6 Q. Are there any evidence of any checks being done on his 7 Libyan qualifications? 8 A. No. 9 Q. No, and so really, as far as the process is concerned -- 10 and this, I think, is consistent with the advert that we 11 looked at a moment ago -- the process is that judgments 12 are made about someone's competence and ability by the 13 panel, and it is a number of different people looking at 14 it, but they do that I think significantly in reliance 15 on the three references, is that right? 16 A. And the fact that he's registered with the GMC. 17 Q. Yes. And indeed has the requisite qualifications to be 18 a consultant neurosurgeon? 19 A. Yes, yes. 20 Q. I think actually in his case there are two routes by 21 which he gets that because he had a fellowship in 22 neurosurgery and also had passed the requisite 23 examination? 24 A. Correct. 25 Q. Which I think is part of the record as well. I wonder Page 96

1 if we could have a look, please, within the file which 2 is NHST-04741, at page 417. In fact, 412. This is, 3 I think, the job description that was available related 4 to the job that was advertised in 1995, is that right? 5 A. Correct. 6 Q. And there's quite a bit of background here involving 7 a description of Dundee which you can tell me whether 8 you agree with or not, it says: 9 "This appointment is to fill the vacancy created by 10 the retiral of Mr I Jacobson in the Department of 11 Neurosurgery, Dundee Royal Infirmary. 12 "Dundee is Scotland's fourth largest city and is 13 located on the northern bank of the River Tay. 14 Sometimes called the 'largest village in Scotland' it 15 provides a mixture of traditional and modern living. 16 The city and the surrounding countryside, with low 17 density population provides a wide choice of housing and 18 schooling. Most leisure activities are available close 19 by with particularly good facilities for hill-walking, 20 climbing, ski-ing and last but not least, golf! Three 21 championship courses are within half-an-hour's drive 22 from Dundee." 23 I won't ask you about the significant of golf 24 courses to a consultant neurosurgeon, but carrying on: 25 "The Dundee Teaching Hospitals NHS Trust which Page 97	1 that, we see the catchment population is approximately 2 between 600,000 and 700,000. We see that the plan will 3 be that there will be three consultant neurosurgeons, 4 Mr Varma, and Mr Gentlemen who are already in post and 5 this post would replace, I think, Mr Jacobson who is 6 mentioned at the beginning. And there is information 7 about the staffing and indeed the facilities. Then over 8 the page, information about various different 9 departments and the individuals -- associated 10 departments I suppose and the individuals, is that 11 right? 12 A. Yes. 13 Q. And at the bottom it says "Special Interests": 14 "The Department currently has a number of areas of 15 special interest and expertise. These include the 16 treatment of chronic pain, neuro-stimulation, functional 17 stereotactic surgery, carotid artery surgery, the 18 management of cranial trauma and its sequelae and 19 various aspects of spinal surgery. With the Department 20 of Neurology there is a well established epilepsy 21 surgery service with a major research programme. There 22 is ample scope for the incumbent to consolidate these 23 areas of special interest or develop complementary 24 specialist services." 25 And then over the page, various other aspects, broad Page 99
1 provides all the acute services in Dundee includes 2 Ninewells Hospital and Medical School (793 staffed 3 beds), Dundee Royal Infirmary (287 staffed beds) and 4 Kings Cross Hospital (204 staffed beds). Tayside Health 5 Board and Fife Health Board are the major purchasers 6 though specialist services are provided for other 7 Scottish Health Boards. 8 "Dundee Royal Infirmary (287 beds) houses the 9 Neurosciences Departments. It is the only accident 10 centre in the city and is also the base for Orthopaedic 11 Surgery, Plastic and Burns Surgery, Urological Surgery 12 and Oral Surgery." 13 And then some information is given about 14 Ninewells Hospital and indeed, as we saw earlier, the 15 advance plans in relation to the move to Ninewells which 16 is anticipated and indeed happened, I think, in 1998? 17 A. Yes, it did. 18 Q. There is then, on the next page, without reading through 19 it all, some information about what the job will 20 comprise, in particular: 21 "Consultant Neurosurgeon. 22 "... expected that the appointee will be offered 23 an Honorary Senior Lectureship by the University. 24 "The post will be based at Dundee Royal Infirmary." 25 As far as staffing is concerned -- sorry, just about Page 98	1 duties of the post, conditions of service. Then over 2 the page, there's a proposed job plan which sets out the 3 number of sessions a week, is that right? 4 A. Yes. 5 Q. I think later on in other documents, one can find out 6 what a "session" is and you tell us, is it four hours? 7 A. Four hours. A session of programmed activity, 8 four hours. 9 Q. So I think, sort of in summary, you may be able to help 10 with this, the documentation which is incredibly 11 complicated about the various different sessions. 12 I think the basic idea is that there would be ten 13 sessions of four hours would be the basic work pattern? 14 A. Yes. 15 Q. I think there is a provision somewhere for an additional 16 session to be able to be undertaken if the consultant 17 receives something called a "distinction award", is that 18 something that rings a bell? 19 A. Discretionary points. 20 Q. Right. So in some circumstances you'll be allowed to 21 work an eleventh and you get extra money for that, is 22 that how it works? 23 A. Yes, and the EPAs, or extra programmed activities, are 24 also tied to private work. So with the new contract in 25 particular and the expectation that NHS work will be Page 100

1 prioritised, if a consultant is going to do private work 2 the expectation is that they will take on an extra 3 programmed activity. 4 Q. I see, okay. We'll get back to private work in a moment 5 but that's very helpful. And effectively, I think the 6 sessions are kind of the basic working hours and then 7 there are on-call obligations on top of that, is that 8 right? 9 A. Yes. 10 Q. And I think, if we go to the next page, one can see 11 there are references that we've seen before in other 12 places to -- this is the sort of plan as to when the 13 three consultants will be on and what they'll be doing 14 and there are -- we see in various places there's 15 reference to the on-call commitment being one in three? 16 A. Yes. 17 Q. Which I think means each consultant covers a third of 18 the time on-call -- 19 A. Correct. 20 Q. -- is that right? Thank you. And I think later on we 21 find out that it becomes one in four because a fourth 22 consultant is taken on at a later point, is that right? 23 A. Correct. 24 Q. Thank you. If we go over the page again, please, to 25 418. This is a minute of a meeting of the committee Page 101	1 experience was required of the consultants. 2 "It was unanimously agreed to recommend to the Trust 3 Board that [Dr Eljamel] should be appointed to the post 4 of Consultant Neurosurgeon. 5 "It was noted that as a result of reorganisation 6 within the department, a further post would arise in 7 approximately twelve months time. The Committee 8 unanimously agreed to recommend to the Trust Board that 9 [Dr Mathew] should be appointed to the second post of 10 Consultant Neurosurgeon with effect from 1st August 1996 11 or a mutually agreed date as soon thereafter ..." 12 So that gives us a broad flavour of what happened. 13 There were a number of candidates, four people applied, 14 three people were interviewed. They were all deemed 15 suitable but Mr Eljamel was deemed to be the most 16 suitable, in particular because of the fact that his 17 broad range of experience suited better the sorts of 18 services the unit would need to offer, is that fair? 19 A. That's what I understand, yes. 20 Q. That's helpful, thank you. 21 THE CHAIR: Sorry, could I just have a page reference to for 22 that? 23 MR DAWSON: Yes, the minute of the meeting was NHST-04741, 24 pages 418 and 419. 25 THE CHAIR: Yes, thank you. Page 103
1 that we talked about and we can see there the identity 2 of the people on the committee and there are various 3 different people, including representatives of the trust 4 and Dundee University, is that right? 5 A. Yes. 6 Q. If we scroll down a little bit further. And performing 7 her important HR function, Mrs Blair is also there, is 8 that right? 9 A. Yes. 10 Q. And there are a number of -- there are four applications 11 listed at the bottom. And it explains the background to 12 the process and over the page on 419, it says three 13 candidates were invited for interview, a process you 14 described earlier, is that right? 15 A. Yes. 16 Q. And the committee considered the applications and read 17 the reports of the referees and interviewed for the 18 appointment of consultant neurosurgeon: 19 "It was noted that both members of the National 20 Panel of Specialists considered all candidates suitably 21 qualified for an appointment of consultant status. 22 However, the Committee believed [that] Mr Boles' 23 experience [may] be too specialised to be suitable for 24 consideration for appointment to a smaller unit such as 25 at Dundee Royal Infirmary where a much broader Page 102	1 MR DAWSON: And if we look, please, at page 421, a couple of 2 pages over. It gives a little bit more insight into the 3 background. This is a letter, 7 July 1995, from 4 a Dr Derek Maclean, Director of Medical Services, to 5 David Ewing at the medical department of, effectively, 6 the government; is that right? 7 A. Yes. 8 Q. And it relates to Mr Eljamel, and it says: 9 "The above Libyan has been appointed by the Trust as 10 Consultant Neurosurgeon and successor to Ivan Jacobson. 11 He is currently working in Connecticut. 12 "The Trust would appreciate any help your Department 13 can give by liaising with your colleagues in the 14 Overseas Labour Service to expedite Mr Eljamel's work 15 permit, application for which was made on 22 June 1995. 16 "You will be aware of the staffing problems in 17 neurosurgery here caused by Mr Jacobson's premature 18 retiral ... now compounded by the restrictions on our 19 other neurosurgeon (which we discussed). 20 "[It is] in a small unit such as ours, all 21 consultants must have the capacity to cope with the full 22 range of procedures at any time, and there seems to be 23 a national shortage of the requisite neurosurgical 24 skills. 25 "It is therefore imperative in order to maintain our Page 104

1 existing neurosurgical services, without overloading 2 Mr Varma, that this appointment can proceed without 3 delay and for the longer term." 4 So obviously I'm not particularly interested in the 5 various immigration issues that getting a work permit 6 required, but this is a letter written by I think 7 somebody in the hospital effectively to somebody in the 8 government, is that right? 9 A. Yes. 10 Q. And what they're asking for is some assistance from the 11 government in trying to expedite, effectively, 12 Mr Eljamel getting into the country to start the job? 13 A. Yes. Just to clarify that Dr Derek Maclean was the 14 medical director. 15 Q. Right, that's helpful, thank you. The interest in this 16 is giving some insight into what the position, the state 17 of the neurosurgical service was at the time when 18 Mr Eljamel arrived. So they had had three consultants 19 and one left, Mr Jacobson, I think, is that right? 20 A. Yes. Yes. 21 Q. And his retiral was described as "premature"? 22 A. Yes. 23 Q. So perhaps unexpected? 24 A. So that's what I read into it as well. 25 Q. Thank you. And there is also reference here, on the Page 105	1 a visa to be able to take the job, is that right? 2 A. Yes. 3 Q. And 428, please. If we scroll down a little bit. That 4 bit answers the Chair's question as to where the job was 5 advertised. As we thought, the BMJ and the Lancet is 6 the answer. And it says, in paragraph 41: 7 "Why are you unable to train or transfer an existing 8 employee to do this job? 9 "This is too specialised a post to transfer a doctor 10 from another hospital. Training of junior staff is 11 ongoing but lengthy. There are no doctors in Dundee 12 ready to be promoted to consultant level in this 13 specialty. 14 "Why do you need to employ [from] the overseas 15 national? 16 "Apart from the one doctor who has been offered the 17 second post, no other UK applicants applied for the 18 post. Lack of consultants in neurosurgery can be 19 life-threatening and the post must be filled. We are 20 particularly fortunate that someone of Mr Eljamel's 21 qualifications and experience has applied." 22 Now, does this evidence tend to suggest that there 23 is a significant urgency about getting someone into the 24 post? 25 A. Yes. Page 107
1 second neurosurgeon, not Mr Varma, having some sort of 2 restriction presumably in the service he was able to 3 offer for some reason? 4 A. Yes. 5 Q. And that therefore, there was a considerable urgency in 6 getting Mr Eljamel into post so that he could pick up 7 the apparently very considerable slack? 8 A. Yes, that's how I read it. 9 Q. Thank you very much. (Pause). Just in addition to 10 that, page 428, please. This answers one of the 11 questions that the Chair asked earlier I think. 12 A. Okay. 13 Q. This is a document again relating to the -- this is part 14 of a document -- actually if we go to 430 we'll see that 15 this is familiar handwriting perhaps? 16 A. Yes. 17 Q. This is a document pertaining to the immigration 18 situation that we were just looking at. This is signed 19 by Mrs Blair, I think? 20 A. Yes. 21 Q. And this is part of the reason why you can recognise her 22 handwriting on other documents? 23 A. Yes. 24 Q. So if we go back then -- so the purpose of this is to 25 try to provide a case, I think, for Mr Eljamel to get Page 106	1 Q. But that there were other people, at least one if not 2 two on an interpretation of the materials, that was 3 suitably qualified? 4 A. Yes, but what's not clear is whether they were in the UK 5 or not. It would suggest that none of them were in the 6 UK so presumably there may have been the same issue with 7 the others. 8 Q. Well, it says there "apart from the one doctor who has 9 been offered the second post, no other UK applicants 10 applied for the post"? 11 A. Yes. 12 Q. Which suggests that the one -- 13 A. (Overspeaking). Nobody, yes. 14 Q. No, it suggests, I think, that the one was a UK 15 applicant? 16 THE CHAIR: One of the two others. 17 MR DAWSON: Yes. 18 A. Yes. 19 Q. The one who was offered the second post, who we named 20 earlier, he was a UK applicant, I think. 21 A. I'd have to -- yes, I believe you're right. Sorry, 22 I'd need to just look back at that. 23 Q. Just take a second to read it: 24 "Apart from the one doctor who has been offered the 25 second post, no other UK applicants applied." Page 108

1 A. Yes, that's fair. 2 Q. So I think the person who had been identified as a bit 3 below but maybe to be offered a job later, he was a UK 4 applicant -- 5 A. Yes. Right. 6 Q. -- but nobody else was I think is what that means? 7 A. Yes. 8 Q. But the key point I wanted to establish is this tends to 9 show that there was an urgency about getting someone 10 into the post, for the reasons we looked at? 11 A. Correct. 12 Q. And also that there were other options other than 13 Mr Eljamel? 14 A. Yes. 15 Q. Someone who was a UK applicant, yes, as we established? 16 A. Yes, that was offered the other job, yes. 17 Q. Indeed, who was sufficiently qualified to be offered 18 a job within the same unit? 19 A. Yes. But what I would -- so yes is the short answer to 20 that but, you know, if it had been determined from the 21 minutes of the meeting of the Advisory Committee, 22 Mr Eljamel was identified -- and this is not my 23 judgment, this is the fact -- was identified to be the 24 most suitable candidate then presumably what the 25 organisation would want is to get the most suited Page 109	1 needed, or would that be something that would be 2 considered later perhaps in conversation with Mr Varma? 3 A. I think the medical director would be able to give you 4 an opinion on that. I think from my perspective I would 5 anticipate that that would be part of the discussion 6 with the candidate at interview but then would be 7 followed up in terms of what that was materially going 8 to look like. 9 Q. It would make sense, wouldn't it? 10 A. Yes. 11 Q. Because if the advert says we're quite interested in 12 fostering the possibility of offering non-core services 13 in certain sub-specialties, it would be logical that it 14 would be part of the discussion to say: are you 15 interested in any of that in particular? 16 A. Of course. 17 Q. Thank you. Is there any evidence on the file of his 18 ability or otherwise to deal with patients having been 19 tested or assessed? 20 A. No. 21 Q. Any evidence on the file of his ability to work with 22 professional colleagues having been tested or assessed? 23 A. No. 24 Q. Any evidence on the file of his teaching ability having 25 been tested or assessed? Page 111
1 candidate into the role. 2 Q. But it might be the case that that judgment would be 3 different if different information were available about 4 Mr Eljamel? 5 A. Of course, of course, it's based on the information that 6 there was at the time. 7 Q. Absolutely. Absolutely. Is there any evidence in the 8 file of there being, other than the three references, 9 any evidence of his technical surgical skills having 10 been tested or assessed? 11 A. No. 12 Q. Is there any evidence -- we mentioned the 13 sub-specialties and the possibility of doing that. Was 14 there any evidence, other than of course again the 15 referees from the three -- the two other hospitals, that 16 there had been any assessment of first of all which 17 sub-specialties he might be thinking about offering? 18 A. No. 19 Q. Or his proficiency in any of those? 20 A. No. 21 Q. Would that -- you may or may not know this but would 22 that decision about the sub-specialties and what service 23 would be offered, would that be expected to be part of 24 the application because it's relevant to the possibility 25 that they will be able to offer a service that might be Page 110	1 A. No. 2 Q. It's quite clear, I think in the adverts, that teaching 3 is going to be part of the role? 4 A. Yes. 5 Q. Any evidence on the file of his communication skills 6 having been tested or assessed? 7 A. No. 8 Q. Any evidence on the file apart from the references of 9 his honesty or integrity having been tested or assessed? 10 A. No. 11 Q. Did the application at this time work on the basis that 12 if you had passed all the requisite tests and if you 13 could provide the three references that looked to be 14 favourable, as they were, that would be the entirety of 15 the investigation, apart from an interview that would 16 require to be undertaken? 17 A. So the three elements of -- that we mentioned earlier: 18 having the qualifications that were required for the 19 role; having a registration with the GMC; references and 20 then any probing that was done in the interview process. 21 Q. Because, I mean, as I understand it from the subsequent 22 material, what then happens is effectively that 23 a consultant -- we've heard the phrase "independent 24 doctor" used. A consultant really then has an enormous 25 amount of freedom, really from day one to conduct their Page 112

