

1 Friday, 25 September 2026 2 (10.04 am) 3 THE CHAIR: Good morning. 4 MRS ELAINE WATSON (continued) 5 THE CHAIR: Mrs Watson, welcome back. Have a seat, please. 6 Mr Dawson. 7 Questions by COUNSEL TO THE INQUIRY 8 MR DAWSON: Good morning, Mrs Watson. 9 As a slight recap, we left off yesterday looking at 10 a number of documents that showed the position of 11 various people who were involved in decision-making 12 around the period of June 2013, in particular in 13 connection with Mr Eljamel's clinical supervision that 14 was imposed around about that time. 15 I'm going to take you to another document relating 16 to that period in just a moment, but if I could just 17 recap, we had seen a note of a meeting of 3 June, 18 I think, which was attended by Mr McLoughlin, Mr Eljamel 19 and Mr Hussain in which they had discussed the 20 possibility that Mr Eljamel had reassured them that 21 there was no need for further action to be taken. 22 Do you remember that? 23 A. I do. 24 Q. And we also then saw that information appears to have 25 come to light via a patient of the fact that, in Page 1	1 this in a particular order -- jumping back one day to 2 24 June, but for particular reasons. 3 Now, one aspect of the document that we're going to 4 look at is that it brings up a number of roles, 5 different roles that exist within a hospital. I thought 6 you might be able to help us with them before we look at 7 the letter given your experience in the HR field. 8 The first is a locum consultant neurosurgeon. What 9 would a locum consultant neurosurgeon be? 10 A. Locum means that it's not a doctor who is permanently 11 employed by the hospital, and is brought in to fulfil 12 a service, usually for a prescribed period of time. 13 Q. Thank you. And another thing that comes up is 14 a specialist registrar, is that something you've come 15 across? 16 A. Yes, so that's definitely a question that I would ask 17 you to explore with the medical director, but my 18 understand of a specialist registrar is it's not 19 a consultant, but it's in that group of highly 20 qualified, in terms of the levels of qualifications, 21 doctor. 22 Q. So my understanding of it, which I think fits in with 23 what you're saying, we've heard quite a lot of evidence 24 already about the various different stages one can go 25 through in a training regime as a doctor before one gets Page 3
1 addition to her wrong-level surgery, that there was in 2 fact another patient who had had wrong-level surgery, do 3 you remember that? 4 A. I do. 5 Q. And then we saw some correspondence from the medical 6 director, Dr Russell, effectively saying that this 7 material and other complaints had come to his attention 8 and that as a result he was of the view that he should 9 instigate an Invited Review Mechanism review from the 10 Royal College of Surgeons, do you remember that? 11 A. I do, yes. 12 Q. And that he had invited Mr McLoughlin and ultimately 13 Mr Mowle to look into setting up some programme of 14 clinical supervision for Mr Eljamel, do you remember 15 that? 16 A. I do. 17 Q. And we looked at an email exchange, a lengthy email from 18 Mr Mowle and a short confirmatory acceptance from 19 Mr McLoughlin, effectively setting out what had been 20 agreed between Mr Mowle and Mr Eljamel on 25 June, about 21 the way in which his clinical supervision would work; do 22 you remember that? 23 A. I do. 24 Q. So that was 25 June. I'm going to ask you to look at 25 a document in a moment which is actually -- I have done Page 2	1 to consultant, are you familiar, broadly, with that 2 picture? 3 A. Yes. Yes. 4 Q. And also we were told by other reasons witnesses that 5 there were also a number of names that were used for 6 different grades of doctor, but within a hospital. So 7 for example house officer, senior officer, registrar, 8 those would be the sorts of things a hospital would use 9 to indicate what level a particular person had reached 10 in their training; would that be right? 11 A. Correct and it's all changed again -- 12 Q. (Overspeaking) Oh yes, indeed. It's hard to keep up 13 with. 14 A. -- so it's definitely historical from my perspective. 15 Q. Thank you. But the specialist registrar, I think 16 without going into the details, is very much at the top 17 level of the training tree, I think, is that right? 18 A. Yes, correct. 19 Q. And I think that the idea, broadly, is that that sort of 20 doctor would be able to take on more responsibility than 21 doctors further down the line, is that right? 22 A. Yes. 23 Q. But obviously the patients remain the patients of the 24 consultant; is that correct? 25 A. Yes, correct. Page 4

1 Q. Thank you, understood. And then another type of role 2 which you may have come across which comes up in this 3 correspondence is something called an advance nurse 4 practitioner. 5 A. Yes. 6 Q. So could you help us with that? 7 A. So an advanced nurse practitioner is a registered nurse 8 who has undergone additional training and education to 9 be able to work at a higher scope of practice than 10 a registered nurse. 11 Q. I see, so they would still perform a nursing role -- 12 A. Yes. 13 Q. -- but they would be able to take on additional 14 responsibilities because they're more highly trained, is 15 that right? 16 A. Correct. 17 Q. And I think that might be the sort of nurse that one 18 would find in a specialist unit like neurology which 19 involves special skills for nurses? 20 A. Yes, and often they do specialise in different areas. 21 Q. Indeed, we've heard some evidence about that from one of 22 your former colleagues, in fact. So if I could take 23 you, please, to the document I'd like to look at this 24 morning, which is NHST-01516. 25 You can see this is dated 24 June 2013, is that Page 5	1 some questions on matters that I think you may be able 2 to help us with, Mrs Watson, if that's okay. It says: 3 "Dear Phil: 4 "Thank you for meeting with me on Friday 21st 2013 5 at [13:00]. I am very grateful for your supportive 6 approach to resolve the recent concerns. 7 "Further to our meeting on Friday 21st 2013, I have 8 now reflected on what you have said. At this juncture, 9 I would like to put in writing the mitigating 10 circumstances leading to these concerns, and how I have 11 addressed them. Meanwhile I welcome the independent 12 college review of neurosurgical services in Tayside 13 including my practice and the proposed supervision of my 14 practice. I would like this letter to be forwarded to 15 the college reviewers along with the review request." 16 So just to pause there, is that Mr Eljamel referring 17 to the invited review mechanism that we've discussed 18 a couple of times already? 19 A. I believe so. 20 Q. Yes. And it seems to suggest that Mr Eljamel's 21 understanding is that the independent review is of 22 neurosurgical services in Tayside including his 23 practice, and the proposed supervision of it, is that 24 what he says? 25 A. Yes, and my interpretation of this is that's Page 7
1 right? 2 A. Yes. 3 Q. And therefore this is the day before the email 4 correspondence that we saw involving Mr Mowle and 5 Mr McLoughlin, isn't that right? 6 A. Yes. 7 Q. And if you remember that email from Mr Mowle to 8 Mr McLoughlin had said that Mr Mowle and Mr Eljamel had 9 met that morning, i.e. 25th, in order to discuss the 10 planning around his clinical supervision? 11 A. Yes. 12 Q. And so this is the day before that meeting happened and 13 that email was sent, is that right? 14 A. Yes. 15 Q. Thank you. And we can see here, this is a letter to 16 Mr Phil McLoughlin, clinical director, who we've come 17 across before; is that right? 18 A. Yes. 19 Q. And if we go to page 5, please. Scroll down a little 20 bit, please. We can see that this is from 21 Professor Eljamel. And scroll down, please, it's copied 22 to the medical director, Dr Russell; is that right? 23 A. Yes. 24 Q. Could we go back to the first page, please. I'm just 25 going to take you through this. I may pause to ask you Page 6	1 Mr Eljamel's interpretation of it. 2 Q. And indeed, we're reading his words here, aren't we? 3 A. Yes. 4 Q. He goes on to say: 5 "I would also like to discuss and agree the 6 following details in advance: 7 "... The terms of reference of the review. 8 "... The extent of the review. 9 "... What information will be provided to the 10 reviewers? 11 "... I would appreciate advanced knowledge who have 12 will perform the review. 13 "... The extent of the supervision of my practice: 14 "... Who will be doing it? 15 "... The roles are clearly defined. 16 "... What happens to my on-call commitment? 17 "... What junior support I will have? And what 18 their roles will be? 19 "... What happens to my other admin, teaching and 20 research commitments?" 21 So again just to pause there, that appears to be 22 Mr Eljamel suggesting that he would like to discuss and 23 agree certain matters about things that were going on in 24 the background, is that broadly correct? 25 A. Yes. Page 8