1 practice as they see fit? 2 A. Yes, but that's -- that has shifted over time with the 3 processes that have come into play around appraisal and 4 revalidation. 5 Q. But at this time? 6 A. Yes. 7 Q. There's no probationary period or anything like that, is 8 there? 9 A. No. 10 Q. He's basically just allowed to go to the ward and get on 11 with it? 12 A. That could be an interpretation. 13 Q. With, it would appear other than the references, no 14 checking of anything with any of the organisations with 15 whom -- institutions with whom he said he had been 16 affiliated? 17 A. So the references would be the connection with 18 organisations that he had been affiliated with. 19 Q. Thank you. But not all of them? 20 A. No. 21 Q. They're the ones that he chose to get references from? 22 A. Yes, but they would need to be appropriate. 23 Q. What do you mean by that? 24 A. Seen to be appropriate. So it would need to be 25 organisations that he had worked in, in roles that were Page 113	1 staffing department at Ninewells dated 28 February 1995, 2 is it? 3 A. Correct. 4 Q. I think I asked you earlier as to whether there were any 5 checks done in relation to the communications skills 6 that Mr Eljamel had and I think you said beyond the 7 references that that hadn't been done, is that right? 8 A. Yes. 9 Q. Communications skills are, however, an important part of 10 the job of a consultant? 11 A. Agreed. 12 Q. Could I just read through this letter for you and we'll 13 maybe pause to see if there are any observations you 14 have as we go through it, it says: 15 "Dear Sir/Madam 16 "With reference to your advertisement of consultant 17 neurosurgeon post based at Dundee Royal Infirmary, 18 I hereby formally apply for this job." 19 Any observation on the sentence as regards the 20 quality of its English? 21 A. Umm ... 22 Q. Between the word "of" and "consultant" one might expect 23 the word "a" or "the": 24 "With reference to your advertisement of [a] 25 consultant neurosurgeon post ..." Page 115
1 relevant for the role that he was applying for, and from 2 people that were suitably able to provide an overview of 3 his performance in those previous roles. 4 Q. Absolutely. 5 MR DAWSON: Sir, that would be a convenient point to break. 6 THE CHAIR: Yes, very well. Mrs Watson, we'll break now for 7 lunch. We usually take an hour. I politely remind you 8 of the same stricture about discussing your evidence. 9 A. Okay. 10 THE CHAIR: And Ms Miller will take you back to the witness 11 room now. 12 A. Thank you. 13 (12.42 pm) 14 (The short adjournment) 15 (1.44 pm) 16 THE CHAIR: Mrs Watson, good afternoon. I think we're ready 17 to resume, Mr Dawson. 18 MR DAWSON: Thank you, sir. Mrs Watson, we were looking at 19 some of the documents related to the application and the 20 application process of Mr Eljamel in 1995. There are 21 a couple of others I just wanted to take you to. Could 22 we go back, please, to NHST-01544. 23 Page 6, please. In this bundle this comes just 24 before the CV with the written annotations on it. This 25 is a letter, I think, from Mr Eljamel to the medical Page 114	1 A. No, I wouldn't have picked that up. 2 Q. Okay. 3 "... I hereby formally apply for this job. I have 4 completed my training in neurosurgery in Liverpool and 5 Dublin and doing some time in the USA." 6 A. Yes, that's not good language. 7 Q. Why? 8 A. Well, it's given the formality of the letter, "Doing 9 some time" doesn't really convey what is actually being 10 done there. 11 Q. Okay, thank you. And perhaps the word "am" should 12 appear before "doing": I am doing some time in the USA? 13 A. Yes. 14 Q. Thank you. It says: 15 "I am very keen to return to the British Islands 16 permanently." 17 Any comment on that? 18 A. That is not how we would describe -- 19 Q. The country? 20 A. The country. 21 Q. Yes, thank you: 22 "I have enclosed my CV for scrutiny." 23 Then it says: 24 "Although, I am a permanent resident of the USA, 25 I will need a work permit to work in the Page 116

1 United Kingdom." 2 Again, any observations on that? 3 A. There's a comma in the wrong place. 4 Q. Okay, I wondered, in fact, what it should say is: 5 because I am a permanent resident of the USA, I will 6 need a work permit? 7 A. Perhaps. Sorry, I didn't mean to interrupt you. 8 Q. Thank you. It says: 9 "I will be very grateful if my application is 10 considered and look forward to hear from you soon." 11 Again, any issues with that in English? 12 A. Well, it's -- the grammar is incorrect. 13 Q. Thank you. And I think you also helpfully reflected 14 you'll have seen many, many application letters for 15 many, many different types of jobs over your many years 16 in the field in which you worked. You mentioned also 17 that you consider this to be an informal way of 18 expressing oneself, certainly in places, for such 19 an important post? 20 A. Yes. 21 Q. Yes, thank you. Could I please also, just as we're with 22 this document, this is a slightly tricky one to read. 23 It's page 1 of this document. It links into 24 a particular -- actually sorry, before we go away, could 25 we just go back to page 6. There's a couple of Page 117	1 "Thank you for your letter of June 22, 1995. I am 2 writing to confirm I formally accept the offer of 3 appointment as a consultant neurosurgical surgeon at the 4 Dundee Teaching Hospitals NHS Trust on full-time basis. 5 I shall forward my job plan [something] prior to the 6 time of commencement of the post. 7 "Further to our conversation on June 15, 1995, 8 I look forward to [joining] the department as soon as 9 possible and when I hear from you I will make the 10 appropriate arrangement of my relocation in Dundee. 11 "Thanks again, and I look forward to hearing from 12 you again." 13 Is that, as best as I can do, what it looks like it 14 says? 15 A. (Overspeaking) Yes, just of note, the version that's in 16 the file isn't any clearer. 17 Q. Thank you. Yes, so the copying is on to the file rather 18 than the copy you sent to us? 19 A. Yes. 20 Q. That's very helpful. So what that is, I think, is 21 Mr Eljamel, without necessarily looking at as much 22 detail as I may not have picked up every word correctly, 23 saying that he's happy to accept the post which, by that 24 time, has been offered to him, is that right? 25 A. Yes. Page 119
1 different handwritten annotations on there. Up in the 2 top right-hand corner "Jan 87-91" does that look like? 3 A. Yes. 4 Q. And then, in the bottom left-hand corner, it says 5 "Dublin ref 227173". Do you think that this is the same 6 handwriting as the one we saw before -- 7 A. It is, yes. 8 Q. -- Mrs Blair? Yes. I wondered whether, just because 9 "Jan 87-91" coincides with the dates at Liverpool, that 10 she is making some notes to follow up on the references. 11 Is that what's happening there, do you think? 12 A. Possibly. 13 Q. So this again, looks like her adding stuff to the 14 material in the HR file to keep notes as to -- 15 A. Yes. 16 Q. -- where the process is going? 17 A. Yes. 18 Q. Thank you. So if we go to page 1, please. This is 19 a tricky one because it hasn't been copied very well 20 I think. So it looks to me like it's a letter from 21 Mr Eljamel dated 28 June 1995, does that look right? 22 A. Yes. 23 Q. I think it's a letter to Mrs Blair, is that right? 24 A. Yes. 25 Q. And I think it says: Page 118	1 Q. The bit I wanted to pick up on was the mention of a job 2 plan because that's something that you've provided a lot 3 of information to us. I think I mentioned earlier 4 you've managed to find on the file a number of job 5 plans. They appear to be annual, is that right? 6 A. Yes. 7 Q. And I think what's being suggested here is that 8 Mr Eljamel himself would be involved in fixing the job 9 plan, is that right? 10 A. Yes. 11 Q. So does this perhaps reflect the need for him to speak 12 with the other consultants to try to work out what, for 13 example, specialty services he's going to be offering 14 and what his other commitments are going to be and work 15 with them to work out how his timetable, if you like, is 16 going to fit in with the others? 17 A. Yes, I think that's a fair assumption but I think the 18 medical director would be able to give you more detail 19 on that, yes. 20 Q. Thank you. But without getting into the details of what 21 the precise job plan was, I think the position is that 22 job plans do form an important feature of the way in 23 which things appear to be organised from the files 24 you've sent us, is that right? 25 A. Yes, that is correct. Page 120

1 Q. And so they set out the broad responsibilities that will 2 be undertaken by a particular consultant but also, 3 I think, set out how the timetable is going to work in 4 terms of when they will be doing surgeries, clinics, 5 ward rounds and maybe teaching commitments and the like, 6 is that right? 7 A. Correct. 8 Q. If we could look, please, at the statement at 9 paragraph 39(a).4. You refer here to there being 10 a draft job plan sent with the advertisement. You say: 11 "A draft job plan, issued with the job 12 description ... at advertisement stage, indicated two 13 sessions a week for outpatient clinics and ten sessions 14 shared between the three consultants of fixed theatre 15 time. The rest of the sessions were flexible and would 16 be agreed with the appointee. In job planning terms, 17 a full-time consultant working a 40-hour week would have 18 10 sessions in their job plan, each of which would be 19 four hours long." 20 So I think, as we discussed earlier, there's 21 an indication as to what the sessions will be but 22 a degree of flexibility to work that out once the person 23 has -- that's the reason it's called a "draft" job plan, 24 I think. Is that right? 25 A. Yes, correct. Page 121	1 Correct me if I'm wrong -- we can go to the detail, if 2 you like, Mrs Watson -- one of the things I think you 3 point out, you actually contrast for us in the statement 4 an earlier job plan which I think was from 1996, the 5 first one. And then you contrast this one which 6 contains within it, I wouldn't necessarily say more 7 work, that might be an assumption, but certainly a much 8 more detailed explanation as to what the job involved, 9 is that right? 10 A. Yes. Yes. 11 Q. So if one scrolls down from here, one can see that there 12 is effectively that timetable you can see at the top. 13 And then down at the bottom those are the fixed 14 commitments, if you like: theatre time, clinics, that 15 sort of thing, and the on-call commitments. But at the 16 bottom a list of things deemed to be activities which 17 are not undertaken at specific locations or times. So 18 for these sorts of activities, would it be left to the 19 consultant to work out how they organise their time to 20 fit these things in? 21 A. Yes. 22 Q. And that would be something that would be part of, 23 I suppose, the consultant's responsibility to manage, is 24 that right? 25 A. Yes. Page 123
1 Q. It's quite clear, perhaps unsurprising in light of the 2 correspondence we looked at earlier which formed the 3 background of the post being advertised, this is 4 a full-time role? 5 A. Yes. 6 Q. Thank you. I won't take you through the various job 7 plans but for the sake of completeness, at 8 paragraph 40(a).2 you set out for us broadly how the job 9 plan worked in 1996 and then gave us a long list of all 10 the others that you managed to find and you've very 11 helpfully told us that the file didn't contain job plans 12 for 1995, 1998, 1999, 2000, 2001, 2002, 2004, 2006 or 13 2007, but did for the other years of his employment; is 14 that right? 15 A. Yes. 16 Q. Do you know, or have any idea based on your experience 17 of the document retention system, why some would be 18 retained and some wouldn't? Because it looks like a job 19 plan is within that category of the sort of thing one 20 would expect to find on the HR file. 21 A. So no, I don't. I would have expected that if we had 22 some we would have them all but I can't explain why some 23 are there and others aren't. 24 Q. Okay thanks. One you sent in was for 2012-13, I think. 25 Could we have a look at that, please. It's NHST-01543. Page 122	1 Q. Would it be fair to say that there is the fixed 2 commitments at the top, which they've agreed with their 3 colleagues they'll be in theatre on a certain day and 4 that sort of thing, but beyond that, the number of 5 things that appear on this list beyond teaching, which 6 is part of the contract I think when one comes to 7 a teaching hospital like the Dundee Royal Infirmary and 8 subsequently Ninewells, beyond that effectively 9 a consultant has freedom as to the other activities that 10 they get involved in? I don't mean social activities, 11 I mean within the scope of their broad work. 12 A. So I would say my understanding is yes, but again this 13 is -- like I said at the beginning, there were a number 14 of areas where there was crossover between myself and 15 the medical director, so this is an area that he will be 16 able to give you a more specific view on. 17 Q. Okay. Again, if we just look at the list of activities 18 that are there. A number of these are quite specific, 19 almost like the way in which to do your job rather than 20 actual separate tasks. So for example prioritising GP 21 referrals using the paper and electronic referral 22 system, that's just really an indication how to do 23 a certain part of the job that's already listed above as 24 I understand it, is that fair? 25 A. Yes. Page 124

1 Q. And there's a number of ones like that. I think this is 2 the point you are making in the statement that this has, 3 at this stage, become more detailed. 4 A. Yes. 5 Q. I don't know whether you can dictate to a consultant, 6 but it's trying to say: this is the way that you've 7 agreed to go about these tasks, is that right? 8 A. Yes, it's surprisingly detailed, to be candid. Yes. 9 Q. Yes. Is that for the reason that I have hypothesise, 10 that one doesn't tend to tell the consultant precisely 11 how to do their job? 12 A. Yes, I think that's a reasonable hypothesis but 13 I couldn't confirm it. 14 Q. Presumably you say it's surprisingly detailed based on 15 your experience of seeing these sort of things in lots of 16 different files, if you like? 17 A. Yes. Well, there's many, many different professional 18 roles within healthcare. I don't know that you would 19 see something so detailed for anybody else, it's just it 20 was surprisingly detailed. 21 Q. Yes, do you have -- you do tell us that, I think, in the 22 statement, but I don't think you proffer any view as to 23 why that might be. 24 A. No. 25 Q. Would that be speculative? Page 125	1 become involved in research, is that right? 2 A. Yes. 3 Q. And I think we've heard from some other witnesses that 4 one of the reasons why a doctor might spend more time 5 doing research, it's something that interests them 6 obviously, but it would be something that would be taken 7 into account as they rise up the various honorary jobs 8 that one can be given in a university. So we heard from 9 some representatives of Dundee University that the more 10 a doctor did teaching and research in connection with 11 the university, the more likely it would be that the 12 person would rise up the ranks of honorary lecturer, 13 senior lecturer, reader and professor; is that your 14 understanding? 15 A. I heard that evidence and I would defer to their 16 expertise in that area. 17 Q. Thank you. I wonder if we could go to page 4 here, 18 please. Maybe actually starting at page 3. The job 19 plan here goes on for several pages and appears 20 extremely detailed, is that right? 21 A. Yes. 22 Q. Again, is this unusually detailed for your experience? 23 A. So I wouldn't say it was unusual for Mr Eljamel. I just 24 think it's unusual in comparison to the planning for 25 other roles within healthcare. That's my opinion, just Page 127
1 A. No, I would be speculating. 2 Q. Yes, I appreciate that. Just to point out some of the 3 things that, by this stage, Mr Eljamel is involved in 4 doing which may go beyond the sort of routine tasks. 5 Numbers 11 to 13 are committees, clinical governance, 6 chairs of clinical governance, clinical governance and 7 quality forum, ethics committee and examiners meetings. 8 12, interviewing potential medical students, vetting 9 their applications. And 13, attending other committee 10 meetings, appraisal, assessments and teaching courses. 11 Now, are those sorts of activities the sorts of 12 things that a consultant may or may not get involved in? 13 A. Yes. 14 Q. Yes, and also, I don't think it says this here, but 15 another thing, would it be fair to say -- we've heard 16 some evidence about this from someone else -- that 17 a consultant may or may not get involved in is research? 18 A. Yes. 19 Q. So whereas teaching, as I understand it, is a component 20 part of a job in this hospital, to some extent one can, 21 I think, choose how much one gets involved in teaching 22 but everyone, all the doctors, do teaching to some 23 extent? 24 A. Yes. 25 Q. Beyond that, if one is doing research that's a choice to Page 126	1 to be clear. 2 Q. Understood, and based on your experience of looking at 3 a lot of these sorts of things, is that right? 4 A. Yes. 5 Q. It has a table here with lots of different activities 6 broken down into average number of hours spent on each 7 activity per week. And on page 4, there's an allocation 8 for multi-disciplinary meetings about direct patient 9 care, is that right? 10 A. Yes. 11 Q. So therefore, this is a job plan which is effectively 12 an agreement between the consultant and the employer as 13 to what it is, broadly, they will be spending their time 14 on, is that right? 15 A. Yes. 16 Q. So therefore there was an expectation that Mr Eljamel 17 would spend time in multi-disciplinary meetings about 18 direct patient care? 19 A. According to this plan, yes. 20 Q. Yes, one aspect that -- again, this may get into the 21 medical director area but I'll see if this is something 22 you recognise from looking at these sorts of things. 23 One thing that doesn't appear here is something called 24 "mortality and morbidity meetings". Is that a concept 25 you're familiar with? Page 128