1 Q. And that includes the way in which the review would be 2 commissioned, what it would cover, is that right? 3 A. Yes. 4 Q. And of course that was being commissioned, we know, by 5 Dr Russell? 6 A. Correct. 7 Q. We also know, from the Invited Review Mechanism 8 evidence, that there is scope, if there is 9 an investigation into an individual, for that individual 10 surgeon or doctor to have some input into the process. 11 So we've heard evidence about that already and this 12 looks to be to an extent what Mr Eljamel is talking 13 about here, is that right? 14 A. I would agree. 15 Q. Yes, he also mentions there that he's keen on 16 understanding what information would be provided to the 17 reviewers, is that right? 18 A. Yes. 19 Q. And he also wants to know who would perform the review; 20 is that correct? 21 A. Yes. 22 Q. And he also wanted to discuss and agree the extent of 23 his supervision, but we know that what in fact happened 24 was that that was discussed between him and Mr Mowle the 25 very next morning, isn't that right? Page 9	1 offered that service in the area at that time? 2 A. That's how I understand it. 3 Q. Because I think it's correct to say that there was 4 Mr Jacobson who was retiring or leaving the practice, is 5 that right? 6 A. Yes. 7 Q. And Mr Eljamel was replacing? 8 A. Yes. 9 Q. There was Mr Varma who was the lead consultant who led 10 the recruitment, is that right? 11 A. Correct. 12 Q. And there was another consultant, I think it was 13 Mr Gentleman? 14 A. Correct. 15 Q. And Mr Gentleman we know, because of some of the 16 documentation, had some element of restriction on his 17 practice I think at that time? 18 A. Yes. 19 Q. Thank you. If I could go on, it says: 20 "My practice grew significantly when Mr TRK Varma 21 left to Liverpool in 1998, [and] I took over his pain, 22 DBS, epilepsy, pituitary and neurosurgery for mental 23 disorders. I was only supported by locum consultants 24 for a long period of time, from 1998 to 2000." 25 So just to pause there. What we can derive from Page 11
1 A. Yes. 2 Q. Thank you. He was also keen to understand from 3 Mr McLoughlin what would happen to his other admin, 4 teaching and research commitments at this time, is that 5 right? 6 A. Correct. 7 Q. He goes on to say, under the heading "Mitigating 8 circumstances": 9 "... Workload: 10 "As I am the most senior consultant on the 11 neurosurgical service in Tayside, taking over one of the 12 biggest neurosurgical practices in the area of the late 13 Ivan Jacobson in 1995. In addition to the practice 14 I have inherited I started skull base surgery in Tayside 15 performing all the acoustics." 16 So, if we pause there, this refers back to some of 17 the documentation that we saw earlier, doesn't it, 18 because we know, from the material we went through that 19 you helpfully found for us, that when Mr Eljamel was 20 taken on in 1995 it was as a replacement for 21 Mr Jacobson, is that right? 22 A. That's right. 23 Q. And he says there that what he took over was one of the 24 biggest neurosurgical practices in the area but that 25 would have been amongst the three neurosurgeons that Page 10	1 this and in fact this information has been provided by 2 some of your colleagues in the statement elsewhere, is 3 that by 1998 what had happened was that the other two 4 neurosurgical consultants had left, is that right? 5 A. Yes. 6 Q. And so this is why I asked you earlier about locum 7 consultants. What we're told there is that effectively 8 in 1998 -- I think actually the case is that 9 Mr Gentlemen left in 1997 is what your colleagues have 10 told us and then Mr Varma left in 1998 and you mentioned 11 in your evidence earlier, you helpfully suggested that 12 that might be because of the move to the new hospital, 13 that might have been a convenient break for people to 14 leave the service. Was that your evidence? 15 A. Yes. 16 Q. And so by 1998 what we know, from the evidence that 17 we've looked at, that in 1995 the position was that 18 Mr Varma, I think it fair to say, was very keen to get 19 in new consultants neurosurgeons because the service 20 then delivered by Dundee Royal Infirmary was really 21 stretched, is that fair? 22 A. That would seem evident from what I've seen and read. 23 Q. Indeed and you'll remember in the interview process they 24 had identified two suitable candidates, the preferred 25 being Mr Eljamel, is that right? Page 12

1 A. Yes. 2 Q. And then there was another consultant or prospective 3 consultant called Mr Mathew, who was kind of put in 4 reserve at that stage, is that right? 5 A. Yes and was, as I understood it, to be offered 6 a position to start the following year. 7 Q. Yes, it looks from this that that didn't happen; is that 8 correct? 9 A. Yes, because we couldn't find any evidence to show that 10 that took place. 11 Q. Yes, so the result of that and the moves of the two 12 consultants out, was by 1998 Mr Eljamel found himself in 13 a situation where he was the only neurosurgical 14 consultant, is that right? 15 A. So I -- that is what I understand from what I have seen, 16 yes. 17 Q. And that would explain why he says that between 1998 and 18 2000 he was supported by locum consultants over that 19 two-year period; these are the sorts of consultants who 20 are broad in to fill that sort of gap, is that right? 21 A. Yes, exactly. 22 Q. And just for some clarity, we heard some evidence last 23 Friday, a lot of very detailed evidence from expert 24 neurosurgeons about various different procedures, but he 25 mentions here having taken over aspects of Mr Varma's Page 13	1 Mr Ballantyne was appointed in 2000, is that right? Is 2 that your understanding? 3 A. Yes. 4 Q. And then at a late later stage, Mr Mowle whom we've 5 heard about in a different capacity also joined, so that 6 brought the capacity up to three consultant 7 neurosurgeons? 8 A. Yes. 9 Q. And again just for the sake of information, some of the 10 surgeries that are mentioned here, we've heard about 11 vascular surgery which I think is to do with handling 12 blood vessel disorders in the brain and spinal cord. 13 There's also a mention here of intrathecal pump service. 14 The intrathecal pump service is a particular 15 neurosurgical technique to address chronic pain and 16 muscle spasticity, where a small device is inserted 17 under the skin of the abdomen in order to deliver pain 18 or muscle relaxing medications in order to address those 19 problems. 20 So again, I'm not asking you for your comment but 21 just so that people understand, that's my understanding 22 of what those are, and information about most of these 23 types of neurosurgery can be found in our neurosurgical 24 experts' report. 25 THE CHAIR: Indeed. Page 15
1 practice when he left in 1998; is that correct? 2 A. Yes. 3 Q. And that includes some pain, DBS -- if you'll take it 4 from me I think that stands for deep brain 5 stimulation -- pituitary, epilepsy and neurosurgery for 6 mental disorders, which I think we heard from our 7 experts last week was sometimes called psychosurgery 8 which was a type of functional neurosurgery. I'm just 9 explaining that for your information, I'm not asking you 10 to comment on that at all. 11 A. No, thank God for that. 12 Q. Reading on, it says: 13 "After the appointment of Mr Ballantyne in 2000, 14 I have had to support him in addition to my own workload 15 and he was able to take off Paediatric neurosurgery and 16 intrathecal pump service, which I was doing when 17 Mr Varma was here in addition to my general practice and 18 skull base. When Mr Mowle joined later, he was able to 19 take the vascular service. Lately the pain surgery was 20 gradually taken over by Mr Ballantyne. Gradually 21 however, the paediatric and vascular sub-specialties 22 weathered away [perhaps means withered away] due to 23 circumstances and outside pressures." 24 So again, this is taking us a bit further along. 25 I think we learned that another consultant, Page 14	1 MR DAWSON: He then goes on to explain that: 2 "I established a joint clinic to review pituitary 3 patients with [Professor] G Leese, a joint skull base 4 clinic with Mr M Hussain, a joint DBS clinic with 5 Dr Swingler and a joint malignant brain tumour clinic 6 with Dr Hannah Lord. Consequently, long waiting times 7 for review patients to come to clinic for review had 8 arisen. As a consequence I [therefore] thought [I] was 9 correct to ..." 10 Then we get to a list. So he then, after telling us 11 that three consultants were in post at a certain point, 12 he then tells us that he established a number of other 13 joint clinics with other doctors; is that correct? 14 A. Correct. 15 Q. And I think we've seen Mr M Hussain before? 16 A. Yes. 17 Q. I think he was the doctor or surgeon who was in 18 attendance at the meeting on 3 June; is that correct? 19 A. Correct. 20 Q. And he was an ENT surgeon as I understand it, was my 21 recollection -- 22 A. That's my understanding, yes. 23 Q. And my understanding is that this the type of clinic 24 that's being talked about here, a skull base clinic, is 25 the type of clinic in which neurosurgeons and ENT Page 16

1 surgeons would work closely together to deal with 2 complex conditions in the skull base; again, just for 3 explanation. 4 So, in these circumstances, against the background 5 of now having had a period where he worked on his own, 6 with the support of locum consultants only from 1998 to 7 2000, he then had Mr Ballantyne arrive, then later 8 Mr Mowle and there was something of a re-organisation of 9 some of the services. Though some of the services, 10 including the paediatric and vascular sub-specialties, 11 appear to have disappeared, is that right? 12 A. That's my understanding. 13 Q. That's what he appears to be saying. So as 14 a consequence, he explains what action he took. He 15 said: 16 "As a consequence I thought it was correct to: 17 "(A) Run concurrent general review clinic with my 18 sub-specialist clinics where the SpR saw the general 19 review patients. However, as it turned out some of the 20 SpRs were not able to handle or spot difficult patients 21 and alert me to see them. SpRs were less experienced 22 as years went [by]." 23 So the SpR I think, would I be correct in thinking, 24 Mrs Watson, that that's the specialist registrar we 25 talked about earlier? Page 17	1 also to have been something that caused problems in 2 clinics when he was away; is that right? 3 A. That's what he's saying, yes. 4 Q. Then he goes on to say: 5 "I agreed to create an emergency clinic ran by the 6 SpR, as it turned out some of my patients who could not 7 be seen in the normal clinic due to long waiting times 8 were booked to this clinic. However, as it turned out 9 most of these patients were difficult to handle by 10 SpRs." 11 So he created an emergency clinic, again, that was 12 run by a specialist registrar it would appear, is that 13 right? 14 A. Yes. 15 Q. And problems arose with that as well because patients 16 that should have been ordinarily seen in the normal 17 elective clinic were turning up at the emergency clinic, 18 is that right? 19 A. Yes. 20 Q. And the reason they appear to have been doing that is 21 because of long waiting times to get an appointment in 22 the normal clinic, I think that's right? 23 A. That's what he's saying. 24 Q. And again, it appears that he is attributing problems 25 that arose there to these patients being difficult to Page 19
1 A. Yes, it is. 2 Q. So the result of that is that one of the things that 3 Mr Eljamel put in place is giving some level of 4 responsibility or certain tasks, if you like, to the 5 sub-specialist registrars is that right? 6 A. Yes. 7 Q. But I think he is saying here that he had found some of 8 them were not able to handle or spot difficult patients 9 to alert him; is that correct? 10 A. That's what he's saying, yes. 11 Q. So my interpretation of that, please correct me if yours 12 is different, would be that he'd got specialist 13 registrars to help out with a certain element of the 14 work, the problem being that one of their jobs would 15 have been to notice particularly difficult cases that 16 needed to go to the consultant; is that probably fair? 17 A. Yes, I'm reading it the same way as you are. 18 Q. Yes, but they turned out not to be very good at that? 19 A. Yes. 20 Q. He goes on to say that one of the other measures he put 21 in place was that he: 22 "... Reduced but not cancelled my clinics when I was 23 on leave. However, as it turned out some of the SpRs 24 were not able to handle or spot difficult patients." 25 So that phenomenon that he identified before appears Page 18	1 handle by the SpRs, is that right? 2 A. Yes. 3 Q. He then goes on to say another measure he took was: 4 "... To accommodate increased workload year in, year 5 out for over 17 years, it was necessary to book new and 6 review clinics based on a minimum of two doctors seeing 7 patients in the clinic; a consultant and SpR. 8 Inevitably this led to some patients being added to 9 waiting list by SpRs or more recently by advanced nurse 10 practitioners. This led to some patients unsatisfied 11 not seeing me in person." 12 So he, first of all, appears to be attributing the 13 increased workload for a period of over 17 years. Now, 14 he started in 1995 and this letter was being written in 15 2013 which is 17 years after he started. So basically 16 he is saying the increased workload problems had existed 17 for his entire time at Tayside, is that right? 18 A. That's what he's saying. 19 Q. And again, he says he tried to put in place some new 20 arrangements, this time involving other problems, 21 including patients being added to a waiting list, by 22 SpRs or more recently by advanced nurse practitioners. 23 What that meant was that some patients didn't get to see 24 Mr Eljamel which had led to dissatisfaction on their 25 part as well, is that right? Page 20

1 A. That's what he's saying, yes. 2 Q. On that score, just to pause to remind ourselves of 3 something we discussed I think before, is that patients 4 coming to a neurosurgery clinic with neurosurgical 5 problems are likely to be presenting with serious issues 6 because, as I understand it, they would have likely gone 7 through other medical services to get to that point. Is 8 that your broad understanding? 9 A. That's my broad understanding but, again, I'm not 10 a clinician. So that would be a question I think the 11 medical director would definitely be able to help with 12 you. 13 Q. That's absolutely fine, but just to fit it into what 14 we're talking about here, that broad understanding in 15 place. Let's carry on: 16 "... Initially I had two full days operating lists, 17 which was great as I was able to keep waiting times 18 under control, then my theatre sessions were reduced to 19 1.5 days per week in theatre with additional one Friday 20 each third week. I was just keeping waiting times 21 reasonably down. Four years ago one of my colleagues 22 (Mr Ballantyne) was appointed Neurosurgery Network 23 Director and reduced his NHS Tayside commitments by 24 4 sessions. This change in service configuration was 25 not discussed with me in advance. I did therefore take Page 21	1 ability to operate as one would wish was the fact that 2 Mr Ballantyne reduced his number of sessions meaning he 3 could deal with less patients, is that right? 4 A. Yes. Yes. 5 Q. On page 3, at (F), the final thing he says that he does 6 in this list is: 7 "... However, from 2011 my fourth colleague was 8 appointed without any additional operating time. My 9 colleagues did not have the capacity to change their 10 weekly schedule, so I stepped in instead and altered my 11 weekly schedule from Monday and Thursday operating days 12 to Monday only, I moved my new clinic and 13 neuromodulation clinic to Thursdays PM. The effect of 14 that I lose several Monday lists due to public 15 holidays. The effects of all these changes meant longer 16 waiting times." 17 Now, I have read it as it was on the page but 18 I think what Mr Eljamel was trying to say is the effect 19 of his fourth colleague arriving in 2011, which I think 20 was maybe Mr Lim; is that correct? 21 A. Yes. Yes. 22 Q. Was that he says "loose", but I think he means lose. He 23 lost one of the two operating slots he would have had in 24 a week, is that right? 25 A. That's how I read it, yes. Page 23
1 additional session in theatre, which was great as I was 2 once again able to keep my waiting times at bay." 3 So, what he's talking about here is one of the three 4 neurosurgeons, the one that arrived first in 2000, 5 Mr Ballantyne was appointed what he's calling 6 neurosurgery network director. I think that may relate 7 to something called the managed network for 8 neurosurgery. 9 A. Yes. 10 Q. Are you aware of that? 11 A. I am aware of it but only from reading the same material 12 as you did. 13 Q. That's very helpful. I think what that is, is 14 a national neurosurgical co-ordinating service which 15 came in I think around 2009, 2010; is that broadly your 16 understanding? 17 A. Yes. 18 Q. And the purpose of that -- we will, I think, sir, hear 19 some evidence of that from another witness, but I think 20 the purpose of that was to try to increase the quality 21 of neurosurgery services by co-ordinating them better 22 amongst each other; was that broadly your understanding? 23 A. Yes. 24 Q. Thank you, that's helpful. But as far as the Tayside 25 service was concerned, the main thing that affected its Page 22	1 Q. So he appears to have been operating on a Monday and 2 a Thursday, he lost one because a fourth colleague came 3 in, he was operating on a Monday, and a Monday was not 4 a great day because it meant if there was a bank 5 holiday, he lost the ability to operate on a Monday; is 6 that what he's saying? 7 A. Yes. 8 Q. It might be deemed -- again, please correct me if you 9 take a different view, Mrs Watson -- slightly unusual 10 when one has been complaining about the lack of 11 consultants going back to 1998 and even before that, 12 that his position when a fourth colleague is added in 13 2011 is not to say: fantastic, that's someone adding to 14 the service. In fact, it's to complain about the fact 15 that he isn't able to operate on two days although 16 obviously the overall service remains the same because 17 presumably Mr Lim has taken his Thursday slot? 18 A. So that's an interpretation and there's -- yeah, that's 19 what I would say, that's an interpretation. 20 Q. Thank you. He then goes on to highlight what he calls 21 "changes to infrastructure and support" and again, these 22 are listed. It says: 23 "a. Due to changes to immigration laws, 24 a significant number of SpR posts remained vacant or 25 filled with doctors who were not performing at a level Page 24