1 A. Yes. 2 Q. And does that mean, in this detailed plan, that 3 Mr Eljamel didn't consider, or in his agreement with the 4 board he didn't consider that that was something he 5 would spend time doing in his average week? 6 A. Well, it's not mentioned here but I can't make a comment 7 on whether that was what his thinking was around it and 8 would agree that it's something that the medical 9 director might be able to give some insight to. 10 Q. Thank you, that's understood. But we are saying that 11 this is detailed and includes multi-disciplinary 12 meetings? 13 A. Yes. 14 Q. But it doesn't include that other type of meeting that 15 I mentioned? 16 A. Yes, I see the point you're making. 17 Q. Thank you. Once, again, small point that I mentioned 18 I just wanted to pick up on. You say, at 19 paragraph 40(a).4, just to do with the hospitals that 20 Mr Eljamel worked in, he worked initially mainly within 21 Dundee Royal Infirmary then mainly within 22 Ninewells Hospital following the transfer from DRI and 23 occasionally other hospitals within NHS Tayside 24 including Perth Royal Infirmary. So because you're 25 helping us with a sort of historical exercise, I assume Page 129	1 neurosurgeon role. We also asked you about clinical 2 lead in a couple of other roles. Almost for every 3 question, it was broken down into (a), (b), (c), (d) and 4 sometimes you cross-refer back to other questions, but 5 one consistent feature of that was we asked you about 6 a role which we understood him to have held which was 7 a head of department role within the University of 8 Dundee and I think I'm right in saying, you answered the 9 question the same way every time which was -- 10 A. Yes. 11 Q. -- first of all, you say that there was nothing in the 12 records to suggest that he ever held that role, is that 13 right? 14 A. Correct. 15 Q. And the second thing was that you wouldn't necessarily 16 have expected any information to be held within his HR 17 file about that because, on its face, it's a Dundee 18 University role, it's not an NHS Tayside role? 19 A. I can't remember that being the exact wording that 20 I used, but the inference was that we didn't have any 21 documentation that referred to roles that were within 22 Dundee University. 23 Q. Okay. I think there maybe are some documents within it 24 talking about aspects of his role. For example, there 25 are documents which we might come on to, relating to his Page 131
1 that's the result of you having found some references to 2 him working at Perth Royal Infirmary in the paperwork 3 somewhere? 4 A. Yes. 5 Q. I was just interested in whether you could help us with 6 what sorts of work he would be doing there, in 7 particular because, as I understand it, there's no 8 neurosurgical service offered from that hospital? 9 A. Anything I offered would be speculative so again, 10 I'm sure the medical director might have a view on that. 11 Q. Okay. But it is the case that he appears to have done 12 some work from that hospital? 13 A. From the documentation I have seen, yes, as mentioned. 14 Q. Thank you, and if I have got a misunderstanding on this 15 please tell me. The neurosurgical service that he was 16 involved in was based at Dundee Royal Infirmary between 17 1995 and 1998 and thereafter at Ninewells? 18 A. Yes. 19 Q. Thank you. I would like to ask you some questions about 20 the aspects of the broad trajectory of Mr Eljamel's 21 career after the point where he had taken up his work 22 connected, to some extent, with the jobs he's doing. 23 One of the things -- we asked you various questions 24 about a number of different roles that we understood 25 Mr Eljamel to have held, including the consultant Page 130	1 promotion up the hierarchy in that honorary circle, so 2 that those are from Dundee University, aren't they? 3 A. Yes. 4 Q. Yes, the reason that I'm getting into this with you is 5 that we've heard evidence from other sources from the 6 university that he, in fact, did not hold that role, 7 so -- 8 A. (Overspeaking) I heard that too -- 9 Q. -- that may explain why you did not have anything about 10 it. Would that be consistent with that evidence? 11 A. Yes, I heard the evidence and yes, it would be 12 consistent. 13 Q. One aspect of the documentation relating to his Dundee 14 University roles over the years, was just to do with -- 15 there's not a lot to do with his Dundee University role, 16 there are, for example, letters explaining that he's got 17 a particular appointment at a certain time but beyond 18 that, there's really very little, if any, detail about 19 what he was actually doing there. Now, I was just 20 interested, from an HR perspective, whether you would 21 expect there to be more information about his commitment 22 to teaching and a particular research within the HR file 23 or that was something that, again, was part of the 24 consultant's responsibility to sort out themselves? 25 A. So I don't think it's one or the other. I think that Page 132

1 they're likely -- and this, again, would be a question 2 that the medical director would have a perspective on 3 but information about teaching would potentially be held 4 within the records of the department of medical 5 education. 6 Q. Right, which was, remind me, a department within 7 NHS Tayside? 8 A. Yes, supporting the medical director. 9 Q. Thank you. Okay, so the reason I ask that is because, 10 in the context of looking at the job plans which for 11 Mr Eljamel in particular at times are quite detailed, it 12 perhaps might be thought of as unusual that there is 13 a detailed breakdown of what Mr Eljamel is agreeing to 14 do in his clinical role in the hospital, but very little 15 regard to what he does in any other aspect of his 16 medical life and practice? 17 A. I think that's a fair comment. 18 Q. Yes, because what I assume the job plan agreement is 19 about is to try to make it clear for both sides what 20 level of commitment he is giving to his primary role as 21 a consultant, yes? 22 A. Yes. 23 Q. And the reason why there needs to be clarity about that 24 is because the health board has responsibilities to 25 offer high quality healthcare to the patients, isn't Page 133	1 A. No, that's correct. 2 Q. I think you tell us -- there is a very detailed 3 assessment in your report which takes us through 4 a number of documents relating to the way that private 5 practice was considered by NHS Tayside? 6 A. Mm-hmm. 7 Q. In particular, my understanding is -- and I think, if 8 I get this wrong, please tell me -- 9 A. It's okay. 10 Q. -- because it is quite complicated, I think, that there 11 was a development in the way that private practice was 12 treated as far as what the NHS Tayside was interested in 13 about it, in that initially, within the consultant 14 contract that Mr Eljamel had, the position was that 15 there was a certain limitation imposed relating to how 16 many hours effectively in a week someone was allowed to 17 spend on private practice, is that right? 18 A. So first of all, it wasn't just Tayside -- 19 Q. Yes, fair enough. 20 A. -- it was national. I think it went from -- there was 21 very little limitations on private practice to then 22 introducing limitations that weren't about hours, but 23 about earnings. So it was about 10%, if you earned more 24 than 10% of your NHS salary in private work you had to 25 declare it and it was a mechanism of trying to put some Page 135
1 that right? 2 A. Yes. 3 Q. And the agreement of the job plan is, to an extent, 4 about making sure that everyone is on the same 5 wavelength about the amount of service that will be 6 offered in a clinical sense to those patients by 7 a consultant? 8 A. Yes. 9 Q. And that everybody needs to be on the same page that 10 a certain level will be expected to be able to meet 11 those standards? 12 A. Agreed. 13 Q. Thank you. So beyond that, I think it's correct to say 14 that there isn't any information, as I think we've 15 discussed, about his university roles and how much time 16 he is spending on those, is that right? 17 A. That's right. 18 Q. It's also the case, I think, that there isn't any 19 information on the files about the work that Mr Eljamel 20 is doing in private practice? 21 A. That's right. 22 Q. I don't think there is -- certainly on my reading and 23 our team's reading, there wasn't even any indication 24 that he had a private practice in the files, is that 25 right? Page 134	1 limitations on that. And then that 10% was removed with 2 the introduction of appraisal and the new contract which 3 put a focus on the job plan and what I mentioned earlier 4 today about if you were going to do private practice 5 then there was an expectation that you would take on 6 extra programmed activities as a means of providing more 7 NHS service than you were contracted to initially before 8 you then went and worked in private practice. And that 9 was all managed through the annual appraisal system, as 10 opposed to having to put in declarations of what you 11 were earning. 12 Q. Okay, thank you. 13 A. If that makes sense, hopefully. 14 Q. It does. There's a significant amount of complexity 15 around this and it, I think as I understand it from the 16 statement, wasn't helped by the fact that you don't have 17 access to all of the documentation in this regard? 18 A. No. 19 Q. So it's a bit of a jigsaw puzzle trying to put it all 20 together, but if we could try to. You mentioned there 21 some extra programmed activities. Could you just 22 explain to us what the concept of that involves? 23 A. So a programmed activity -- if I can explain this then 24 I'm doing really well. A programmed activity is 25 equivalent to a session, which is a four-hour block of Page 136

1 time, and for a full-time consultant, it's 40 hours, so 2 that would be 10 four-hour blocks would make up your 3 40 hours. Anything above that would still be blocks of 4 four hours and extra programmed activities are beyond 5 whatever your contracted hours are. 6 Q. Understood. So, as we discussed earlier, there's 7 a basic number of sessions of four hours, 10 sessions 8 I think Mr Eljamel would do in a week, yes? 9 A. Yes. 10 Q. And if he wanted to do more, or there was a need for him 11 to do more, there would need to be a specific agreement 12 about extra sessions being taken on, is that right? 13 A. Yes, but no consultant has to, and if they don't and do 14 private work it could affect their progress through the 15 salary scale. 16 Q. Yes. So I think what you were saying earlier -- just to 17 get this extra programmed activities so we're clear on 18 it, I think the position is that in the event that there 19 was a need or, with the consent of the consultant, he 20 could be authorised to do more than ten sessions in 21 a book, is that right? 22 A. Yes. 23 Q. And the position I think is that at a certain point in 24 time it was necessary to have taken on the extra 25 programmed activities, an extra session or extra Page 137	1 terms at 10(b).1, it says: 2 "Work systems and rules were governed by the 3 consultant contract, including working in private 4 practice. During the relevant period there were two 5 contracts. From 1995 to 2004, consultants were still 6 working under the 1948 contract with incremental 7 updates -- and private practice was governed by that 8 older framework NHS Tayside does not hold a copy of the 9 1948 contract, and it is no longer available from online 10 sources." 11 But you do refer us, for example, to the hospital 12 medical and dental staff, terms and conditions of 13 service handbook, which is from April 2003. And that is 14 a handbook you have provided to us. Now, this is quite 15 complicated but one of the questions I had for you, 16 there is a transition in 2004 between the two different 17 contracts. 18 Do you know, or did you work out, whether 19 the April 2003 handbook, which is a book that sets out 20 a number of the sort of expected conditions that would 21 be in addition to someone's basic contract, I think, 22 whether that pertained to the old system or the new 23 system? 24 A. So that's a good question I don't know the exact answer 25 to and we wouldn't have been able to compare it to the Page 139
1 sessions, before effectively you were permitted to go 2 and do private work, is that right? 3 A. So you can't stop a consultant from taking on private 4 work. So that's theirs but there are some parameters 5 put around it in terms of honouring what has been agreed 6 in the job plan and an expectation that you'll take on 7 EPAs if you're going to do private work, but you don't 8 have to. As I say, the medical director will have much 9 more insight on this than I do. 10 Q. Just one last point on it before we move on, just to 11 clarify what you said about it. I think you said that 12 you're absolutely right that you couldn't force 13 a consultant to do more, however there were incentives 14 to taking on extra NHS work which would involve being 15 able to rise up the pay scale more easily, is that 16 a good way of putting incentive? 17 A. Yes, that's it, yes. 18 Q. Could we look, please, on this subject at 19 paragraph 10(b).1 of the statement. So I think in this 20 section, what you're setting out for us is a general 21 indication as to the various documents, contracts, that 22 governed over the period he was involved in, 23 Mr Eljamel's employment, but I think in other places you 24 tell us some specific aspects related to private care 25 which is what we've been talking about. So in general Page 138	1 '48 contract because we didn't have it, but I can try 2 and get an answer on that for you. 3 Q. It would be helpful because the April 2023 handbook 4 contains a lot of detailed provisions about how one is 5 expected to do the job at various different grades but 6 including consultants. And I think it's important for 7 the Inquiry to be able to understand whether that's 8 reflecting the old or the new system because, as you've 9 set out here, you don't have access to all the 10 documentation. 11 A. Yes. 12 Q. But I think that would be an important piece of 13 information to be able to unlock how the old system and 14 the new system works, so that would be very much 15 appreciated. 16 A. Okay. 17 Q. If we could carry on, please, it says: 18 "Consultants could undertake private practice so 19 long as it did not interfere with NHS duties." 20 So at all times, was it the case that effectively 21 consultants were expected to give their primary 22 attention to their NHS responsibilities? 23 A. Yes. 24 Q. "There was no cap on private work and consultants could 25 organise it independently. The contract did not require Page 140

1 detailed job plans, making it challenging for Health 2 Boards to monitor or limit private work." 3 So, in that paragraph I think, as I understand it, 4 you're talking about the pre-2004 system? 5 A. Yes. 6 Q. So the contract that would have governed Mr Eljamel's 7 work from 1995 to 2004, there would have been no cap on 8 the private work that he could do? 9 A. Correct. 10 Q. So there was the freedom that we talked about? 11 A. Yes. 12 Q. And then, it says in the next paragraph: 13 "From 2004, a new contract was 14 introduced (April 2004) ... The new contract allowed 15 Boards to plan consultants' work around the needs of 16 patients and the service, limit consultants' 17 working hours in line with the European Working Time 18 Directive ... and make it easier for the NHS to recruit 19 and retain consultants. 20 "The new contract aimed to reduce conflicts around 21 private practice and contained conditions that: 22 "NHS must have first call on consultant time." 23 I think that was always the position, was it not, 24 from what we've just seen? 25 A. Yes. Page 141	1 Q. So, at least under the system from 2004 onwards, there 2 was a need which we think had existed the whole time 3 that NHS has first call on consultant time and private 4 practice must not conflict with NHS duties? 5 A. Yes. 6 Q. But we think maybe it was an innovation that consultants 7 required to compare private commitments and that job 8 plans required to specify all NHS and private work, is 9 that right? 10 A. Yes. Yes. 11 Q. So what that means, as I understand it, is we're not too 12 sure of the position before 2004 but certainly after 13 2004, your understanding was that there would have been 14 an obligation on Mr Eljamel within the NHS system to 15 declare his private commitments? 16 A. Yes. 17 Q. And also that his job plans specify effectively the 18 split between the NHS and the private time in a week, is 19 that right? 20 A. Yes. 21 Q. That, I think, would be completely consistent with what 22 we discussed earlier -- 23 A. Yes. 24 Q. -- about the need to make sure that there is clarity 25 within the NHS system as to what it is that a consultant Page 143
1 Q. "Private practice must not conflict with NHS duties." 2 Again, I think that was always the position before, 3 was it not? 4 A. Yes. 5 Q. "Consultants must declare private commitments." 6 Was that an innovation at that time or had that 7 always been the position? 8 A. I think so. 9 Q. Yes: 10 "Job plans specify all NHS and private work." 11 That would be consistent that that's an innovation, 12 I think, as well: 13 "Extra PAs (EPAs) regulate private practice during 14 NHS time." 15 Could you just explain what that means, that last 16 part? 17 A. So that's pulled from the document. My interpretation 18 of that is what I've explained, that if a consultant was 19 intending to do private work that there was 20 an expectation that they take on extra PAs for NHS work. 21 Q. The PAs were the programmed activities that we talked 22 about? 23 A. (Overspeaking) Programmed activities, yes. 24 Q. So EPAs were the extra programmed activities? 25 A. Yes. Page 142	1 is spending his or her time on. Because ultimately, if 2 a consultant, for example, hypothetically, were doing 3 many, many hours in private practice, that might start 4 to impinge on the quality of care that the NHS patients 5 received, is that right? 6 A. Agreed. 7 Q. And that's why there is a real interest for NHS Tayside 8 to know what a person is doing because they have 9 a statutory responsibility to make sure that consultants 10 like Mr Eljamel keep the standards up? 11 A. Yes. 12 Q. And just on that last one, that's the point we discussed 13 before I think, where there was an incentive for people, 14 in terms of pay grade within the NHS, effectively, if 15 they have extra time, do it in the NHS first rather than 16 doing it private practice, is that right? 17 A. That's it, yes. 18 Q. Thank you. 19 THE CHAIR: Sorry. One effect of that arrangement, unless 20 I'm not following what is happening, is that if 21 a consultant wished to do private work over and above 22 what was expected of them, let's say in their 40-hour 23 a week contract with the NHS, firstly, there would be 24 an expectation that they would do additional work with 25 the NHS. Page 144

1 A. Yes. 2 THE CHAIR: With the result that, second, any decision taken 3 to do private work would effectively be creating quite 4 a significant increase in workload, not just by virtue 5 of taking on extra private commitments but NHS 6 commitments as well? 7 A. Yes. 8 THE CHAIR: Over and above the 40 hours a week already 9 budgeted for, if you like; have I got that right? 10 A. Yes. 11 THE CHAIR: Thank you. 12 MR DAWSON: Thank you. Is it the consequence of the 13 principles set out here, which we think applied at all 14 times, NHS work to take priority, that it would never 15 have been permissible in terms of the NHS conditions of 16 service for a consultant, for a consultant to have been 17 doing private work while on-call in his NHS duties? 18 A. Correct. 19 Q. Thank you. And again, that's consistent with that 20 principle, isn't it? 21 A. (Nods). 22 Q. There's another phrase which is used. I'm not going to 23 go into the detail of the documents because they are 24 complex and I think we've managed to roughly work out 25 what the important parts are, but in one of the Page 145	1 A. Yes. 2 Q. Thank you. 3 A. Well, there's an expectation to fulfil what you have 4 signed in terms of the terms and conditions of your 5 employment. 6 Q. Yes. Thank you. Could we have a look, please, this is 7 within the HR file, which is NHST-04741 and looking at 8 page 233. This was something I referred to very briefly 9 earlier, it's a letter I think dated 4 March 2005, is 10 that right? 11 A. Yes. 12 Q. And I think this is a copy of a letter to Mr Eljamel, if 13 you go down to the bottom, from a Pamela Milne, director 14 of human resources, so it's copied to NHS Tayside 15 I think. This is solving a mystery that came up in 16 a previous part of the evidence, which is, it says: 17 "Dear Mr Eljamel. 18 "I am pleased to inform you that, on the 19 recommendation of the Principal and Deans Committee, the 20 Senatus Academicus has agreed that you should be granted 21 the above honorary appointment under the Faculty 22 Clinical Grading Scheme for such time as you continue to 23 hold your present post." 24 And that is an honorary reader in surgical 25 neurology, is that right? Page 147
1 documents there is an expression, which says that 2 whole-time practitioners -- this is in the April 2003 3 document and I don't know whether it falls on one side 4 of the line or the other, so if you could find that out 5 as you've undertaken, that would be very helpful -- 6 however, what it says is: for whole-time 7 practitioners -- and Mr Eljamel was one of those, is 8 that right? 9 A. Yes. 10 Q. It said: whole-time practitioners required to devote, 11 and the quote is: 12 "Substantially the whole of their professional time 13 to their duties in the NHS." (As read) 14 A. Yes. 15 Q. That, again, is consistent with what we've looked at, 16 I think? 17 A. Yes. 18 Q. And just to be clear, duties in the NHS would be their 19 main clinical consultant work, yes? 20 A. Yes. 21 Q. And it would also cover teaching, for people in the 22 teaching hospital, is that right? 23 A. As outlined in the contract of employment, yes. 24 Q. Indeed, so those duties require to take precedence over 25 other duties, is that right? Page 146	1 A. Yes. 2 Q. Thank you, so it appears that at that time Mr Eljamel 3 was given that honorary title? 4 A. Yes. 5 THE CHAIR: 2005. 6 MR DAWSON: 2005, yes, sir. I think in a previous session 7 there was a bit of a mystery around that, but I think 8 that maybe solves it. 9 Could we go to the statement, please, at 10 paragraph 21.4. The first part we've discussed already, 11 which says: 12 "After taking up his appointment in October 1995, 13 Mr Eljamel worked within [the Dundee Royal Infirmary] 14 until the Neurosurgery service was transferred to 15 Ninewells Hospital on around 16 November 1998. After 16 appointment to NHS Tayside as a Consultant, Mr Eljamel 17 took on the role of Clinical Lead, and this is described 18 in Question 8(j).2." 19 Could we go to 8(j).2, please. I think 8(j).2 was 20 a paragraph you did not write, is that right? 21 A. Yes. 22 Q. So perhaps -- I don't want to get into the details of 23 it, but it's really just to clarify what that role 24 involved. Could we just scroll down a little bit. Yes, 25 the first bit I just wanted is 8(j).3: Page 148

1 "Mr Eljamel served as Neurosurgery Clinical Lead 2 between 1997 [to] 2009. On review of Mr Eljamel's job 3 plans, the Clinical Lead time allocation was generally 4 low." 5 And then there's a narration about that which wasn't 6 your responsibility. If we go back up to the top, 7 please. This is an explanation provided, I think, by 8 one of your colleagues as to what that role involved: 9 "Supporting each Clinical Group Director was 10 a Clinical Group Manager -- a senior full-time manager 11 accountable for the day-to-day operational management of 12 the grouping. The Clinical Services Manager would be 13 an equivalent job title to Clinical Group Manager. 14 Clinical Team Managers reported to [the] Clinical Group 15 [Manager] and were responsible for management of a small 16 number of services within the Clinical Group. Further 17 information on the structure and [the] hierarchy can be 18 found [elsewhere]. Within each specialty, there was 19 also a Clinical Lead (consultant leading subspecialties 20 on a part-time basis, also referred to as Lead 21 Clinician) and Clinical Team Manager, responsible for 22 the day-to-day running of [the] services. A job 23 description for Lead Clinician/Clinical Leader can be 24 found [at] NHST-04599_13. Key functions of the clinical 25 lead included providing appropriate clinical, scientific Page 149	1 A. So, even though it's got a job description, and it is 2 a significant role, it's very informal in how these 3 positions are appointed to. It tends to be the 4 consultants in the group take their turn of doing that 5 role which is why there isn't any information held 6 formally within the HR file around how Mr Eljamel came 7 to be appointed to that role. But the medical director 8 will be able to give you more information on how that 9 role works in practicality. 10 Q. Thank you. In one of the passages that you wrote, 11 I think, which is paragraph 72.1 it says something 12 I think you just referred to there: 13 "In general terms, there's no formal appointment 14 process to Clinical Leader/Lead Clinician roles. The 15 roles are usually rotated around the consultants in 16 a department. No specific appointment process would 17 normally be undertaken. Mr Eljamel was the most senior 18 consultant in the department following retirements around 19 1998." 20 So if the role was rotated around the department, 21 would you have expected him to have held it around 22 12 years? 23 A. So that's surprising and I don't know if that would be 24 the case now. We can get that information, but, yes, 25 I was surprised that it had been held for that long. Page 151
1 and professional leadership to the Group Management 2 Team, management of speciality specific operational 3 matters and lead role in clinical governance for the 4 speciality." 5 So you've referred us to this, although the details 6 of aspects of that are certainly not for you to speak to 7 but just in terms of the clinical lead role, Mr Eljamel 8 held that between 1997 and 2009. One of the 9 responsibilities I think we see there is 10 a responsibility for clinical governance for that 11 particular group, is that right? 12 A. Well, that's what it says. 13 Q. Yes, are we getting beyond your experience there? 14 A. A little bit, yes. 15 Q. That's fine. I think another thing that it said which 16 might be more in your area is that the amount of time 17 allocated to this tended to be low? 18 A. Yes. 19 Q. Does that tend to indicate that, although this was 20 a role which was held, Mr Eljamel certainly didn't think 21 that this was something that would take up a lot of time 22 in his week? 23 A. So I obviously can't speak for what Mr Eljamel thought 24 about it. 25 Q. Yes. Page 150	1 Q. Just on another thing you might be able to help us with 2 here which is to do with retirements. We looked earlier 3 at the fact that when Mr Eljamel arrived in the unit in 4 1995 the position, I think, there were two 5 other consultants, Mr Jacobson having just left. 6 Mr Varma was the lead consultant and there was another 7 consultant and there was some mention of them having 8 some restriction unspecified on their time, is that 9 right? 10 A. Yes. 11 Q. And I think the position is, which I think you've 12 confirmed somewhere in your helpful narrative, that 13 Mr Varma left in 1998; is that right? 14 A. (Overspeaking). 15 Q. Is that what that means? 16 A. Sorry, I'm cutting across you again. I'll let you 17 finish your thought. 18 Q. No, it's okay. Yes, "the most senior consultant in the 19 department following retirements in around 1998". So 20 I think there was some significance to 1998 and 21 effectively Mr Eljamel, who had only been there for 22 three years, now became the most experienced person 23 there because the others had left; is that not right? 24 A. Yes, and I think that also aligns with the transfer of 25 the department from the DRI to Ninewells and a bit of a, Page 152

1 you know, assumption on my part that could have been 2 a point where long-standing consultants decided that 3 they didn't want to go to Ninewells. 4 Q. Yes, although we know that the plan to do that was 5 certainly in train in 1995? 6 A. Yes, yes. 7 Q. Could we look at paragraph 39(c).1, please. This was 8 one of the passages where we asked you about the 9 different roles and, for example, you can see at 39(b).1 10 that, as you often tell us, there's nothing to do with 11 the Dundee University role because we don't think he 12 actually held it, but the 39(c).1: 13 "There is no information within Mr Eljamel's HR 14 file ... held by NHS Tayside regarding his appointment 15 to this role. It is not clear how this appointment 16 occurred. The duties of Clinical Lead are ..." 17 Set out above. 18 So there wasn't any information about any formal 19 assumption of the role. Does it perhaps appear that 20 effectively he was the only consultant really? Because 21 the other two left, he'd been there for three years and 22 so he took on the role and then of course others joined 23 later; is that broadly what happened? 24 A. It could be, yes. 25 Q. But in any event, I think your understanding is the way Page 153	1 induct employees into the organisation but we couldn't 2 find any information. And that is something that has 3 evolved over time in terms of the need for better 4 induction for everybody when they join the organisation. 5 Q. Yes, I think in fact you told us about, again, in 6 passages you gave us, that you told us that after the 7 due diligence review that that was one of the things 8 that the organisation took forward. That was in the 9 period you were there, I think -- 10 A. Yes. 11 Q. -- that more training and information for clinical 12 leaders was something that came out of that, that has 13 now been taken on as an initiative? 14 A. Yes. 15 Q. And I think, right at the beginning of your evidence, 16 you mentioned, as part of your cultural role -- 17 A. Yes. 18 Q. -- the sort of thing that you got involved in. Was that 19 what you were talking about amongst other -- 20 A. (Overspeaking) Yes, in part. 21 Q. Thank you. So the question of inductions, to be clear, 22 although one might expect the evidence of the particular 23 sessions or whatever an induction to sit elsewhere, one 24 might, for example, have expected to see some reference 25 to inductions in materials around a job and the Page 155
1 in which that role is assumed is on a rotational basis, 2 is that right? 3 A. Yes. 4 Q. And would a reason for that be that it imposes certain 5 extra responsibilities on an individual surgeon, 6 including for clinical governance? 7 A. That could be. 8 Q. And that therefore, one takes it on for a period before 9 passing the baton on to a colleague; would that be fair? 10 A. That seems like a reasonable assessment. 11 Q. But Mr Eljamel held those responsibilities, whatever 12 they are, clinical governance et cetera, for 12 years? 13 A. Yes. 14 Q. I think you were asked -- there's a specific reason for 15 asking about this because of our Terms of Reference 16 cover it. You were asked as to whether there was any 17 information on the file about for any of the roles that 18 Mr Eljamel ever had, any induction. And I think you 19 tell us quite simply that there is no such information, 20 is that right? 21 A. That's right. 22 Q. If there had been any induction for any employee, would 23 one expect to see that on an HR file? 24 A. No, you might expect to see it beyond the HR file in 25 terms of what's available, in terms of what was done to Page 154	1 application for at least to indicate there would be 2 an induction? 3 A. Yes, that's not unreasonable. 4 Q. And I think you also said that, nevertheless, your 5 search for information about inductions was not 6 restricted to the HR file. You, in fact, as you told us 7 at the beginning, looked elsewhere; is that right? 8 A. Yes. 9 Q. And again, you found nothing? 10 A. No, that's not to say that it didn't happen in some 11 informal way, there was just no evidence that we could 12 find. 13 Q. Okay. So would it be your evidence then that it 14 wouldn't exclude the possibility there was informal 15 induction, but would it be fair to say that the absence 16 of evidence, amongst there being quite a lot of evidence 17 of other things, would tend to suggest there was no 18 formal induction? 19 A. I think that's my evidence, yes. 20 Q. Thank you very much. Could we look, please, at 21 paragraph 44(c).1 of the statement. Again, in this 22 specific paragraph, there's a specific aspect -- we'd 23 asked you about lead clinician for neurosurgery and pain 24 here and you drew out a particular aspect of that, which 25 said: Page 156

1 "These responsibilities would have been the same as 2 in Mr Eljamel's consultant role. Please refer to 3 paragraph 44(a).1, and to the comments in paragraph 32.1 4 above, in relation to Mr Eljamel's responsibility for 5 a pain clinic. This was a lead clinician role and would 6 have included providing leadership to other clinicians 7 who may have been involved in running a pain clinic." 8 We can go to 32.1, but I think 32.1, again, was 9 something someone else had drafted. I was just 10 interested in trying to understand, based on your 11 assessment and your liaison with others, what the 12 reference to the pain clinic means. Is that simply 13 something that one is doing in the way that a consultant 14 neurosurgeon would normally interact, or is this 15 something extra to that? The reason I ask is the phrase 16 "lead clinician for neurosurgery and pain" is used in 17 some documentation and it doesn't say, for example, 18 "lead clinician for neurosurgery and anaesthesia" 19 because there would be liaison with anaesthesia, it 20 tends to suggest that the "and pain" in the title is 21 meaningful in some way? 22 A. Yeah, so when I re-read this in preparation for today, 23 I had to read it a few times to remember what exactly it 24 was trying to say here. I think what I'm trying to say 25 is that his role with neurosurgery and pain is not Page 157	1 put one thing in that increased our knowledge. Here, 2 you say: 3 "NHS Tayside also has evidence of Mr Eljamel 4 submitting his interest, via letter to the Medical 5 Director Mr Lyall, in the post of Clinical Group 6 Director of Specialist Services on 02 November 2004 ... 7 NHS Tayside holds no documentation in relation to the 8 outcome of this process, however it should be noted that 9 Dr Richard Roberts, who was also scheduled to interview 10 for the post alongside Mr Eljamel ... subsequently 11 became the Clinical Director of Specialist Services in 12 2005, as outlined in response to Question 8(d)." 13 So I was interested in understanding -- so there's 14 information about the fact he applied for a role? 15 A. Yes. 16 Q. Is the information about Richard Roberts, does that tend 17 to suggest that he took that role or that he took 18 a different role? 19 A. So what the evidence shows is that Mr Eljamel made 20 application for the clinical group director role to 21 Mr Lyall. There's no documentation of the interview 22 process other than there's documentation that shows that 23 both Dr Roberts and Mr Eljamel were interested. And 24 then the documentation shows that Dr Roberts was the 25 clinical director. So the assessment, or the assumption Page 159
1 different than his role as consultant because there's no 2 evidence that we could see that extrapolated the 3 particular role around pain. I think that's what I was 4 trying to say here. 5 Q. I understand. So I think what I understand it to mean, 6 and please correct me if I'm wrong, is liaison with 7 a pain clinic would be a normal part of a consultant 8 neurosurgeon's job; is that right? 9 A. So that definitely would be a question for the medical 10 director and, you know, that could be part of the 11 discussion that we spoke about earlier today in relation 12 to what other sub-specialties Mr Eljamel was interested 13 in being involved in. I couldn't say that every 14 consultant was part of the pain clinic. 15 Q. Understood, but I think your evidence is that there is 16 no basis, from an HR perspective if you like, that he 17 held a role which was called "lead clinician for 18 neurosurgery and pain", is that right? 19 A. Correct. 20 Q. Thank you. I'll follow up with other people on the 21 specifics of that, thank you. Could we have a look at 22 paragraph 21.5, please. In addition to the named roles 23 that we've been able to ascertain from other 24 documentation ourselves, we also asked you whether there 25 were other roles that Mr Eljamel held and you helpfully Page 158	1 we're making is that Dr Roberts was the successful 2 candidate. 3 Q. Thank you. There's a very specific aspect I was just 4 honing on is that when you talk about the application, 5 the phrase that's used is "clinical group director of 6 specialist services", whereas the role that Dr Roberts 7 eventually acquired the next year is "clinical 8 director". Is that the same thing? 9 A. The same job, yes. 10 Q. Thank you. So what that's telling us is it looks like 11 Mr Eljamel applied for that role but that Dr Roberts has 12 got it? 13 A. Correct. 14 Q. Now, one aspect, just to break away, again, I know this 15 is covered by other people but you might be able to help 16 us with it. It's just to have an understanding, because 17 it pops up all the time, is what "specialist services" 18 means, if you can? 19 A. I think anything that I say would need to be verified by 20 others, so if you don't mind -- 21 Q. (Overspeaking) Yes, absolutely. I know there are others 22 who have answered very specific questions on this. 23 A. Yes, and they will know the detail of that. 24 Q. Right. We heard from Ms Connor that there were, sitting 25 under her, various different divisions. I think acute Page 160