1 expected. This has meant increasing the demand on my 2 time." 3 So again, a theme that came from earlier, this time 4 particularised to do with immigration laws, but 5 effectively what he's saying is that the specialist 6 registrars weren't up to the standard he expected? 7 A. Yes. 8 Q. He goes on to say: 9 "... The main training SpR post rotating with 10 Glasgow was normally at ST3." 11 Now, ST3 would be a level, would it be, in the 12 training programme? 13 A. Yes, in the training, yes. 14 Q. Thank you: 15 "Instead three years ago due to problems in Glasgow 16 we were forced to accept an ST1 on the service, his 17 second year was ST2 which involved significant time out 18 of service. I was surprised that a run through trainee 19 stayed in Tayside for 3 years and had not spent a single 20 full month in my service. Every time he was due to come 21 and work with me he was sent out of neurosurgical 22 service." 23 So again, a problem with a particular trainee that 24 he had thought would be a certain grade, turned out to 25 be at a lower grade and appears to have had issues with Page 25	1 practitioners are very skilled and very highly qualified 2 but that's obviously the opinion that he's putting 3 forward about that comparison. 4 Q. Absolutely, and then he says (D): 5 "Trainee support in the ward has deteriorated over 6 the last few years to the extent that hand over of my 7 patients was not sufficiently done to enable me to deal 8 inpatient problems proactively. 9 "(E) Direct access of MRI and CT to GPs resulted 10 an increased referrals and conversion ratio from 11 outpatient to waiting lists. Furthermore availability 12 of radiology reports to GPs prior to my review of the 13 MRI and CT and their correlation to physical findings 14 led to increased phone calls to my secretary and 15 requests to expedite patients' outpatient appointments." 16 If you have a different impression, please tell me, 17 Mrs Watson, but I think what he is saying here is that 18 another one of the problems was at some point general 19 practitioners started to get access to scans; is that 20 right? 21 A. Yes. 22 Q. And general practitioners were thereby, as one would 23 imagine their job might be, looking at the scans and 24 trying to work out what's going on here and ultimately 25 referring them into the neurosurgery service; is that Page 27
1 availability, is that right? 2 A. It could have been availability, it could have been 3 because of the level of training that that person was 4 at, that there were other obligations in training that 5 meant they weren't in the service. 6 Q. Indeed, that's helpful. So what I think he's 7 identifying is that that person wasn't there as much as 8 he wanted him to be, but you're helpfully suggesting 9 it's because they might have been off doing certain 10 training at the level they were at? 11 A. Yes. 12 Q. That's helpful, thank you. (c) says: 13 "... Two years ago because of recruitment problems, 14 two of the SpR positions were replaced with 2 advanced 15 nurse practitioners, who were skilled their work but not 16 to the level of an SpR. Furthermore appointment of 17 a fourth consultant with reduction of junior staff 18 numbers from 6 to 4 reduced their daytime availability 19 and continuity of care." 20 So it appears that the issues with the specialist 21 registrars meant that some of the duties that they would 22 normally have been expected to take on were in fact 23 taken on by two advanced nurse practitioners who were 24 not at specialist registrar level; is that correct? 25 A. Yes, I mean there is an argument that advanced nurse Page 26	1 correct? 2 A. Yes. 3 Q. And he's complaining about that because of the fact that 4 that resulted in more people coming into the service 5 before he had had the ability to correlate the scans 6 with the physical findings which would be part of his 7 job? 8 A. That's what he's saying, yes. 9 Q. Again, one might have thought that the ability of the 10 GPs to contribute to the decision-making in this way 11 would be helpful; would that be fair? 12 A. Yes. 13 Q. And over the page, please, to (F). This is the last one 14 in this list: 15 "Due to overwhelming workload and increased waiting 16 times made worse by time to treatment guarantees 17 resulted in increased phone calls to my secretary 18 overwhelming her to the extent that she could not cope 19 anymore and leading to a flurry of complaints which were 20 not helped by her line managers." 21 So we mentioned the secretary and the important role 22 that a secretary plays earlier, you helped us with that 23 Mrs Watson, but again, what Mr Eljamel appears to be 24 saying here is that he and his secretary were 25 overwhelmed by the workload and increased waiting times, Page 28

1 which he says were made worse by time to treatment 2 guarantees. Now, time to treatment guarantees would be 3 something that would be put in place by the government 4 or the health board to try to minimise the amount of 5 time people have to wait to get their treatment, isn't 6 that right? 7 A. That's right. 8 Q. But again, how he appears to be interpreting those 9 measures is causing him inconvenience because of the 10 fact that more people get upset because he can't cope 11 with seeing them within those prescribed time periods; 12 is that correct? 13 A. Yes, that's what he's saying. 14 Q. He goes on to say more about that, in fact, under "3- 15 Time to treatment guarantees": 16 "... Implementation of the TTG [time to treatment 17 guarantee] put an excessive pressure on my service and 18 my secretary. There were no additional resources put in 19 place in terms of secretarial, admin, operating time or 20 locum consultant to do the extra work necessary. 21 "(B) Simply asking an overstretched service to do more 22 evening lists, Saturday lists and evening clinics was 23 not ideal, this did not lead to permanent solution and 24 evening clinics added more and more patients to the 25 waiting list. As it turned out patients seen by SpR, Page 29	1 work to do their best and it's often systemic issues -- 2 I think I said the "systematic" yesterday but I meant 3 systemic -- issues that create the conditions for them 4 not to do that well. And so there are lots of differing 5 factors across a complex system like healthcare, with 6 targets being set, directives from various areas, that 7 can cause issues for services to be able to provide the 8 best care that they can. Again, I emphasise I'm not 9 speaking about Mr Eljamel here, I'm just talking in very 10 general terms. 11 And so from an HR perspective, yes, someone having 12 to work beyond what they are contracted to do in order 13 to how I would describe it keep their head above water 14 would certainly be a sign that there needs to be some 15 kind of review of how that work is done. And in the 16 vast majority of cases that is not because of the 17 performance of the individual, it's because of the 18 systems that are set up that are not conducive to that 19 person doing their best work, which is why it often 20 makes it difficult to hone in on a performance 21 issue about an individual. 22 Q. Understood, thank you. That's very helpful. And we 23 mentioned many times yesterday in many different 24 contexts the importance in the documentation of getting 25 human resources involved in lots of different aspects of Page 31
1 Physiotherapy or Advanced Nurse Practitioners either at 2 the outset or on review clinics were a source of 3 complaints and dis-satisfaction of patients, leading to 4 ongoing complaints, which [were] wearing everyone down 5 including myself." 6 Now, as we've said already, the consultant remains 7 overall responsible for all of this, doesn't he? 8 A. Correct. 9 Q. And this was an area I was interested in your 10 perspective to answer as an HR professional because what 11 he's starting to say here is that one of the solutions 12 that appears to have been put in place within the system 13 is that they're starting to do evening clinics, adding 14 more patients to the waiting list and having Saturday 15 clinics. Would it be fair to say that a sign, in a sort 16 of management sense, that someone is not coping is for 17 example that they start to stay late at work or they 18 start to do extra work or they start to need to take up 19 time that shouldn't be taken up with work, to try to do 20 what they should be able to do in their working day? 21 A. So I don't think that that's -- there's not 22 a straightforward answer to that because you will recall 23 that my evidence yesterday, that I said that -- I'm not 24 talking about Mr Eljamel here, I'm just talking about in 25 general terms, that the vast majority of people come to Page 30	1 working life within the hospital. But in that sort of 2 situation, when someone was struggling to keep their 3 head above water, as you said, I imagine that that would 4 be the sort of situation which human resources 5 professionals would have a particular responsibility to 6 get involved and try and help find a solution? 7 A. So, not necessarily right off the bat. So if I was 8 struggling to keep my head above water, my first avenue 9 would be to speak to who I report to, to say: this is 10 how things are going down, I need some support with X, Y 11 and Z. It isn't necessarily the case that HR would be 12 involved in those situations. But as things escalated, 13 I would expect that the leader of that person would be 14 reaching out to HR to say: I have a bit of an issue 15 here, help me figure out what's the best approach to 16 take. 17 Q. So the leader could contact HR in order to allow them to 18 be part of the solution? 19 A. Yes. 20 Q. And just to be clear, in these circumstances, obviously 21 we've gone through what Mr Eljamel said about the 22 sequence of events, and from 1998 to 2000, he was the 23 only consultant in the department and beyond that, we 24 know that he was the clinical lead, although there were 25 other colleagues that arrived gradually over the years. Page 32