1 services is one that she mentioned. Would specialist 2 services be another one? 3 A. Yes. Well, no. Acute services is all of the acute 4 services that are provided by NHS Tayside and specialist 5 services would be within the acute services. 6 Q. A subdivision of acute services? 7 A. Yes. 8 Q. That's very helpful, thank you. And the clinical 9 director of that group would be some sort of clinical 10 leadership role within it, is that right? 11 A. Yes. 12 Q. And so would specialist services be where neurosurgery 13 sits? 14 A. Yes, yes. 15 Q. Yes. So effectively, Mr Eljamel I think by this time, 16 is certainly in the role as the clinical lead? 17 A. Yes. 18 Q. And he carries on with that role after this for another 19 five years. And this is him being interested in another 20 clinical role which sits in a sort of executive position 21 within the specialist services group, is that right? 22 A. So not to be pedantic, just to be specific. It would 23 not be an executive role. So the medical director is 24 the executive role and the clinical director would 25 report to the operational medical director, who reports Page 161	1 helped us, again, with other committees here: 2 "The statement that Mr Eljamel was a member of 'many 3 internal and external clinical committees and groups 4 over the years' is based on information recorded in 5 Mr Eljamel's CV as at approximately the summer of 6 2013 ... The majority of these roles are external to 7 NHS Tayside, and some are not related to his role as 8 a Neurosurgeon. The formal roles identified in his CV 9 that relate to his role as a Neurosurgeon within 10 NHS Tayside are, Chairman [of the] Clinical Governance 11 Committee Specialist Services Group from 2006 to 2010, 12 Chairman of Malignant Spinal Compression Group from 2008 13 to 2012, Chairs of the Clinical Governance Committee and 14 the Committee of Quality and Clinical Governance of 15 Secondary Care [from] 2005-2009." 16 And you've helpfully set out in an appendix, 17 a fuller list of his various different local, regional, 18 national and international committee roles. He held 19 positions in all of those fields, if you like, is that 20 right? 21 A. As per the documents, yes. 22 Q. Absolutely, in appendix 6? 23 A. Yes. 24 Q. Thank you. Presumably, in the same way as we've 25 discussed the impact of things like private practice and Page 163
1 to the executive medical director. 2 Q. Okay, thank you. You also have provided us with 3 a considerable amount of information about his 4 involvement in various committees, 87(a).1, please. 5 You looked at the possibility he was involved in 6 an ethics committee and it's said: 7 "In relation to Questions 87(a)-(d), there is no 8 evidence held within Mr Eljamel's HR file ... of how 9 Mr Eljamel was appointed to the Ethics Committee. In 10 respect to Question 8(d), in general terms, a member of 11 the Ethics Committee would be required to review 12 applications, attend committee meetings and provide 13 either an expert or lay opinion, dependent on [the] 14 role." 15 Was it your understanding that he was on the ethics 16 committee at some point? 17 A. Yes, and in looking at that wording again, I think 18 I have said the HR file but there was no evidence at all 19 of how he came to be -- 20 Q. (Overspeaking) Thank you, that's helpful clarification. 21 And again, if we ask others if you don't know, but the 22 ethics committee, is that involved in providing ethical 23 oversight of things like clinical trials? 24 A. Yes. 25 Q. Thank you. If we could look at 91, please. You've Page 162	1 teaching, these committees, albeit perhaps to a lesser 2 extent than those commitments, do also take up time and 3 effort and commitment to fulfil the roles properly? 4 A. Yes. 5 Q. And we looked at what we think is an unsuccessful 6 application to be in a particular role, but are these 7 committees that Mr Eljamel would have had to have 8 applied to become part of? 9 A. I can't answer that. 10 Q. Okay. We note there that he was the Chairman of the 11 malignant spinal compression group from 2008-2012, is 12 that your understanding? 13 A. From that CV from 2013. 14 Q. Is that something that you know anything more about, 15 that group, or not? 16 A. No, I hadn't heard of it until I saw it on that 17 document. 18 Q. Okay, thank you. And at paragraph 89.1, you said. 19 "Within Mr Eljamel's CV from around 2013 ... it is 20 noted that he was Clinical Director of the Scottish 21 Photodynamic Centre from 2008 and Co-Director of the 22 National Centre of Neurosurgery for Mental Disorders 23 from 2007. There is no other evidence within [the] HR 24 file ... in relation to these roles." 25 Again, those are perhaps external roles, is that Page 164

1 right? 2 A. Yes. 3 Q. So one would not necessarily expect to find evidence of 4 those internally, is that right? 5 A. Correct. 6 Q. And 92.1, please. You were asked here, in particular 7 you were asked about the specialist services group 8 clinical governance committee. And this was one of the 9 ones that we'd seen at 91.1. There had been a claim on 10 a CV that he was a member of from 2006-2010. It says: 11 "NHS Tayside has been unable to locate specific 12 records relating to NHS Tayside's Specialist Services 13 Clinical Governance Committee for the period up to 2014. 14 "NHS Tayside holds documents which record Mr Eljamel 15 as being the Clinical Governance Chair for Specialist 16 Services in 2007 ... However, NHS Tayside has found no 17 evidence beyond these documents of the specific role 18 that Mr Eljamel played as the Clinical Governance Chair 19 for Specialist Services. [And] these roles followed the 20 definition from ..." 21 Clinical governance documentation: 22 "It should be noted there are no formal selection 23 processes or defined criteria for participation in 24 clinical governance groups within NHS Tayside. 25 Membership and involvement are generally determined Page 165	1 introduction of the new arrangements. So you may not 2 have heard of the term "agenda for change". So agenda 3 for change is the group -- there's three groupings of 4 staff within the NHS right now: one is medical and 5 dental; one is agenda for change and it's the biggest 6 grouping of employees; and the third is executive and 7 senior management. Whitley Council preceded all of 8 those and covered, with different subsections, the 9 employment of the workforce in the NHS. 10 Q. Thank you. So effectively what the handbook that 11 I referred to, in other places -- 12 A. The handbook, it was about this thick. 13 Q. Right, so that's the Whitley Council? 14 A. Yes. 15 Q. Right, well that would make sense because I think what 16 that document is seeking to do is to say: there are 17 other rules that shall be deemed to be incorporated in 18 here, but it would take far too long to rehearse them 19 all, so you have to look at that too -- 20 A. Yes. 21 Q. -- and there would be certain sections of that, I think, 22 that might be applicable to consultants as well; is that 23 right? 24 A. Yes, and you couldn't put in place anything that was 25 contradictory to Whitley Council rules, for want of Page 167
1 through professional roles, responsibilities, and 2 operational requirements rather than through 3 a structured selection procedure." 4 So again, there is sort of limited evidence of the 5 extent to which he was involved in that particular role. 6 Is that likely to be due to inconsistent record 7 retention or is that likely to indicate that it was only 8 in 2007 that he held that role? 9 A. It could be either of those things. 10 Q. Okay. Could I ask, again, a very specific question that 11 came up that I'm sure you are able to help with. 12 Without going into all the various terms and conditions 13 documents which are incredibly complex, one aspect which 14 we thought it might be helpful for you to refer to is 15 that in the 2003 handbook and in other places, it says: 16 "The handbook should be read in conjunction with the 17 General Whitley Council conditions of service. Those 18 sections of the General Council conditions of service 19 that apply to medical and dental staff are listed in the 20 appendices to the handbook." 21 Could you just help us understanding what the 22 General Whitley Council conditions of service are? 23 A. I'll try. Whitley Council was the terms -- there's 24 probably a better word than that -- that governed the 25 employment of everybody in the NHS prior to the Page 166	1 a better word. You might be able to put in place 2 guidance that would interpret what it says locally but 3 it couldn't replace it. 4 Q. I see, so that had to apply although you could refine it 5 for local circumstances -- 6 A. Correct. 7 Q. -- but the obligation was those were sacrosanct, 8 effectively? 9 A. Yes. 10 MR DAWSON: Sir, that would be a convenient moment for 11 a break. 12 THE CHAIR: Yes, certainly. 15-minute break? Thank you. 13 (2.52 pm) 14 (A short break) 15 (3.08 pm) 16 MR DAWSON: Thank you, sir. Mrs Watson, you helped us in 17 the passages to which you contributed in the statement, 18 with another major area of interest to the Inquiry which 19 are the rules relating to clinical supervision, 20 suspension, resignation, et cetera, of medical 21 practitioners within NHS Tayside and also the specific 22 details that you were able to find in the documentation 23 relating to those processes and indeed, the removal of 24 Mr Eljamel's name from the medical register to 25 Mr Eljamel himself. Page 168

1 You helped us, in particular, with a document -- 2 I don't think we need to go to it -- but it's NHST-01579 3 which I think was a disciplinary. I think it's called 4 a medical and dental disciplinary procedures document? 5 A. Yes. 6 Q. If we could just put it up just to make sure we're all 7 talking about the same document. There's the 8 disciplinary procedure that, you can see from the front 9 there, relates to all different grades including 10 consultants and indeed beyond doctors, into dental 11 profession as well. You recall that document? 12 A. Yes. 13 Q. Can we look at the statement at 10(f).1, where the 14 procedure here, in this quite complicated although 15 relatively short document, is summarised quite helpfully 16 for us. It says: 17 "The procedures relating to suspension and dismissal 18 for the period in question are laid out in NHS Tayside's 19 Disciplinary Procedures for Hospital Medical and Dental 20 Staff ..." 21 Which is the document we just looked at: 22 "The document covers the entire relevant period, it 23 is a collection of documents that were issued relating 24 to Medical and Dental Disciplinary procedures from 1990, 25 with addendums which were incorporated into the Page 169	1 A. Yes, correct. 2 Q. I think there are perhaps more than one but they started 3 in about 1990, which I think is coincident with this, is 4 that right? 5 A. Correct. 6 Q. You've helped us here with the sort of bare bones of 7 what the process is. You say, in the first instance, 8 that it would depend what had triggered the 9 investigation or the disciplinary action in the first 10 place, whether it was personal or professional and there 11 would be different routes to follow. So, personal might 12 involve aspects of personal behaviour, I'm assuming; is 13 that right? 14 A. And conduct. 15 Q. And professional would be issues of competence in one's 16 professional field, is that broadly -- 17 A. Correct. 18 Q. -- what we're talking about? You also mentioned that 19 there would be a potential that there would be 20 an investigation that would be undertaken and that the 21 investigation is undertaken by the medical director. 22 That's because we're dealing with clinical staff here, 23 is that right? 24 A. Yes. 25 Q. So the medical director is in charge of the Page 171
1 document, in 1994, 1999 and 2001. These procedures are 2 separated into two routes: personal conduct; and 3 professional conduct and competence. The mechanisms for 4 investigation of the latter are different depending on 5 the potential disciplinary outcome as a result of the 6 level of misconduct or competence. 7 "The procedures require a review point to determine 8 whether the conduct is personal or professional, 9 allowing the investigation to take the appropriate route 10 through the procedures. In either case disciplinary 11 action would not be taken until such time as 12 an investigation had taken place. Investigations are to 13 be conducted under the direction of the Medical 14 Director. 15 "The procedures note that following the 16 investigation, a decision on whether or not to convene 17 a formal disciplinary hearing must be taken. They 18 broadly outline the format a hearing must take and the 19 levels of sanction, including dismissal in cases of 20 gross misconduct, amongst others." 21 That's a helpful summary of what is quite 22 a complicated procedure. I think, as I understand it as 23 we've seen from other evidence, this disciplinary 24 process really is NHS Tayside's incorporation of rules 25 that actually emanate from government, is that right? Page 170	1 investigation because the medical director is 2 effectively in charge of the all the medical staff, is 3 that right? 4 A. Yes. 5 Q. Thank you. If there were allegations made of bullying 6 of intimidation of junior colleagues, which category 7 would that fall into? 8 A. Without knowing -- in general terms, that would be 9 personal conduct. 10 Q. Personal conduct? 11 A. Yes. 12 Q. And I think, we'll come on to the details of it, that 13 a process of disciplinary process, if I put it broadly, 14 started in Mr Eljamel's case, is that right? 15 A. So I think the introductory discussions about it had 16 begun. 17 Q. Yes. Had they got to the stage of deciding whether it 18 would go down the personal or professional route? 19 A. So, from my understanding of the documentation, they had 20 begun the consideration of what's called preliminary 21 inquiry, which is the -- so, the first formal step is to 22 do what's called a preliminary inquiry which is really 23 to determine the facts of the case and to classify it, 24 to determine whether it is personal or professional. My 25 understanding, from the evidence that I've seen, is they Page 172

1 didn't get as far as classifying it because Mr Eljamel 2 gave notice to retire. 3 Q. Yes, we'll get on to the details of that. 4 A. Yes. 5 Q. I think there was a particular individual who was 6 contacted who was identified as potentially having 7 a role in the process? 8 A. Yes. 9 Q. But we'll look at it in some detail. So the broad 10 process is they had hadn't got to the point of 11 classifying it. Would that initial preliminary stage be 12 a scoping of what it's all about, because there's still 13 an investigation stage that comes later; isn't that 14 right? 15 A. Yes, so it's a bit more formal than scoping. It is 16 a formal step in the process and the medical director 17 would identify a senior medical leader to conduct that, 18 who would do the preliminary review and make 19 a recommendation to the medical director as to the 20 potential next steps. 21 Q. Yes and I think, from the passage that we've just looked 22 at, that would involve determining, I suppose, whether 23 there was a case that should proceed, is that right? 24 A. Yes. 25 Q. But also determining, on the assumption that there was, Page 173	1 Q. Thank you. And I think you've told us already that we 2 didn't get any of those matters determined in 3 Mr Eljamel's case because effectively any disciplinary 4 procedure, investigation, whatever you want to call it, 5 was brought to a halt when he intimated that he intended 6 to retire? 7 A. That's my reading of the evidence. 8 Q. Thank you. I was just interested in understanding also 9 what the purpose of this process is because we've heard 10 evidence from various sources about the fact that 11 certain investigations might serve a number of different 12 purposes. Is the purpose of an investigation or 13 a disciplinary proceeding of this nature purely related 14 to the possibility of a sanction being imposed on 15 an individual or is there a component part of this which 16 is to do with the possibility that an investigation, 17 such as the one you've explained could happen but we 18 didn't get to it in this case, may give rise to some 19 lessons or learning that could be of wider value to the 20 service? 21 A. So I would like to say that it's both. 22 Q. So I'm interested in that initial determination phase, 23 there would therefore be some consideration given to 24 what is it we need to do about this individual for whatever 25 reason may pertain but also we need to have an eye to Page 175
1 whether it would go down this personal or professional 2 route, is that right? 3 A. Correct. 4 Q. And I think also there's some mention there as to there 5 would need to be consideration of the potential 6 seriousness of the sanction that might be imposed and 7 that would determine, to an extent, the procedure that 8 would need to be followed? 9 A. Correct. 10 Q. Yes. So the same way as in a criminal court you might 11 determine whether a case goes to the High Court or the 12 Sheriff Court. There are different procedures depending 13 how serious this might be? 14 A. So I don't know if there are different procedures. 15 Q. Okay. 16 A. The different procedures are purely based on the 17 determination -- so there's two parts to it. One is the 18 appendix A, B, C, which is particular to medical staff 19 which would determine the level. And there is also 20 personal or professional. 21 Q. Okay. 22 A. Personal conduct would use the process, which is for all 23 staff not particular to medical staff. If it's 24 professional, it's a particular process for medical 25 staff. Page 174	1 the fact that this might be something we could learn 2 something from, because it is a learning organisation, 3 isn't that right? 4 A. Yes. 5 Q. I'm also interested in the way in which this sits within 6 other systems of regulation, if I could put it that way. 7 This is to do with an employer exercising rights under 8 an employment contract with regard to investigations 9 about whether someone has done something that they 10 shouldn't have done under that contract, is that right? 11 A. Essentially, yes. 12 Q. Yes, with an eye, both to the enforcement of the 13 contract with that individual, but also with an eye to 14 the possibility that such an investigation may give rise 15 to some learning for the organisation? 16 A. Yes. 17 Q. It is separate, therefore, from, for example, 18 a regulatory investigation with whatever the regulator 19 might be, in this case the GMC, is that right? 20 A. Yes, but in my view they are connected. 21 Q. How are they connected? 22 A. Because there is an obligation on the organisation and 23 the doctor, in this case, to ensure that the GMC is 24 aware of any proceedings that may be leading to 25 a potential disciplinary investigation. Page 176

1 Q. I see, and so there is an obligation, once the state of
2 knowledge within either of the doctor's mind or the
3 organisation's mind reaches a certain point, that the
4 organisation and the doctor need to tell the GMC that:
5 this is something that needs to be brought to your
6 attention?
7 **A. Yes, so from a procedural perspective, yes, but as**
8 **I've explained, it is complex and there's a number of**
9 **different factors, so there may be a bit of judgment in**
10 **terms of what's the appropriate time to do that.**
11 Q. Yes. Indeed. You mention, in the passage that we've
12 looked at, in fact probably the next paragraph, if we
13 look at 10(f).4, it says:
14 "The procedures also note the process for
15 suspension. They note that this does not constitute
16 disciplinary action; would always be on full pay; and is
17 pending potential disciplinary action based on the
18 outcome of the investigation. They note a requirement
19 to review suspensions on a four-weekly basis and for the
20 employee to be notified in writing."
21 So in effect, suspension is an interim measure while
22 the investigation is going on, is that right?
23 **A. Correct.**
24 Q. And that did happen in this case, didn't it?
25 **A. Suspension, yes, it did happen but not immediately in**

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1 **the December.**
2 Q. Yes, there was a suspension -- when you say "not
3 immediately", what time period might it have happened
4 at?
5 **A. So, there's an option when -- and again, there's**
6 **judgment in all of this. As I said earlier, there's the**
7 **process and then there's the application of the process**
8 **imposed. So there was the discussion and the decision**
9 **that was made around clinical suspension in the June of**
10 **2023, and then a decision --**
11 THE CHAIR: Sorry, do you mean clinical supervision?
12 **A. What did I say then?**
13 MR DAWSON: Suspension.
14 **A. Sorry, my apologies. I'm getting a bit punchy now.**
15 **Clinical supervision in June of 2013 and then the**
16 **decision to suspend in December of 2013.**
17 Q. As I understand the evidence that you've helpfully set
18 out from the documents, there was that earlier stage at
19 which a decision was taken in the June of 2013 to go
20 down the route -- and we've heard some detailed evidence
21 about this already -- of imposing a period of clinical
22 supervision on Mr Eljamel, and to instruct an invited
23 review mechanism report from the Royal College of
24 Surgeons, is that right?
25 **A. Yes.**

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1 Q. But I think what you're telling us is it would have been
2 open to the medical director to make the decision that
3 Mr Eljamel should be suspended at that stage?
4 **A. Yes.**
5 Q. And that a formal investigation would be launched, the
6 suspension being an interim measure as part of that
7 formal investigation; is that correct?
8 **A. Correct.**
9 Q. We also heard some evidence, which features in materials
10 you've provided, of the fact that there was a serious
11 clinical event analysis which took place in relation to
12 a case of wrong-site surgery. The surgery had taken
13 place in 2011, the serious clinical event analysis took
14 place and reported in May 2013.
15 **A. Yes.**
16 Q. But we heard evidence from your former colleague,
17 Mr Dunn, that that had been initiated by a complaint
18 intimated to the medical director by the patient
19 in December of 2012.
20 **A. Yes.**
21 Q. And on the basis of that complaint, the medical director
22 instigated the serious clinical event analysis. But
23 again, it would have been open to him to have started
24 a formal investigation at that point and to have
25 suspended Mr Eljamel, isn't that right?