1 So when you say "go to your superior", who would that be 2 in his circumstances? 3 A. So if he was the clinical lead, then it would be the 4 clinical director. 5 Q. Right, so would that be Mr McLoughlin at this particular 6 time? 7 A. Yes, at that time I believe he was in that position, 8 yes. 9 Q. Yes, I think he described himself as the clinical 10 director of specialist services, would that be -- 11 A. Correct. 12 Q. Yes. So perhaps then that's why he's involved in the 13 decision-making around things like the supervision 14 because he's the superior; is that correct? 15 A. Yes, I'm saying that off of my understanding of the 16 structure, the medical director. There may be others 17 but I don't think so. At that time, I believe that 18 would be the role. 19 Q. Thank you. He goes on to say: 20 "Due to aforementioned mitigating circumstances, 21 human errors have occurred, however, I have always acted 22 in the best interests of my patients and their safety 23 was always my top priority at all times." 24 So that appears to sum up his position with regard 25 to all the problems he's set out, which is: this isn't Page 33	1 Q. Yes, indeed. Is insight an important quality in 2 consultant neurosurgeons? 3 A. Yes. 4 Q. Does this letter show any insight? 5 A. No. 6 Q. He then goes on to set out a number of proposals as to 7 how he wishes to resolve the situation. Do you recall, 8 Mrs Watson, that there was reference, in the 3 June 9 short minute, to the fact that Mr Hussain and 10 Mr McLoughlin had felt reassured by whatever it is at 11 that time Mr Eljamel had been telling them about what he 12 was going to do to address the situation; do you recall 13 that? 14 A. I do. 15 Q. So what he says is: 16 "What has changed recently to resolve these issues: 17 "(1) I see all new patients before they are put on 18 the waiting list. 19 "2-(2) All patients are reviewed before surgery after 20 admission to make sure their condition had not changed 21 since they went on the waiting list. 22 "3-(3) All spinal surgery patients get 23 an intraoperative X-ray to confirm the level of 24 intervention required. 25 "4-(4) I have moved my review clinic to Friday Page 35
1 my fault. Is that right? 2 A. Well, the first time I read this letter, that was the 3 conclusion that I reached. 4 Q. He calls them "mitigating circumstances". 5 A. Mm-hmm. 6 Q. But in fact what this letter is designed to do is to 7 shift the blame away from him on to other aspects of the 8 service, isn't that right? 9 A. So, what I would say is that going through any process 10 where an individual's performance is being scrutinised, 11 there's always going to be an element of someone trying 12 to defend themselves and you would expect that. And for 13 someone in the medical field, that would be supported by 14 their BMA rep or whoever it is that's supporting them. 15 However, what was -- and this is my professional HR 16 opinion -- what I would have expected was there to be 17 some self-reflection about the part that an individual 18 had played in the circumstances they found themselves 19 in. 20 Q. Thank you. We heard a word that was used in the 21 evidence of one of the representatives of the General 22 Medical Council that gave evidence to this Inquiry last 23 week, and the word that he used was "insight". Is that 24 a word that you're familiar with? 25 A. Yes. Self-reflection or insight. Page 34	1 afternoon so that I can see my patients by myself. This 2 will allow my sub-specialty clinics to run separately 3 and I'll be able to see patients personally in both 4 clinics. 5 "5-(5) I have moved my neuromodulation clinic from 6 Thursday afternoon to Wednesday am so that all my 7 sub-specialist clinics fall on the [Wednesday] am. In 8 essence from [August] 1st 2013 I will be performing 9 three clinics per week. 10 "6-(6) I will cancel all clinics when I am on leave." 11 Then, over the page: 12 "7-(7) I will not agree to elective patients to be seen 13 in the neurosurgery emergency clinic and myself will 14 screen referrals to the physiotherapy clinic. 15 "8-(8) I will be reducing the number of patients on my 16 operating lists inline with other colleagues and when 17 I have an emergency procedure I will cancel elective 18 procedures to make room for the emergency/urgent 19 procedure. 20 "9-(9) I have discontinued my private practice from 21 Monday 24th June 2013 till further notice to reduce my 22 workload." 23 So there is a number of different components there. 24 I won't get into the details because there's a clinical 25 aspect of it, but in essence it appears that a number of Page 36

1 these features seem to think that the solution is in 2 Mr Eljamel becoming more personally involved in things. 3 Would that be a fair characterisation? 4 A. Yes. 5 Q. So again, there is an underlying assumption, I think, in 6 these proposed new measures that the problem is that he 7 hasn't been involved enough and it's other people that 8 have caused the issues; would that be a fair 9 characterisation? 10 A. So I think the first part of your statement that he 11 feels that the solution is that he hasn't been involved 12 enough, is fair. 13 Q. But not the second part? 14 A. I don't know that I can make a judgment on that. 15 Q. Well, given that he already said that a lot of the 16 problems are caused by specialist registrars and the 17 like, it seems like that would be consistent? 18 A. Yes, so whether -- so he has made comment about the 19 level of competence of specialist registrars but whether 20 he's explicitly, in what he has put there in terms of 21 what he's going to do, is blaming them, I don't know 22 that I see that in what he's written there. 23 Q. Okay. In that particular part? 24 A. In that particular part. 25 Q. Thank you. The final thing relates to him having Page 37	1 raised, is that right? 2 A. Yes. 3 Q. And do you think it would be fair to say that this 4 letter gives us some interesting insight into the way in 5 which Mr Eljamel's entire career has gone, he really 6 does reflect right back to the beginning, is that 7 correct? 8 A. I think that's fair. 9 Q. And I think it would be fair to say that one thing that 10 one might take from this document, in particular related 11 to junior doctors, is that he appears to have quite 12 a dismissive attitude towards their contributions; would 13 that be fair? 14 A. I think that's a reasonable view. 15 Q. And beyond that, the way in which he's characterised him 16 being on his own and having a limited amount of help is 17 concerned, it would also be fair to say that for periods 18 of his consultant career, in particular between 1998 and 19 2000 and to an extent beyond as the consultant support 20 built up and up, he wasn't working in an environment 21 where there were other consultants around, working 22 alongside him in the unit, is that right? 23 A. Yes. 24 Q. Because one of the things that we've heard quite a lot 25 of evidence about, from a professional perspective but Page 39
1 discontinued his private practice. There's no mention 2 there of there being any personal issue related to ill 3 health on his part, is there? 4 A. No. 5 Q. In fact, there's nothing mentioned in this letter at all 6 about there being any personal issue or pressure on him? 7 A. No. 8 Q. Nothing to do with his family? 9 A. No. 10 Q. Nothing to do with his personal circumstances more 11 broadly? 12 A. No. 13 Q. The letter then concludes: 14 "As you can see there were mitigating circumstances 15 that led to a flurry of complaints and dissatisfied 16 patients and I have made significant changes in my 17 practice to prevent these complaints in future and 18 improve patients' experiences under my care." 19 The letter doesn't address the issue of the 20 supervision, does it? 21 A. No, it doesn't. 22 Q. Although we know that it appears Mr Eljamel has some 23 views on his supervision because he talks about it in 24 broad terms and we know that the meeting took place the 25 next place with Mr Mowle about that, but it's not Page 38	1 I think also from an employment perspective, is that 2 an important feature of the way that medical services 3 are delivered in hospitals is that there's a degree of 4 check and balance between the medical professionals, is 5 that right? 6 A. There has to be, yes. 7 Q. Yes, why is that important in delivering a hospital 8 service? 9 A. Because one person isn't an island, and this is coming 10 from a non-clinician who has worked in healthcare for 11 a long time. There needs to be the ability to work with 12 colleagues, to understand what you may not be seeing, 13 that very -- especially in complex cases there's very 14 rarely or often -- not very rarely, often situations 15 where there's more than one specialty that needs to be 16 involved, and there's just going to be better outcomes 17 in any situation, not just clinical, if it's 18 a multi-disciplinary or multi -- or a team effort to 19 support whatever outcome it is you're looking for. 20 Q. And I suppose those systems exist in professional 21 regulation but also in the employment side, don't they? 22 A. Yes. Yes. 23 Q. Because it's good to have the systems that support that 24 sort of approach from every angle, if you like. So 25 there are professional obligations that attempt to Page 40

1 promote that and employment obligations that attempt to 2 promote that; is that right? 3 A. Yes. 4 Q. And in circumstances where a consultant is an island, 5 effectively, as Mr Eljamel is describing, then those 6 sorts of systems don't exist where they should; isn't 7 that right? 8 A. That's a fair statement, yes. 9 Q. One other aspect I just wanted to pick up because it's 10 something we talked about in some detail yesterday is 11 it's at this point, at this point, Mr Eljamel asserts 12 that: from this day forward, 24 June 2013, I'm not doing 13 any more private practice. Now, you told us yesterday 14 in some detail about the way in which the various 15 contracts and documents which changed over the years had 16 one golden thread that went through them which is: you 17 have to prioritise your NHS work over your private work? 18 A. Correct. 19 Q. And in this letter Mr Eljamel is describing that 20 throughout his entire career there were significant 21 pressures on his ability to be able to deliver his NHS 22 work to the standard that might have been expected, is 23 that fair? 24 A. That's correct. 25 Q. But throughout -- or for significant part of that Page 41	1 plan that you have agreed in each year. 2 Q. Yes. Well, I rather take it here that, although there 3 are some particular manifestations, we looked at job 4 plans, some more detailed than others, but effectively 5 being able to handle the patient load you're being given 6 is kind of what the job plan is all about, isn't it? 7 A. That's exactly it, yes. 8 Q. So in highlighting all those problems and needing to 9 rely on more junior doctors and nurse practitioners 10 et cetera, what, in effect, one might say Mr Eljamel is 11 saying is: I haven't been able to meet my job plan; is 12 that right? 13 A. Yes. 14 Q. That's very helpful. To put it in an HR context, if 15 I could. 16 A. Yes. 17 Q. There are mention in this letter of mitigating 18 circumstances and human error. And what I might I hope 19 fairly describe as an assertion made by Mr Eljamel that 20 he had always acting in the best interests of his 21 patients and their safety had always been his top 22 priority at all times. That's not a matter for you to 23 decide, it's a matter perhaps the Chair might decide at 24 a later stage. However, this letter, apart from that 25 assertion, doesn't appear to reflect at all, does it, Page 43
1 period, not throughout but for a significant part of 2 that period, we know that he was still doing private 3 work despite the fact that he was characterising his NHS 4 work as really being incredibly difficult to deliver; is 5 that correct? 6 A. Yes, and that point struck me when I read this letter as 7 well. 8 Q. Thank you. Why did that strike you in particular? 9 A. Well, because he's going to great pains to describe 10 challenges that he'd had over 17 years with being able 11 to work effectively and deliver -- and that's my words, 12 it's not what he's saying -- his work within the NHS 13 sphere but was carrying out private practice at the same 14 time. So if -- and this is just an opinion -- if he 15 genuinely wanted to create the space to be able to do 16 the work that he needed to do within the NHS, then 17 I would have expected that private practice might need 18 to end earlier. 19 Q. Indeed, and as you told us, that is in fact the key 20 obligation. 21 A. It is. 22 Q. It's not -- it becomes not a question of choice it 23 becomes a question of what you have to do under your 24 contract, is that right? 25 A. Yes, well there's an expectation that you meet the job Page 42	1 and I have read it all out, on any harm or disadvantage 2 that patients may have suffered as a result of any of 3 this? 4 A. No, it doesn't. 5 Q. I'm interested also to understand, because you've 6 conducted, as you told us yesterday, an extensive search 7 amongst documentation, the 460-page HR file, the various 8 other places you've looked, and of course we've 9 indicated that, I think, you thought that the HR file 10 was likely to be everything that was always on it, was 11 that right? 12 A. Yes. 13 Q. But there could be other documents that existed in other 14 places that may have been destroyed. We can't know 15 that. 16 But I'm interested to know whether, in your 17 researches in the HR documents and beyond, whether there 18 was evidence of these problems being advanced by 19 Mr Eljamel at an earlier stage? 20 A. No. 21 Q. There was no evidence of that? 22 A. No evidence of that. 23 Q. And was there any evidence, at this stage or in any 24 other documents before this point, that Mr Eljamel had 25 always intended to retire early? Page 44

1 A. No. 2 Q. None? Because we know that comes in later but there was 3 no indication at this stage or earlier that he intended 4 to retire early. 5 A. There was no evidence that I could see of that. 6 Q. Okay. There must have been, I think, as we discussed 7 earlier to do with the Saturday clinics and things, 8 there were aspects of what was going on here that even 9 although there appears to be no evidence of Mr Eljamel 10 communicating these problems earlier, there must have 11 been self-evident to other people in the hospital. So 12 for example the fact that he was doing evening clinics 13 and Saturday clinics, someone must have allowed him in. 14 A. Yes. 15 Q. So it must have been known that those were happening, 16 yes? 17 A. Yes. 18 Q. It must have been known that by the authorities, HR 19 et cetera, broadly in the hospital, that Mr Varma in 20 1995 had been very keen to get in a new person to 21 protect Mr Jacobson, in fact get another person in due 22 course; that was known within the hospital authorities, 23 wasn't it? 24 A. Yes. 25 Q. And it would be known that one of the consultants left Page 45	1 correlated to the reduction that Mr Ballantyne had done. 2 Q. The EPAs were the extra sessions? 3 A. Yes, one EPA. 4 Q. Yes, but I think you were only allowed to take on one 5 more, wasn't that right? 6 A. Yes. 7 Q. My understanding -- it's complicated when you look at 8 documents, to do with eleven 10ths or something like 9 that, but I think what happens is you have 10 sessions, 10 you are allowed to take on one more -- 11 A. (Overspeaking) Take on an 11th, yes. 12 Q. Yes, so you get paid like an 11th of your pay extra or 13 something, is that right? 14 A. Yes. 15 Q. And it must have been known also that services were 16 being delivered by locum consultants? 17 A. Yes. 18 Q. It must have been known also services were being 19 delivered by specialist registrars? 20 A. I would imagine so, yes. 21 Q. It must have been known that specialist registrars were 22 coming and going? 23 A. Yes. 24 Q. Because they would either be there or they would not? 25 A. Yes. Page 47
1 in 1997? 2 A. Yes. 3 Q. And that Mr Varma, the lead consultant, left in 1988? 4 A. Yes. 5 Q. And that despite the background, that left Mr Eljamel -- 6 if his assessment here is right, which I think accords 7 with what your colleagues have told us in the 8 statement -- that he was then left alone to deliver this 9 service? 10 A. So that's how it looks. Again, I would hope that that 11 could be discussed with the medical director as well to 12 ensure that's -- 13 Q. (Overspeaking) Yes, when I say "left alone", it's 14 important to bear in mind that he does mention there 15 being locum consultants, but I think, as I read the 16 level, I think there is criticism of the fact that he's 17 carrying the can as the only main member of staff, is 18 that right? 19 A. Yes. 20 Q. And it then it must have been known, for example, that 21 when Dr Ballantyne arrived that he reduced his number of 22 sessions to go off and work within the neurosurgical 23 network? 24 A. Yes, and there's evidence in Mr Eljamel's file of him 25 taking on EPAs -- and we discussed EPAs -- that was Page 46	1 Q. It must have been known that services were being 2 delivered by advanced nurse practitioners? 3 A. Yes. 4 Q. Is it the case that the systems we discussed yesterday 5 to do with picking up problems in the hospital have 6 failed to pick up the fact that there was an obvious 7 enormous problem with the way that the neurosurgical 8 services were being offered? 9 A. So what I would say is that there's no evidence that it 10 was but that doesn't mean to say that there weren't 11 discussions happening within the service that recognised 12 the challenges that the neurosurgery department was 13 clearly having, given what you have described, which is 14 evidenced within the documents that we were able to 15 glean. 16 Q. But that might well be right. Again, we're speculating 17 to an extent but it wouldn't be unreasonable to think 18 there wouldn't be discussions. But what there appear 19 not to have been, at least on Mr Eljamel's contemporary 20 account, were any solutions? 21 A. So, no, but then that letter is Mr Eljamel's account of 22 what's going on. That doesn't necessarily mean to say 23 that that's a shared view by others. 24 Q. Indeed, that might be the case but there are certain 25 objective facts that I put to you about staff coming and Page 48