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1 **A. Yes.**
2 Q. So really what it's about, as I think you've said, both
3 in terms of making judgments about intimating to the
4 GMC, but also about which procedure is the most
5 appropriate at any given time; it's a matter of
6 judgment, isn't it?
7 **A. A judgment and managing risk.**
8 Q. What do you mean by "managing risk"?
9 **A. So -- and I'm talking in general terms here, not**
10 **specifically.**
11 Q. Okay.
12 **A. Risks to patients, risk to the employee, risk to the**
13 **organisation.**
14 Q. So that would depend, to an extent, on the information
15 one had?
16 **A. Yes.**
17 Q. And it would depend on the seriousness of the alleged
18 information?
19 **A. Yes.**
20 Q. And the potential that that information may lead one to
21 exercise judgment in such a way that it would be
22 important to try to suspend someone, to protect others
23 from harm, is that right?
24 **A. Yes.**
25 Q. And what we heard from Mr Dunn, we looked at the adverse

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45 (Pages 177 to 180)

1 incident management policy, and we heard that in 2 December 2012 when the patient intimated a complaint to 3 the medical director, that that complaint came from 4 a patient who was also a medical professional; was that 5 your understanding? 6 A. Yes. Yes. 7 Q. And that what was being alleged was something called 8 wrong-site surgery; do you understand broadly what that 9 is? 10 A. Yes. 11 Q. And that in terms of the policy, the adverse incident 12 management policy, it was included in a category of 13 something called a "never event"? 14 A. Yes. 15 Q. Is that a term you've heard? 16 A. I hadn't heard it until this process, but I understand 17 what it means now. 18 Q. I see. It's not something that you'd come across in 19 your previous career at all? 20 A. No. No. No. 21 Q. But what do you understand it to mean? 22 A. It's something that should never happen. 23 Q. Yes, so it's a very serious event. 24 A. Yes. 25 Q. So in December of 2012, a complaint was made by Page 181	1 it took place the year before; is that right? 2 A. Yes. 3 Q. And the policy was very clear about the fact that it was 4 incumbent upon any member of the NHS Tayside staff to 5 report an accident or an incident in a broad sense, but 6 in particular a never event, within an hour of it 7 happening? 8 A. Yes. 9 Q. It must have been the case that those who were 10 responsible for the care of the patient knew that 11 something had gone wrong in the surgery, isn't that 12 right? 13 A. I can't make a judgment on that. I'm not clinical, 14 so -- 15 Q. In the event they were aware of it, it was incumbent on 16 them to have reported it an hour after it had happened 17 in 2011? 18 A. Yes. Yes. 19 Q. And on the hypothesis that that is correct, assuming 20 that that is correct, what the medical director also 21 knew in 2012 is not only that a patient was alleging 22 that it had happened, but on that hypothesis that no one 23 had bothered reporting it in accordance with the system? 24 A. So I don't know about the language "no one had bothered 25 to report". What I would say is it was not reported. Page 183
1 a patient who themselves was a medical professional? 2 A. Yes. 3 Q. Of something that, in terms of the adverse incident 4 management policy, would be deemed a never event, 5 something that should never happen; yes? 6 A. Yes. 7 Q. And also it related to a surgery which had taken place 8 the previous year in 2011, isn't that right? 9 A. Yes. Yes. 10 Q. We heard from Mr Dunn when we looked at the policy, that 11 it was important that never events, in particular, be 12 reported very quickly after they occur? 13 A. Yes. 14 Q. And we heard from Mr Dunn, we went through it with him 15 and he accepted, I think, that the reason why it was 16 important that something should be reported quickly was 17 that so that the system could kick in, the matter could 18 be looked at and any remedial action could be taken as 19 quickly as possible to try to minimise harm; is that 20 your understanding? 21 A. Yes. 22 Q. And so it would have been open to the medical director, 23 at least at December 2012, to have realised not only 24 that someone was alleging that a never event had taken 25 place but that it had not been reported at the time when Page 182	1 Q. That in itself, in terms of the risk management that you 2 alluded to earlier, is an important factor, is it not, 3 because that might tend to suggest that those who were 4 there, who might have had information that a never event 5 had occurred, or something had occurred, had concealed 6 it despite the fact that the system requires one to 7 report it? 8 A. So I don't feel that I'm in a position to be able to 9 make that assessment. 10 Q. I'm not asking you to make any clinical assessment, 11 I'm asking you about systems. 12 A. So what I would say is that if somebody is aware of 13 something, both in terms of their employment with 14 NHS Tayside and if they are a regulated professional, 15 under the professional rules that they are expected to 16 abide by, there would be an expectation of reporting 17 something that they were aware had happened. 18 Q. Thank you and those obligations would apply not only to 19 the person who might have been responsible for it, so 20 the surgeon who conducted the surgery, but to other 21 medical professionals who might have been aware of it 22 because -- 23 A. (Overspeaking) Anyone who was -- 24 Q. -- they participated? 25 A. Yes. Yes. Page 184

1 THE CHAIR: Sorry, just be careful. I think you are 2 crossing over and we need to get the notes clear, 3 please. 4 MR DAWSON: Is that correct, Mrs Watson? 5 A. Sorry, would you repeat -- 6 Q. What I've just asked you, is that correct? It applies 7 not only to the medical professional who is carrying out 8 the surgery, but other medical professionals who may be 9 involved and become aware of it? 10 A. Yes. 11 Q. Thank you. And just to be clear, those obligations, 12 because we talked about two different systems here, 13 there would be obligations from the regulator to report 14 that to the GMC, if it was serious enough? 15 A. Yes. 16 Q. And there would be internal obligations within 17 NHS Tayside in a separate, but I think you've said 18 complementary, system to report it through the 19 NHS Tayside routes as well? 20 A. Yes. 21 Q. Thank you. One sort of slightly side question about all 22 of this. I won't go into the details of the document. 23 We've been through it all, and you have explained, 24 I think earlier on, that in relation to these sorts of 25 processes there would need to be HR input, is that Page 185	1 the suspension is part of the disciplinary process? 2 A. So it is a disciplinary action. It is a mechanism to 3 remove the employee from the workplace to allow for the 4 disciplinary or the investigation process and potential 5 disciplinary action to wend its way. 6 Q. Yes, it's not an outcome of a disciplinary process? 7 A. No, it isn't. 8 THE CHAIR: Nor a punishment? 9 A. Correct. 10 MR DAWSON: It is a step which can be taken, as part of the 11 disciplinary process, in order to have the effect of 12 removing the individual from the hospital; is that 13 correct? 14 A. So just to be really specific, it's not part of the 15 disciplinary process, it's part of the investigation 16 process. So, you have to do an investigation to 17 determine if you're going to move into a disciplinary 18 process because the end of the investigation process 19 could potentially mean that there's no disciplinary 20 action taken. 21 Q. Yes, but if we're looking at the whole process under the 22 guidelines, effectively a suspension is an interim 23 measure you can take, but something before that must 24 have triggered there being an investigation, I suppose? 25 A. Yes. Page 187
1 right? 2 A. Yes. 3 Q. And I think you told us earlier that the person who had 4 input at this stage was someone called Mrs Fraser, is 5 that Lorraine Fraser? 6 A. Yes, for the most part. I think there was -- 7 I'm assuming because she wasn't around, I think somebody 8 else gave advice at one point, but for the most part it 9 was Mrs Fraser. 10 Q. So this policy sets out various different roles for 11 different people and there's an HR function described in 12 it and it was Mrs Fraser that was doing that role 13 broadly, unless she was on holiday or something? 14 A. Yes. 15 Q. Thank you. Mr Eljamel was formally suspended on 16 21 June 2013, is that right? 17 A. No, that was when the clinical supervision was June. 18 Q. Sorry, yes, the clinical supervision started on that 19 day, is that right? 20 A. Yes. Yes. 21 Q. And the clinical supervision effectively came to an end 22 on 10 December 2013, at which point the suspension was 23 imposed, is that right? 24 A. Yes. 25 Q. And am I right just in understanding the procedure, that Page 186	1 Q. Thank you. Could we look, please, at paragraph 35.1 of 2 the statement. You were asked some questions here about 3 the clinical supervision and you tell us: 4 "Based on documentation within Mr Eljamel's HR file, 5 Mr Eljamel attended a meeting held on 3 June 2013 with 6 the Clinical Director and the Neurosurgery Clinical 7 Lead ... Based on a note of that meeting ... it appears 8 to have been held to discuss performance, specifically 9 the escalating number of complaints involving Mr Eljamel 10 ultimately resulting in a Significant Critical Event 11 Analysis ..." 12 That was the one I think we mentioned earlier, is 13 that right? 14 A. Yes. 15 Q. "It is noted that personal communication was also 16 discussed as a performance issue. It was agreed at that 17 meeting that these issues would be managed at Clinical 18 Director level in the first instance. It was accepted 19 by the attendees of the meeting that Mr Eljamel had been 20 under a significant amount of pressure in recent years 21 with his clinical practice. It is noted that Mr Eljamel 22 had reflected and agreed to alter his practice 23 significantly. It was agreed that any further issues 24 would be raised and managed through the appraisal 25 process ..." Page 188

1 So could we have a look, please, at NHST-01550. Is 2 this the note of the meeting on 3 June? 3 A. Yes, but what I have just noticed is in the statement -- 4 so you'll notice that this document is referring to 5 a previous meeting at which the clinical lead was at. 6 The clinical lead was not actually at this meeting on 7 3 June, so just to clarify that point. 8 Q. Yes. So there is indeed a reference to a previous 9 meeting in the first -- is there any record of that 10 meeting? 11 A. No, I tried to find it because when I noticed that in 12 prep for today and can't find a note of that meeting. 13 Q. So again, this note that we have here was on the HR file 14 but the earlier one was not, is that right? 15 A. Yes, correct. 16 Q. And again, would that be consistent with the general 17 discussion that we had earlier, that it's surprising 18 that it isn't because you would expect it to be there, 19 is that right? 20 A. Yes and even as recent as earlier this week I was trying 21 to find the note of that earlier meeting to see if we'd 22 missed it. 23 Q. Okay, but what we do know from this note is that that 24 was a meeting which had different people at it, if I can 25 put it like that. That meeting had Mr Eljamel, Page 189	1 that was about, is that right? 2 A. No. 3 Q. But by this stage, it says: 4 "At this meeting there was a general discussion of 5 events that had taken place leading to an escalating 6 number of complaints involving Professor Eljamel, 7 ultimately resulting in a Significant Clinical Event 8 Analysis. There had been other items of personal 9 communication that had raised a performance issue, and 10 we had chosen to address this at a Clinical Director 11 level in the first instance." 12 So it appears that those who were at this meeting 13 somehow had seen some personal communication that had 14 raised a performance issue and the decision had been 15 taken to raise it at this level rather than, for 16 example, at the medical director level at this instance, 17 is that -- 18 A. (Overspeaking) That's how I have interpreted it. 19 Q. That's helpful, thank you. And then we know from other 20 sources that by this time, there had been a number of 21 complaints against Mr Eljamel. We know that from the 22 narrative in the Royal College of Surgeons' report, 23 which was commissioned at about the time of this, that 24 there had been three in 2011, four in 2012 and eight in 25 2013. So this is presumably the escalating issues, Page 191
1 Mr McLoughlin and Mr Mowle, who by this stage was the 2 clinical lead for neurosurgery, is that right? 3 A. Yes. 4 Q. Whereas this meeting was attended by Mr Eljamel, 5 Mr McLoughlin, who was the clinical director of 6 specialist services and oncology, and 7 a Mr Musheer Hussain, a consultant ENT surgeon and "AMD 8 for professional governance". Is that associate medical 9 director? 10 A. Yes. 11 Q. Okay, and just to understand, do you know what 12 Mr McLoughlin's role in this process was? 13 A. So as the clinical director of specialist services by 14 that time, he would have oversight of neurosurgery and 15 my understanding from other documentation in the file, 16 it was Mr McLoughlin and the general manager, 17 Audrey Warden, who had brought issues to the attention 18 of the medical director. 19 Q. I see. So in some way they had become involved -- 20 aspects or issues had been raised with them and they had 21 escalated that through the normal channels to the 22 medical director, is that right? 23 A. Yes. 24 Q. Okay, and so there had been some sort of meeting that 25 took place before this but we don't really know what Page 190	1 escalating number of complaints that they're talking 2 about? 3 A. So that is a fair assumption but what I also understood 4 from my review is that between this meeting on 3 June, 5 and a subsequent meeting on 21 June, more concerns had 6 come to light. 7 Q. Indeed. 8 A. And so then it was raised and a different decision was 9 made than what has been outlined here. 10 Q. Understood, but this was the way in which, at that 11 stage -- and we can work out how many complaints there 12 were at this stage -- the decision had been made 13 involving, it would appear Mr Mowle, Mr McLoughlin and 14 at this meeting, Mr Hussain as well and Mr Eljamel that 15 it would be best dealt with in this way, in this 16 discussion, is that right? 17 A. Correct. 18 Q. And it says: 19 "We accept that Professor Eljamel had been under 20 significant pressure in recent years with his clinical 21 practice due to a culmination of factors. These 22 included a deterioration in the quantity and quality of 23 junior staff support, an increased through put of 24 patients and the pressures of Waiting Times Guarantees. 25 "Professor Eljamel had reflected on these factors Page 192

1 and has altered his practice significantly, such that he 2 is able to maintain the quality of his service within 3 these constraints. 4 "Mr Hussain was in agreement that any other issues 5 would be dealt with adequately within the Appraisal and 6 Revalidation System and that we are happy with the 7 measures that Professor Eljamel has taken and that there 8 is no requirement for any additional input at this 9 juncture. I was advised that Professor Eljamel has not 10 been personally unaffected by these events and will be 11 afforded all the support necessary in the 12 coming months." 13 The explanations given by Mr Eljamel appear hardly 14 to accept any blame on his part, is that fair? 15 A. That's how I would see it. 16 Q. In fact, the explanation he appears to have given, at 17 least as is narrated here, rather points the finger at 18 other factors beyond his control, isn't that right? 19 A. Based on what's written here, I think that's a fair 20 assessment. 21 Q. He says that he has been under significant pressure in 22 recent years with his clinical practice, is that right? 23 A. Well, that's what it says, yes. 24 Q. Yes? And he says -- do you have any reason to think 25 this is inaccurate? Page 193	1 need to be extremely intentional around how you document 2 discussions of this kind and I think that some of the 3 language in here is ill-advised. 4 Q. In particular, what aspects you would say are 5 ill-advised? 6 A. So the acceptance that says professor -- I'll say Mr -- 7 Eljamel had been under significant pressure. So it's 8 effectively accepting that there had been 9 a deterioration in the "quantity and quality of junior 10 staff, increased throughput and wait time guarantees". 11 So it accepts that, as medical leadership, I think needed 12 some further explanation. 13 Q. And if you had been the HR professional or one of your 14 staff, hypothetically, sitting in that would be the sort 15 of point they would be raising, would they? 16 A. So without having been involved in the discussions, 17 I would have expected that. But as I said earlier, HR 18 doesn't have any authority. We only have our ability to 19 influence and so that advice could have been given, it 20 doesn't mean to say that it would have been taken. 21 Q. But as we said earlier, there are numerous places which 22 remind people that it's very important that HR are 23 involved in this sort of thing, is that fair? 24 A. Correct. 25 Q. And the reason perhaps -- correct me if I'm wrong -- Page 195
1 A. So, no, I don't. 2 Q. Yes, I mean, one would imagine in these circumstances 3 taking a note of a meeting about something as serious as 4 this by a clinical director of specialist services, 5 a senior consultant neurosurgeon and another consultant 6 ENT surgeon acting in his capacity as associate medical 7 director, they would want to be careful that they had 8 narrated precisely what the position was in this note? 9 A. So I would agree but what I would also note is there was 10 nobody from HR at the meeting. 11 Q. Would you have expected there to have been? 12 A. Yes. 13 Q. And what would the role of the -- 14 A. (Overspeaking) To ensure -- 15 Q. (Overspeaking) Just before we get on to that, that would 16 be in accordance with a number of the provisions we've 17 seen in a number of the documents which remind people to 18 involve HR in these sorts of discussions, wouldn't that 19 be right? 20 A. Yes. 21 Q. So, please, what would the role be of the HR 22 representative? 23 A. Well, and this is my professional opinion, as you say 24 we're obviously talking about some pretty significant 25 serious issues if an SCEA had taken place. I think you Page 194	1 that those reminders exist in various places is that 2 it's very important that someone from HR is explaining: 3 there are procedures to be followed here and this is 4 a serious situation? 5 A. I agree. 6 Q. It refers here to the pressure on Mr Eljamel having 7 existed "in recent years" rather than it being something 8 that arose five minutes before. There seems to be 9 an acceptance here that this is something that has been 10 going on for a period of years; is that correct? 11 A. That's -- I'm reading the same as you, yes. 12 Q. And again, based on your professional analysis, that 13 would be something that I would imagine that an HR 14 professional, had they been in the meeting, would have 15 thought: goodness me, that makes it all the more 16 significant? 17 A. Well, yes, and I think, again, having not been in the 18 meeting -- and it's easy to apply your judgment to 19 something that you haven't been involved in -- I would 20 imagine that I would have wanted that to have been 21 explored a bit further. 22 Q. Yes, because as is narrated in the previous paragraph, 23 the only case, by this stage, that the system had thrown 24 up, if you like, to put the complaints to one side, 25 which are people saying there was a problem, but the Page 196

1 only analysis that had come to a conclusion by this 2 point was the single case that we talked about earlier, 3 the single client event analysis? 4 A. That's what I understand. 5 Q. Thank you. And so if Mr Eljamel was accepting that 6 there had been these pressures, which he is attributing 7 as the reason for what's going on as having gone back 8 into the period of recent years, that might tend, to 9 a reasonable professional HR representative, to make 10 them think: well, I wonder whether perhaps there is more 11 going on here that hasn't come to light because all 12 I can see is the one clinical event analysis, serious 13 enough as that is, but is that fair? 14 A. I think that's reasonable. It's a fair assumption. 15 Q. Thank you. And there is a suggestion here that 16 Mr Eljamel had reflected on these factors and altered 17 his practice significantly such that he's able to 18 maintain the quality of a service within these 19 constraints. There isn't any detail there given as to 20 how he intends to deal with these and I think the 21 suggestion is they will all remain. The pressures will 22 all remain, is that right? 23 A. So that -- yes I mean, I'm not sure if that was the 24 intent but it's certainly the way it reads. 25 Q. And then, just to understand, Mr Hussain, he's not from Page 197	1 Q. Now, my understanding of the appraisal and revalidation 2 system is that, although it imposes ongoing obligations, 3 it doesn't necessarily involve anybody checking in to 4 make sure the doctor is addressing ongoing issues, other 5 than fairly irregular annual assessments or appraisals; 6 is that right? 7 A. So I think it's a bit more than that but that would be 8 a question for the medical director. 9 Q. But I think what we probably can work out here is that 10 nothing special is being suggested here, just the 11 routine system which had existed before? 12 A. Agree. 13 Q. And there is, in fact, a focus in the final sentence on 14 the fact that Professor Eljamel has not been personally 15 unaffected by these events and will be afforded all the 16 support necessary in the coming months. And although, 17 of course, it would be important in these and any other 18 circumstances to afford to a consultant neurosurgeon or 19 any medical colleague the support that they require, 20 there's no focus on patients here, is there? 21 A. No. No, it's not evident in the evidence. 22 Q. There is, to be fair, a mention of patients in the third 23 paragraph that we looked at where it refers to "the 24 increase throughput of patients", is that right? 25 A. Yes. Page 199
1 this field but he's there, I think, because of the fact 2 he's involved in professional governance, is that right, 3 because he's the AMD for professional governance? 4 A. Sorry, I'm trying not to cut over you, I apologise. 5 I've done it a couple of times. So, I was trying to 6 understand Mr Hussain's role in this. I'd understood 7 from other documentation that I saw that he was 8 Mr Eljamel's support person but the wording in here 9 suggests that he had a more significant role in that 10 last paragraph where it says he was in agreement. So 11 I'm not actually sure what his role was. 12 Q. I see. But when he says he is in agreement, he says 13 that any other issues, undefined, would be dealt with 14 adequately through the appraisal and revalidation system 15 and that they were happy with the measures that 16 Professor Eljamel had taken and that there was no 17 requirement for any additional input at this juncture. 18 So effectively they were saying: everything you've done 19 is fine; is that what they're broadly saying? 20 A. Well, that's a fair assumption. 21 Q. And that Mr Hussain not only has agreed but he said that 22 the appraisal and revalidation system would be able 23 adequately to deal with any remaining issues; is that 24 correct? 25 A. That's how I read it. Page 198	1 Q. But the reference to patients isn't about trying to make 2 things safer for patients, the reference to the patients 3 is effectively suggesting that there's too many of them? 4 A. Yes. 5 Q. Could we go to NHST-01555, please. In fact, let's go to 6 35.6 of the statement first which helpfully summarises 7 the subsequent events. So we're at 3 June there and 8 this tells us: 9 "In a letter from the Clinical Director [of] 10 Specialist Services, dated 21 June 2013 ... a meeting 11 was held with Mr Eljamel on that date, attended by the 12 Clinical Director, and accompanied by the HR Business 13 Lead. During that meeting the Clinical Director shared 14 that a further two complaints had been received, hence 15 the need to meet to discuss formal provisions to manage 16 the clinical and individual/professional risks. It is 17 noted that Mr Eljamel was advised that the Medical 18 Director had decided to commission an external review, 19 the scope of which would encompass the issues raised 20 previously along with the more recent complaints." 21 So, this is what you were talking about earlier, 22 I think, about more complaints coming along, isn't that 23 right? 24 A. Yes. 25 Q. And I think you've helpfully told us already, that Page 200

1 prompted a change in the approach that had been adopted 2 at the earlier meeting but through events, if you like, 3 rather than the individuals changing their own minds, is 4 that right? 5 A. Yes. 6 Q. Could we look, please, at NHST-01555. So this is 7 a letter dated 20 June from -- scroll down to the 8 bottom, we can probably see at the top as well -- from 9 Dr Russell, the medical director, I think that you 10 mentioned already, to Mr McLoughlin who we saw in the 11 previous meeting and Mrs Audrey Warden. They I think, 12 both have a role in this specialist services division; 13 is that right? 14 A. Yes. 15 Q. And we weren't going to get into that in any great 16 detail, but they obviously have some sort of 17 jurisdiction or role in what's going on at this stage, 18 is that right? 19 A. Yes, so they were part of the management team of the 20 specialist services clinical group within which 21 neurosurgery sat. 22 Q. Right, and Mr McLoughlin was a clinician, he was 23 a surgeon himself, I think? 24 A. Yes. 25 Q. And Mrs Warden, I think, was -- we've seen the phrase Page 201	1 about a pattern of practice and behaviour that has 2 resulted in significant concern being raised by patients 3 and colleagues. 4 "Given the level of concern I believe it is 5 appropriate that we commission an external review into 6 Professor Eljamel's practice. I will seek to commission 7 the review through this office and will do so in 8 conjunction with yourselves. I will, in the first 9 instance, seek to do this through the Royal College of 10 Surgeons in London. 11 "I would ask you to meet with Professor Eljamel and 12 discuss this decision with him and the reasons behind 13 it. I will leave you to determine the range of 14 restrictions that you feel should be placed upon his 15 clinical practice during the period of the investigation 16 and its subsequent report. I would hope and anticipate 17 that Professor Eljamel understands the significance of 18 what is a supportive action. Should he not wish to 19 comply with what you believe to be reasonable 20 restrictions, I would ask you to seek further guidance 21 from myself." 22 So this is, I think, an indication that there had 23 been a meeting that had taken place amongst the three 24 individuals, Mrs Warden, Mr McLoughlin and Dr Russell, 25 is that right? Page 203
1 before -- general manager. She held an important role 2 in that division, is that fair enough? 3 A. Yes. 4 Q. So in this letter of 20 June we see Dr Russell writing 5 to these two individuals, Mrs Warden and Mr McLoughlin 6 and it says: 7 "Thank you for meeting with me to share concerns 8 with regard to Professor Eljamel. During the 9 conversation I shared with you a letter from [a certain 10 individual] dated 6 June [20]13 in which she indicates 11 that she is aware of another patient who has undergone 12 wrong level surgery under Professor Eljamel's care and 13 has asked that we consider a full audit of the care of 14 all the patients who have undergone spinal surgery 15 between 2010-2013. 16 "You brought to my attention the case of [another 17 individual] and expressed concern that this had not be 18 escalated appropriately despite a second opinion from an 19 external neurosurgeon suggesting that there were 20 significant concerns with the surgical practice. 21 "You also shared with me an itemised list of 22 complaints that focus on poor communication between 23 Mr Eljamel, his patients and colleagues. 24 "You did not express concern with regard to any 25 current patient safety issues but clearly were worried Page 202	1 A. Yes. 2 Q. And that had taken place, I think, earlier that day 3 which is 20 June? 4 A. Yes. 5 Q. And by the time that that meeting took place, Dr Russell 6 had the letter from an individual relating to not only 7 her own wrong-level surgery but also a suggestion that 8 another patient had undergone wrong-level surgery and 9 that he had had that since 6 June, or it was dated 10 6 June; is that right? 11 A. Correct. 12 Q. And then obviously a discussion ensued at the meeting, 13 is that right? 14 A. Yes. 15 Q. And the discussion gave rise to further revelations 16 about problems, of which Mr McLoughlin and Mrs Warden 17 were aware, to do with Mr Eljamel? 18 A. Correct. 19 Q. And indeed there was an itemised list of complaints 20 referred to and that, in addition to the allegations and 21 indeed by this time findings related to wrong-site 22 surgery, they focused on poor communication between 23 Mr Eljamel and not just his patients but Mr Eljamel and 24 his colleagues, is that right? 25 A. Yes. Page 204

1 Q. And at the meeting, despite that escalating pattern, it 2 appears, as Dr Russell has recorded it, to have been the 3 position of Mrs Warden and Mr McLoughlin that they did 4 not express concern with regard to any current patient 5 safety issues but that they were clearly worried about 6 a pattern of practice and behaviour that had resulted in 7 significant concern being raised by patients and 8 colleagues. So a significant concern had been raised by 9 patients and colleagues but that was not a concern which 10 Mr McLoughlin and Mrs Warden appeared to share, is that 11 right? 12 A. I'm not sure I'm following your train of thought there. 13 Q. I'll read this out again. This is referring to the 14 meeting which had taken place, I think: 15 "You did not express concern with regard to any 16 current patient safety issues but clearly were worried 17 about a pattern of practice and behaviour that has 18 resulted in significant concern being raised by patients 19 and colleagues." 20 So what that tells us is, by this point, significant 21 concern had been raised about Mr Eljamel by patients and 22 colleagues; does that appear correct? 23 A. Yes, I understand what you're saying now, yes. 24 Q. But despite that apparent fact and the information 25 relating to the reports and complaints above, it Page 205	1 A. Yes. 2 Q. And indeed, as we discussed, he could have done that at 3 an earlier stage as well? 4 A. Yes. 5 Q. Furthermore, he could have thought that the level of 6 concern being raised by patients and colleagues were 7 such that he felt it incumbent upon him to contact the 8 General Medical Council, is that right? 9 A. Yes. That's all in theory but obviously I don't know 10 what the conversations were beyond what's written here. 11 Q. Absolutely. I'm simply asking you about the process. 12 I'm not asking you to make any judgment yourself, that 13 would be unfair. 14 A. Understood. 15 Q. Thank you. Instead of doing that, those options that 16 could have been available to it, in terms of the 17 procedures which is what I'm interested in speaking to 18 you about, in fact what he does is to seek to commission 19 the review, which we know he then did; is that right? 20 A. Yes. 21 Q. And then he says that he's asking Mrs Warden and 22 Mr McLoughlin "to meet with Professor Eljamel and 23 discuss this decision with him and the reasons behind 24 it" and he decides to leave it to them "to determine the 25 range of restrictions that you feel should be placed Page 207
1 appears, from this letter at least and Dr Russell's 2 words are that Mr McLoughlin and Mrs Warden did not 3 express concern with regard to any current patient 4 safety issues but that they were worried about a pattern 5 of practice and behaviour. 6 Does that at least indicate what Dr Russell 7 understood their position to have been at the meeting? 8 A. Yes. 9 Q. He then says that he thinks that, given the level of 10 concern, he thinks that the best thing to do would be to 11 instigate an external review. So that was the change 12 I think you talked about earlier, we're now moving into 13 a territory where a review is being commissioned, is 14 that right? 15 A. Correct. 16 Q. And we know, from subsequent events, that that was the 17 invited review mechanism review which was undertaken by 18 the Royal College of Surgeons of England; is that right? 19 A. Correct. 20 Q. And at this stage, I think we've already established 21 that it would, in theory, have been open to Dr Russell 22 to have decided that: the concerns that have been 23 expressed by patients and colleagues are such that 24 I think I need to suspend Mr Eljamel from practice. He 25 could have done that? Page 206	1 upon his clinical practice during the period of the 2 investigation and its subsequent report". And he 3 expresses the hope and anticipation "that 4 Professor Eljamel understands the significance of what 5 is a supportive action" and that if Mr Eljamel did not 6 wish to comply with what they believed to be reasonable 7 restrictions, that they should seek further guidance 8 from him. So what that means is that it is being left 9 to the people who did not express concern with regard to 10 any current patient safety issues, despite the concerns 11 expressed by patients and colleagues, it was being left 12 to them to determine the range of supervision 13 restrictions that should be imposed, is that right? 14 A. Based on this letter, that's factually correct. 15 Q. Thank you. 16 And given that Dr Russell says, if there's any 17 issue with Mr Eljamel not complying with what you 18 suggest, given that this is designed to be supportive 19 action, he says: you can come back and speak to me about 20 that, is that right? 21 A. Yes. 22 Q. So at this stage, in addition to the possibility that he 23 could have imposed a suspension, he could have said: 24 these are the restrictions that I think you should be 25 looking at. He could have dictated that, as the medical Page 208

1 director? 2 A. Yes, he could have. 3 Q. Thank you. 4 THE CHAIR: Mr Dawson, I'm conscious that although we 5 haven't reached the end of the day, it may be that we 6 have had another hour's session, that a ten-minute break 7 for the witness, if she wants it, would -- 8 MR DAWSON: Absolutely. 9 A. I'm okay. 10 THE CHAIR: Are you all right to carry on? All right. 11 MR DAWSON: Are you sure? You would be very welcome to have 12 it. 13 A. No, I'm good. Just keep going. 14 MR DAWSON: Okay, fine. I know the feeling. Thank you very 15 much. 16 A. I had a couple of paracetamol, so I'm feeling okay now. 17 THE CHAIR: I'll keep out of it. 18 MR DAWSON: Well, if you do wish to stop you must say, 19 please. 20 A. I will. 21 Q. If we could go, please, to NHST-01556. This is 22 a letter from the next day, 21 June, from Mr McLoughlin 23 to Mr Eljamel; is that right? 24 A. Yes. 25 Q. And this is following up, I think, on what Dr Russell Page 209	1 Q. And instead what Mr McLoughlin appears to have done is 2 delegated that responsibility to Mr Mowle, is that 3 right? 4 A. Yes. Yes, that's what it reads to me. 5 Q. Mr Mowle, I think, by this stage I think we found out is 6 the clinical lead in neurosurgery? 7 A. Yes. 8 Q. And he is one of the consultant colleagues of 9 Mr Eljamel? 10 A. Yes. 11 Q. It says: 12 "In the meantime you will not participate in the 13 on-call rota, you will however, of course, continue to 14 be paid in line with your expected commitment. In 15 relation to your teaching commitment it is proposed that 16 this would continue but be restricted to teaching and 17 will not extend to Junior Staff undertaking cases on 18 your behalf. 19 "I note that you indicated you wished time to 20 consider this proposal and we agreed you would provide 21 a response by Monday afternoon. However I must stress 22 that if you cannot agree to that adjustment to your 23 practice it will be necessary to consider alternative 24 measures which may result in a decision being taken to 25 suspend you from duty." Page 211
1 has asked him and Mrs Warden to do, namely to contact 2 him and set out the position; is that right? 3 A. Yes. 4 Q. And it says -- it sets out the position and it says, in 5 the penultimate paragraph: 6 "In the meantime ..." 7 Sorry, we'll go to the previous paragraph: 8 "I advised that pending the outcome of the review it 9 has been determined that there is a need to implement 10 measures to support you to continue in your role on 11 a basis that ensures neither patients or you are at 12 risk. I confirm that it is proposed that until such 13 time as the review has concluded, or earlier if 14 appropriate, your clinical practice will be supervised 15 by Mr David Mowle acting in my stead. As explained it 16 is intended that the detail of how this will function in 17 practice will be agreed by yourself and Mr Mowle and 18 will include discussion regarding your on-call 19 commitment. Thereafter the detail of this arrangement 20 will be communicated to me." 21 So what Dr Russell I think had asked Mr McLoughlin 22 and Mrs Warden to do was to propose a schedule of 23 restrictions for Mr Eljamel that they thought were 24 appropriate, is that right? 25 A. Yes. Yes. Page 210	1 So in essence there is a reference here to the 2 possibility that suspension might happen if there 3 couldn't be an agreement reached, is that right? 4 A. Yes. 5 Q. But effectively what's being said by Mr McLoughlin is 6 there could be a suspension if you don't agree to terms 7 I am not aware of because I have delegated that to 8 Mr Mowle, is that right? 9 A. So in binary terms that's correct but if you consider 10 the previous letter, it could be interpreted that any 11 view of Mr Eljamel not to agree to the terms should be 12 brought back to the medical director for consideration. 13 Q. Yes. And if one reads the two together, given the 14 powers that we know the medical director had, what he's 15 anticipating is, well, if you don't agree to this then 16 it may be -- he hasn't mentioned in the statement of 17 going to Dr Russell, but maybe Dr Russell will think: 18 well, we actually have to suspend you? 19 A. Yes. 20 Q. If we have a look at paragraph 35.8 of the statement. 21 Probably easier to go to 35.7 first, just for 22 completeness. Just to say you say in the statement: 23 "It is noted that Mr Eljamel further advised during 24 the meeting on 21 June 2013 ... that it had been 25 determined by the Medical Director to implement measures Page 212