1 going, there not being enough people et cetera, 2 et cetera that are all indicative of there being 3 a problem, whether you agree with them the more 4 subjective elements of this assessment or not; is that 5 fair? 6 A. I think that's a fair statement, yes. 7 Q. Thank you. Because what we do know is that by this time 8 of course, action was being taken and that's why this 9 letter was being written, isn't that right? 10 A. Yes. 11 Q. And as I understand it, what had precipitated this 12 action being taken was something we discussed yesterday 13 which was the report, I think, that was made in fact 14 initially to the chief executive in December of the 15 previous year, 2012, by the patient who we discussed who 16 herself was a medical practitioner; do you remember 17 that? 18 A. Yes, I do. 19 Q. And that led to there being a serious case, a clinical 20 event analysis of that case, which had reported in May 21 of 2013, is that right? 22 A. That's correct, yes. 23 Q. And the upshot of that had been more attention had been 24 put on to Mr Eljamel's practice and issues, and indeed, 25 more issues started to come to light around that, is Page 49	1 is one of the ones that you helped us with, where you 2 said: 3 "Documentation within Mr Eljamel's HR file outlines 4 that following receipt of the 2013 RCS report ... 5 a meeting was held at 11:30 on 10 December 2013 ... 6 attended by the Medical Director, Associate Medical 7 Director Surgery, Operational Medical Director and 8 General Manager. The documentation indicated that the 9 RCS report had been shared with all attendees prior to 10 the meeting. The attendees at the meeting discussed the 11 contents of the 2013 RCS report ... and it was agreed to 12 action the report's recommendations regarding 13 Mr Eljamel's practice. 14 "Those recommendations were that: 15 "1. 'The GMC liaison officer should be made aware 16 as there was a need to investigate with a view to 17 considering Mr Eljamel's fitness to practice. 18 "... 'Mr Eljamel should not be allowed to undertake 19 any spinal surgery meantime. 20 "... 'There were some concerns with regard to the 21 probity of some of Mr Eljamel's activities.'" 22 And at 36.3: 23 "It is noted that attendees at the meeting agreed 24 that, given the scale and level of concern expressed by 25 the external neurological opinion, it was felt Page 51
1 that right? 2 A. That's right. 3 Q. But we also know that there had been a number of 4 complaints that had been made at least from 2011, so 5 there was some context to all of that? 6 A. That's right. 7 Q. But it appears that it was the December 2012 complaint 8 and escalation and investigation that appears to have 9 moved things forward to this point, is that your 10 understanding? 11 A. That's my understanding, yes. 12 Q. Okay, and therefore it appears to be the case that it 13 took a complaint being made by that individual at that 14 time for the systems to kick in and start to realise 15 there was a problem here? 16 A. That would -- that's what the evidence says, yes. 17 Q. Yes, thank you. You very helpfully also addressed, in 18 the aspects of the statement you address, Mrs Watson, 19 a number of other important areas. In particular, 20 I'd like to ask you some questions in relation to -- we 21 go further in time to December 2013 -- 22 A. Yes. 23 Q. -- where I wanted to talk to you about the suspension of 24 Mr Eljamel, which we've touched on already. If we could 25 have paragraph 36.1 up from the statement. Again, this Page 50	1 inappropriate to allow Mr Eljamel to continue working. 2 The decision was therefore taken to suspend him from 3 duties that day, 10 December 2013 ..." 4 So, there was a meeting with all these various 5 important people who were at it, because this was 6 a serious situation, wasn't it; is that right? 7 A. Yes. 8 Q. And indeed, they looked at the recommendations from the 9 report, one of which was that Mr Eljamel should not be 10 allowed to undertake any spinal surgery, in particular; 11 is that your understanding? 12 A. Yes. 13 Q. But in fact at the meeting, they considered matters and 14 thought: well, that should in fact extend out to all of 15 his practice. And he was suspended in the way that we 16 discussed the process yesterday, is that right? 17 A. That's right. 18 Q. I wonder if -- this is the point at which, I think, the 19 intimation of the issue to the GMC is made and again, we 20 discussed that yesterday. And just to be clear, I think 21 we covered this, I asked you several times during the 22 sequence of events going back to at least 2011, whether 23 the medical director could have suspended, under the 24 procedures, Mr Eljamel at an earlier point. And you 25 said in theory that was a power available to him, yes? Page 52

1 A. Yes. 2 Q. But similarly, could there have been intimation to the 3 GMC of these issues at an earlier stage? 4 A. In theory, yes. 5 Q. And this is where the professional and employment 6 obligations get a little bit intermingled, but is it 7 possible to define the point at which there would be 8 an employment-related obligation to report matters to 9 a regulator? 10 A. So it is a bit of a judgment call. 11 Q. Yes, understood? 12 A. Because as I'm sure you would appreciate, there are 13 often issues that arise that need to be looked into as 14 it pertains to the practice of any employee and there 15 has to be a judgment point at which it's assessed that 16 this is serious and there may be a need to contact 17 a regulator. And it really depends -- I think the best 18 answer you'll often get from an HR person is it depends. 19 And that's true because it really does depend on the 20 circumstances. There's no specific point but certainly 21 once there's a decision that there's a concern about 22 someone's fitness to practise, then that would be the 23 time that GMC or any regulator should be advised. 24 Q. I supposed, to be fair, the use of the word "concern" 25 there, when there's a concern, that might be the trigger Page 53	1 a Mrs Fraser that was involved. 2 A. Mrs Fraser. 3 Q. So Mrs Fraser might have been the person they could turn 4 to for assistance if they -- 5 A. (Overspeaking) Yes, and I do know she wasn't -- nobody 6 from HR was at the meeting on the morning that the 7 decision was made to suspend, but Mrs Fraser was at the 8 meeting in the afternoon and I know Mrs Fraser, she's 9 an excellent, very seasoned, qualified HR person. 10 I'm sure that she would've had a view on that. 11 Q. Should she have been at this meeting that -- 12 A. (Overspeaking) My belief is she would have been, yes. 13 Q. Based on your knowledge of her, she would've had 14 something helpful to contribute, I'm sure? 15 A. Yes. 16 THE CHAIR: Can I just pick up on one thing you mentioned 17 just now, when you referenced what you might have 18 thought to be informal contact with the regulator 19 through the local ELA. Just taking matters out of the 20 present circumstances and just looking at it as a matter 21 of procedure, which of course is very important in 22 employment terms. Would such informal contact about 23 somebody's practice require the individual most nearly 24 concerned to be told that such contact and discussions 25 were taking place? Page 55
1 but there's judgment involved in when that point is 2 reached; is that correct? 3 A. Yes. Yes and there's two parts to it. I mean, there's 4 the formal communication of that to a regulator, but the 5 board has contacts with the local liaison officer and at 6 any time, there can be an informal conversation with 7 that person to get some advice on whether it's 8 something -- if the medical director or anyone isn't 9 really sure that there's maybe a niggles that maybe 10 I probably need to speak to somebody about this, they 11 can do that, outwith there being actually a formal 12 reporting. 13 Q. Yes. Again, that would be an example of a situation in 14 which you're not on your own when you work in 15 a hospital, you've got other people who can help you 16 with these sorts of decisions, is that right? 17 A. Yes. 18 Q. And one group who can help you are the HR people who may 19 have dealt with this sort of thing on other examples, 20 for example? 21 A. Yes, but when it comes to the GMC and, you know, the 22 medical field, there's -- the medical director and other 23 medical leaders are, you know, probably in as good, if 24 not better, position to make those decisions. 25 Q. And we know, I think if I remember correctly, it was Page 54	1 A. So, I would say no but that's definitely a question to 2 check with the medical director. 3 THE CHAIR: Okay, thank you. 4 MR DAWSON: You've obviously had a look at all of this, 5 you're trying to help us. You weren't involved at the 6 time but you were looking at the documentation and 7 giving us your long-standing experience of these sorts 8 of matters from an HR perspective. One of the aspects 9 that I was interested in understanding was the sequence 10 of events, as you understand it from the file as best 11 you can, and also based on your experience of the sorts 12 of things that might have happened at the time, as to 13 how it might be that the Royal College of Surgeons' 14 report was communicated to the hospital, effectively. 15 The reason is that I asked some questions of another 16 gentleman, Professor Smith, who I told you was doing the 17 same sort of job as you. He's in charge of the Invited 18 Review Mechanism at the Royal College of Surgeons and he 19 was trying to help us with what he thought would have 20 happened without -- he, in fact, was working just from 21 the report and a lot less information than you have been 22 able to glean. So I asked him in particular what his 23 views were around how the report, which was dated 24 6 December, would have been communicated to the 25 hospital, the medical director, I assume, who had Page 56