1 to support him to continue in his role on a basis to 2 that ensured neither patients nor himself were at risk. 3 It was proposed that until the review had been 4 completed, Mr Eljamel's clinical practice would be 5 supervised by the Clinical Lead. The detail of how that 6 would work in practice was to be agreed between the 7 Clinical Lead and Mr Eljamel[...]. Immediately, however, 8 Mr Eljamel was to be removed from the on-call rota, as 9 he was not allowed to supervise junior staff undertaking 10 cases on his behalf." 11 That's what we saw in the letter that you've 12 helpfully narrated for us. It says: 13 "A timeline held within Mr Eljamel's HR file [...] 14 suggests the supervision would involve reflective 15 discussions." 16 Now, the timeline document that you're referring to, 17 it's NHST-01549. I wonder if you could tell us what you 18 thought that -- where that document had come from? 19 A. Can I have a look at it, please? 20 Q. Yes. NHST-01549. 21 A. So in terms of where it's come from, my understanding is 22 that this was a timeline that was developed by the 23 general manager, Mrs Audrey Warden. 24 Q. Okay. 25 A. I may be incorrect in that so I can check that. Page 213	1 Clinical Director, from the Clinical Lead confirmed the 2 supervision would comprise joint ward rounds on 3 post-operative days and would be followed with 4 a detailed case-based discussion. It was also agreed 5 that the Clinical Lead and Mr Eljamel would discuss the 6 cases that were subject to complaints." 7 Now it mentions there NHST-01557. If we could go 8 to that, please. This I think is following on from 9 where we were before. This is Mr Mowle reporting back 10 to Mr McLoughlin, Mrs Warden the outcome of his 11 discussion with Mr Eljamel in trying to fix what the 12 agreement would be relating to what the restrictions on 13 his practice would be; is that correct? 14 A. Correct. 15 Q. So it says -- could we go down to the bottom email 16 because that's just a response, but the bottom email 17 which is dated 25 June 2013, says: 18 "Dear Phil and Audrey, 19 "I have met with Sam this morning to discuss the way 20 forwards. We will do a joint ward round at 10 a.m. on 21 Tuesday mornings. This is Sam's regular post-operative 22 and post on-call day. We will follow this with a 23 detailed case based discussion. I have also suggested 24 that we could discuss the cases that are subjects of 25 complaints and Sam is agreeable to this. Page 215
1 Q. Okay. But you're trying to recreate this for us, 2 Mrs Watson. We appreciate that you're doing that. You 3 weren't there at the time. And so you're trying to -- 4 you've done a very thorough search of the files and 5 beyond the HR file to try and help us here, that's what 6 you're trying to do? 7 A. Yes. 8 Q. So it's not easy for you to work out what documents are; 9 you weren't involved personally. But this is a document 10 which contains some level of narrative as to what was 11 going on at any given time. It does appear, from what 12 it looks like to me, to include annotations and things 13 as if it isn't a completed document; is that correct? 14 A. Yes. 15 Q. And it says "Confidential" in the background. But this 16 is the source of the suggestion that the supervision 17 would involve reflective discussions, is that right? 18 A. Yes. 19 Q. In fact though we also have access to an email dated 20 25 June 2013, which we'll go to in a moment, received by 21 the clinical director from the clinical lead which you 22 say in the statement -- we better go back to that, 35.8. 23 Thank you. This is just picking up where we were, the 24 timeline we've mentioned. 25 "An email dated 25 June 2013 [...] received by the Page 214	1 "I do not think that there is any safety issue with 2 Sam continuing his regular on-call duties and we will 3 discuss the emergency cases during the joint ward round. 4 Cases arising from emergency referrals are a significant 5 part of regular neurosurgical practise and I think it's 6 important that Sam continues to have this 7 responsibility. 8 "We have discussed pressure of time on operating 9 lists. This is a very difficult problem that affects us 10 all. Both the pressure of trying to provide 11 an efficient service to our patients and complying with 12 clinical need and waiting time targets can lead to 13 putting too many cases on an operating list. The 14 priority is now to provide thorough, safe surgery with 15 no corners cut and no rushing. It is essential that we 16 have management support with this and that waiting time 17 pressures do not take priority over clinical need and 18 safety. 19 "I realise that these arrangements will be subject 20 to the scrutiny of the external investigation and that 21 I will be taking clinical responsibility for the 22 patients under Professor Eljamel's care during this 23 period. I intend that this will be done in a rigorous 24 and thorough but supportive way with excellent patient 25 care being the central priority. I would be grateful if Page 216

1 you let me know if this is an acceptable plan." 2 Then if we scroll back to where we were at the top, / 3 you can see Mr McLoughlin's response, which is: 4 "Dear David. 5 "This is an entirely acceptable and workable plan. 6 It strikes a good balance with the correct emphasis. 7 I thank you both for discussing and agreeing this." 8 So the first aspect of this that I would like to 9 pick up on is that it says here, "I do not think there 10 is any safety issue with Sam continuing his regular 11 on-call duties and we will discuss the emergency cases 12 during the joint ward round." 13 Had it not been anticipated by Dr Russell in the 14 earlier correspondence that he would be taken off the 15 on-call rota? 16 A. Yes. 17 Q. Equally, if we could go back to 35.8, please. I read up 18 to the point where it said: 19 "It was also agreed that the Clinical Lead and 20 Mr Eljamel would discuss the cases that were subject to 21 complaints." 22 And the next sentence reads: 23 "The Clinical Lead would take clinical 24 responsibility for the patients under Mr Eljamel's 25 care." Page 217	1 an appropriate balance to try to achieve patient safety 2 but also another component to this which features in the 3 email is trying to effectively rehabilitate Mr Eljamel 4 back to a normal level of practice, is that the 5 thinking? 6 A. Yes. 7 Q. And in the last sentence you say: 8 "This could have ranged from direct supervision of 9 all aspects of practice or target elements of practice." 10 Are you trying to point out there that this 11 supervision could have included other elements that are 12 not included here? 13 A. Yes. 14 Q. So, for example, there's nothing here, as I understand 15 it and read it, about Mr Mowle actually supervising 16 Mr Eljamel being in theatre? 17 A. Correct. 18 Q. As far as you're concerned, given your inclination to 19 try and correct the word from "would" to "should", do 20 you think it should have included that at this stage? 21 A. So based on the fact that the complaints that there were 22 at that time related to Mr Eljamel's activity within the 23 theatre, it doesn't make sense to me that that would not 24 have been part of clinical supervision. 25 Q. Thank you. Obviously we now know from other evidence Page 219
1 And that is something which he said in the email: 2 I will be taking clinical responsibility for patients 3 under Professor Eljamel's care during this period. 4 So that's correct and then the following sentence 5 says: 6 "The level of supervision would have been determined 7 by the underlying concerns and risk assessment. This 8 could have ranged from direct supervision of all aspects 9 of practice or target elements of practice." 10 So is what you are trying to tell us there that you 11 are assuming that the level of supervision was fixed by 12 them in accordance with what they saw as you said 13 earlier the risk profile to be, is that right? 14 A. Yes, and I think re-reading this the word "would" should 15 say "should" as opposed to "would". 16 Q. So the risk assessment, you talked about that earlier? 17 A. Yes. 18 Q. All of this is about risk assessment really, isn't it? 19 A. Yes. 20 Q. And you said your view is that at this stage the level 21 of supervision should have been determined by the 22 underlying concerns and risk assessment, is that right? 23 A. Yes, correct. 24 Q. So therefore they should have been weighing up what was 25 going on at that time, what had happened in the past, Page 218	1 that one of the things that happened subsequent to this 2 was that the invited review mechanism report was 3 undertaken and that we've gone through, with 4 Professor Smith from the Royal College who is currently 5 in charge of the invited review mechanism there, doing 6 a similar exercise to you, looking at paperwork in which 7 he was not directly involved, he's tried to piece 8 together events for us. And he mentioned that there 9 were various important milestones in that investigation 10 during the course of 2013 and he expressed an opinion, 11 from his perspective of knowing how these things work, 12 as to what he thought might have been going on in 13 addition to what one could see from the paperwork? 14 A. Yes. 15 Q. One of the things that could see was that there was 16 a visit that took place in September of 2013, where the 17 reviewers spent two days discussing things with a wide 18 variety of different professionals, clinical, nursing, 19 executive, various different people, and it was 20 suggested by Professor Smith, given subsequent events 21 that one could see from the paperwork, that it would 22 have been likely that the reviewers would have offered 23 a preliminary review at that meeting. 24 A. Yes. 25 Q. Do you think that is likely, based on your sort of Page 220

1 understanding of these things? 2 A. So I haven't really had much involvement -- 3 Q. Okay, that's fine. 4 A. -- so that would be for the medical director. 5 Q. I understand. That was his view as to what there would 6 be, it would be normal for there to be a verbal 7 assessment and he expressed a view that subsequent to 8 that, as I think you know, there was an interim report 9 issued in early October? 10 A. Yes. 11 Q. And his view was he thought it likely that what would 12 have been said would have been of the same nature as was 13 contained in the verbal report. So by September he 14 thought there would have been a verbal instruction 15 given, one assumes to Dr Russell who had ordered the 16 review, of the nature of measures which should be taken 17 as was expressed in the October interim report. 18 Is it the case that you looked amongst the 19 documentation that was available to you to see if there 20 was any evidence either of the visit, any 21 recommendations given in September, and the interim 22 report? 23 A. So I looked for that, as did the medical director, 24 looked for that and I couldn't see anything that laid 25 that out. Page 221	1 A. Yes and just to be clear, that what I would expect, and 2 is actually what happens now, is that all documentation 3 that refers to a process that has been undertaken with 4 an employee is contained within the employee file. Now, 5 it may be that it's put into a confidential envelope 6 within the file so that if someone is filing, you know, 7 things to do with payment or applications for annual 8 leave, that all of that documentation isn't there for 9 them to see, but it should certainly be there. 10 THE CHAIR: Thank you. 11 MR DAWSON: Okay, thank you. And as we discussed earlier, 12 it's very important that these matters be done in 13 accordance with procedures that are enshrined within the 14 NHS Tayside system, isn't that right? 15 A. Absolutely and we would be held to account by the BMA if 16 we didn't. 17 Q. Absolutely and in many ways the experts in those 18 procedures are yourself and your former colleagues? 19 A. Yes, and the team that provides that support. 20 Q. Okay. Did you find in the materials any information 21 beyond what we've looked at, at the moment with the 22 email exchange -- well, for a start, I suppose, did the 23 email exchange we just looked at come from the HR 24 materials or did it come from somewhere else? 25 A. I saw it within the HR file, yes. Page 223
1 Q. So would you have expected information of that nature to 2 have appeared in the HR files, if I can put it as 3 broadly as that? 4 A. Yes. 5 Q. Because this is part of a disciplinary process which is 6 governed by the document we went to earlier which is one 7 of many documents that makes it clear that HR must 8 remain involved in these matters throughout, is that 9 right? 10 A. Correct. 11 Q. So -- 12 THE CHAIR: I hesitate to get involved in nomenclature, but 13 is it strictly correct, given what you've already told 14 me, that we're involved in a disciplinary process or 15 an investigation at this point? 16 A. Yes. 17 THE CHAIR: It is, yes? 18 A. Yes. 19 THE CHAIR: That's what I wanted to know. 20 MR DAWSON: I'm using that term in its broader sense under 21 reference to the document, which would cover everything 22 from the start to the very end. I think you use the 23 phrase in the statement, "formal disciplinary 24 proceedings" which is the later part after the 25 investigation, is that right? Page 222	1 Q. Right, okay. So that exchange recording what the 2 agreement was amongst Mr Mowle, Mr Eljamel and 3 Mr McLoughlin was in the HR file? 4 A. Yes. 5 Q. Was there any information about the actual supervision 6 that did take place beyond that in the HR file? 7 A. No, other than what was contained within the timeline 8 that we referred to earlier. 9 Q. Yes, but I suppose what I mean is more primary evidence. 10 For example, Mr Mowle reporting back with a summary to 11 say: well, this week I assisted in my role as supervisor 12 by meeting Mr Eljamel and supervising his ward round, or 13 something like that? 14 A. No. 15 Q. None of that? Is that documentation, again, that you 16 would expect to find in the HR file because they didn't 17 need to know every detail that would be in, for example, 18 the patient's notes but they would need to know broadly 19 what was going on; is that right? 20 A. So, I think that's fair. Whether -- I mean, the 21 comments that I made earlier about what you would expect 22 in terms of the totality of the documentation that 23 refers to a process that's been undergone. So I think 24 it would be fair to expect that to be there, or at least 25 some kind of summary of the supervision that took place. Page 224

1 Q. Thank you. Based on the importance that throughout
2 today's evidence we've placed on human resources being
3 involved in these processes, which are set out very
4 clearly and in great detail, if it were to be suggested
5 that what was going on here was a group of medical
6 professionals keeping something to themselves that they
7 should have shared more widely within the board, do you
8 think that that would be a reasonable assessment of what
9 was going on?

10 **A. So what I would say is that, and it reflects the**
11 **comments that I made at the beginning of the day about**
12 **the role of HR, I think the role of HR in supporting**
13 **decision-making as it pertains to people has evolved**
14 **over time. I would suggest that, at the time that this**
15 **was going on, it probably wasn't considered that HR**
16 **needed to be involved right from the beginning, and**
17 **often HR gets brought in to support the implementation**
18 **of a decision that has been made. That is not what the**
19 **expectations are of HR now but I think that was the**
20 **culture and the consideration at that time.**

21 THE CHAIR: So that's something that's developed over the
22 course of time --

23 **A. Yes.**

24 THE CHAIR: -- and since that time?

25 **A. Yes.**

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1 THE CHAIR: Yes, all right.

2 MR DAWSON: Yes. Of course there are the core participants
3 as well who have the right to pose questions.

4 THE CHAIR: Indeed so. I'm not losing sight of that either.
5 Mrs Watson, you've heard what we've just said. It's
6 been a long day for you and indeed for people who have
7 been listening attentively, taking notes, not to say the
8 stenographer as well. So I'm afraid I'm going to have
9 to ask you to come back for a short period tomorrow.
10 The same strictures about discussing your evidence
11 apply, but thank you very much your attendance and your
12 efforts today. I'll look forward to seeing you at
13 10 o'clock tomorrow morning.

14 **A. Okay, thank you.**

15 THE CHAIR: Okay, 10 o'clock. Thank you.
16 (4.21 pm)
17 (The hearing adjourned until 10.00 am, on Friday,
18 25 September 2026)

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1 MR DAWSON: And I think you told us earlier that culture was
2 something that you had been involved in trying to
3 improve --

4 **A. Sorry, I can't hear you.**

5 Q. Sorry. You told us earlier that culture was something
6 that you had been involved in personally trying to
7 improve in your time in your former role since 2023?

8 **A. Yes.**

9 Q. Even -- well, despite the culture that you've explained
10 existed at that time, is it the case that human
11 resources should have been involved in this information?

12 **A. Yes. I would say yes.**

13 MR DAWSON: Okay. Sir, as it's clear that I'm not going to
14 finish my examination of Mrs Watson today and some
15 arrangements, I think, have been made for her to attend
16 for a short period tomorrow to allow questions to be
17 asked, that would be an appropriate point to break.
18 I also am conscious that Mrs Watson has been giving
19 evidence for some time.

20 THE CHAIR: I am too and obviously these things are
21 unpredictable but I'm sure she would like some
22 reassurance to know that when you refer to "a short
23 period tomorrow", that is indeed what she might
24 anticipate for her own private arrangements.

25 MR DAWSON: That is indeed what she might anticipate.

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