1 ordered it. The reason for that -- there was some 2 context to that which we discussed yesterday and I think 3 you said you didn't have any evidence from the 4 documentation you'd seen but I think you were aware of, 5 was that there had been a visit in September at which he 6 thought would have resulted in some verbal advice about 7 the situation being given. There was also an interim 8 report which was done in October which was sent, and had 9 given indications that this was a serious situation and 10 that steps should be taken to try to curtail the 11 possibility of any further harm being caused. 12 In those circumstances, it was Professor Smith's 13 view, although he was just working on the basis of what 14 he understood the position to be, that it may well have 15 been the case that the report would have been emailed to 16 the hospital on the 6th. Now, the 6th was a Friday, we 17 know that. So the 7th, 8th was a weekend, the 9th was 18 a Monday and the 10th when this meeting took place was 19 a Tuesday. Obviously the content of the email, as we've 20 already seen, contained a recommendation that there 21 should be a suspension, as we've discussed. It actually 22 was only related to spinal surgery but eventually the 23 decision was taken it should be all surgery. 24 In those sorts of circumstances, it does appear to 25 be the case that there was an urgency about the Page 57	1 the hospital? 2 A. Yes, but there's no email in the file. 3 Q. Understood. And the information that we have also 4 shows, I think, that Mr Eljamel did -- I think we know 5 this from what he was saying, that his operating day on 6 the Monday, remember he was complaining about that being 7 a bank holiday sometimes? 8 A. Yes. 9 Q. And we know that he did a full operating list on the 10 Monday. 11 A. Yes. 12 Q. So in the circumstances, would it have at least been 13 feasible if they had known about things, say, on the 14 Friday by an email or something like that, for quicker, 15 more precipitative action to have been taken to put the 16 suspension in place? 17 A. Yes, I have thought about that. So, you know, in 18 general terms as soon as a decision is made to suspend 19 somebody, then it should be done as quickly as possible 20 because effectively what you're saying is that that 21 person should not be carrying out any duties -- why 22 would you have somebody do work when you know that 23 you're going to have them stop doing work? But the 24 decision to suspend -- and I'm not -- this is just the 25 facts. The decision to suspend was not taken until the Page 59
1 situation, would that be fair? 2 A. Yes. 3 Q. Because patient safety and care is paramount, isn't it? 4 A. Yes. 5 Q. And in those circumstances, was there any evidence on 6 the file that there had been an email sending the report 7 to the hospital or the medical director? 8 A. No, and I heard that evidence, and actually went back 9 and did -- it's probably the fifth or sixth time 10 I'd been through it, but just to look and just 11 double-check. No, and there was no evidence of it. And 12 there is an email exchange from the medical director's 13 office. It was very specific that the report arrived by 14 Royal Mail and it was opened at 11:30 in the morning 15 or -- not 11:30, earlier in the morning of the 10th -- 16 the 9th. Let me just get my dates right. 17 Q. The 9th, the Monday? 18 A. The Monday morning. Around 11:30 it was opened and 19 brought to the attention of individuals and a meeting 20 planned for the morning of the 10th. So it's not to say 21 that it wouldn't have been received both ways but 22 there's no evidence of an email being received. 23 Q. Yes, but it could have been in the sense that, we've 24 seen here, sometimes letters are sent, sometimes emails 25 are sent, it was in a period when emails were used in Page 58	1 morning of the 10th. So when the report was received, 2 irrespective of whether an email was received on the 3 9th, it will have had to have been digested by the 4 people that it was shared with. The recommendation was 5 that he stopped doing spinal surgery, as you've already 6 said, not to completely stop doing everything. They've 7 convened a meeting as quickly -- in my view, they maybe 8 could have done it on the afternoon of the 9th. They 9 made it on the morning of the 10th and suspended in the 10 afternoon. But the decision to suspend wasn't actually 11 taken until the morning of the 10th, as far as the 12 evidence shows. 13 Q. To be clear on that, you say the decision was taken to 14 suspend in relation to spinal procedures on the 9th, is 15 that right? 16 A. No, no. The recommendation from the Royal College in 17 there was around spinal surgery, as you said. 18 Q. That's right. 19 A. I'm not making any judgment on it whatsoever, it's just 20 what I have been able to determine from the 21 documentation. 22 Q. Okay, but as I think you've accepted, this was an urgent 23 and serious situation, is that right? 24 A. Yes. 25 Q. And we know now, of course, that this wasn't the first Page 60

1 intimation that had been received about the broad 2 opinion, if you like, of the Royal College reviewers 3 because there had been the interim report from October? 4 A. Yes. 5 Q. So there was a sort of prior notice, if you like, that 6 within the actual report arrives what the tenor of it 7 was likely to be? 8 A. Yes. 9 Q. So therefore I think it was the case that there would 10 have been an expectation that it would contain advice 11 that there should be some sort of restriction here 12 because we knew, from the position in the 6th October 13 letter, that that was the broad opinion? 14 A. Yes, and it could be argued -- and just in, you know, in 15 terms of the assessment of what's been seen, that 16 a different decision should have been taken in October 17 when the interim report was received. 18 Q. Because, I think we've covered this already, but as was 19 the position from -- well, any time really, but 20 certainly from the complaints coming in, in 2011, there 21 was no impediment to the medical director suspending 22 Mr Eljamel at any point in time over this, and it was 23 about making that judgment? 24 A. Yes. 25 Q. And on one view, I think you're telling us that Page 61	1 before? 2 A. So I don't know that I can give an absolute view on 3 that. I think it was more verification and 4 clarification of the concerns that had been raised 5 particularly around probity. 6 Q. Was there any material in the documentation you looked 7 at that indicated that, at the time when the suspension 8 was decided to be put in place, there was intimation to 9 Fernbrae Hospital which was the private hospital where 10 Mr Eljamel did his work? 11 A. No. 12 Q. It is, of course, the case that the letter we looked at 13 earlier did intimate that it was Mr Eljamel's intention 14 to stop doing his private practice at least at that 15 point on 24 June? 16 A. Yes. 17 Q. Was there any information within the documentation that 18 suggested there was any intimation given to any other 19 body that the hospital would have known Mr Eljamel had 20 a connection with, for example, the university? 21 A. No. 22 Q. Thank you. 23 I wanted to ask you, just in my final section, a few 24 questions. You also helped us with information relating 25 to documentation you found about Mr Eljamel's ultimate Page 63
1 a different judgment might have been made at that time? 2 A. Yes, and changes in judgment would be based on new 3 information coming to light and there was no new 4 information that came to light in October. 5 Q. Yes. And just to be clear, I rather said this to you 6 rather than asked you. I should have asked you. 7 I think it was clear it was known that Mr Eljamel did in 8 his theatre day on a Monday? 9 A. That's what the documentation shows. 10 Q. Yes. So it's not as if people couldn't have known that. 11 There would be a rota that would be there saying that he 12 did it on the Monday? 13 A. Yes, but what's not clear -- and again, I just really 14 want to emphasise that I am not in any way defending any 15 decision that's been made. I can see gaps in the 16 decisions. It was opened at 11:30 on the 9th, according 17 to the evidence but there's no evidence of when it was 18 actually read. 19 Q. Okay. Based on your analysis of the materials, what 20 information that was contained in the final report -- 21 I'm not going into the surgical or clinical details, but 22 broadly what the recommendations were -- what 23 information that came in the final report, as far as the 24 seriousness of the situation and the need to take action 25 were concerned, wasn't already available to the board Page 62	1 resignation? 2 A. Yes. 3 Q. And subsequent removal of his name from the medical 4 register. So the resignation sort of kicked in, if you 5 like, formally on 31 May 2014; was that right? 6 A. Yes, correct. 7 Q. And did the documentation that you found -- let's just 8 actually go to 37.1 which gives the context. It says 9 there: 10 "Mr Eljamel gave notice of intention to take 11 voluntary early retirement by letter to the NHS Tayside 12 HR department dated 27 December 2013 ... The NHS Tayside 13 HR department received Mr Eljamel's formal Voluntary 14 Early Retirement application, for onward submission to 15 the Scottish Public Pensions Agency (SPPA), on 16 10 February 2014, with an intended leaving date on 17 31 May ..." 18 And if you scroll down a little bit, it says: 19 "A letter dated 13 February 2014 [NHST-01561] from 20 the Associate Medical Director to Mr Eljamel noted that 21 Mr Eljamel had indicated his intention to retire on 22 31 May 2014. It noted that, following consideration of 23 this intention, the Associate Medical Director had 24 agreed with the Medical Director not to proceed with the 25 internal investigation. The letter further notes the Page 64

1 outcome of the GMC enquiry remained outstanding and 2 arrangements would be put in place to extend his 3 suspension from duty. It also notes that Mr Eljamel's 4 suspension would be amended to enable remaining annual 5 leave entitlement to be taken." 6 So at that stage it was the position of Mr Eljamel 7 that he intended to retire and there was contact made 8 with the pensions authority, et cetera. I think you've 9 helped with this, or there's some documentation showing 10 that -- I'm interested in finding out what retirement 11 means from an HR perspective in this context because 12 I think what the paperwork shows us is that the 13 correspondence with the pensions authority is intimating 14 an intention to retire, which as I understand it from 15 the documentation, requires the individual to certify 16 that they won't continue working within the NHS in 17 Scotland, is that right? 18 A. So that has changed over time. That's not the case now. 19 There's been provisions put in place to allow people to 20 return to the NHS after retirement, case in point. But 21 at that time, I'm not sure exactly what the provisions 22 were, but I'd be happy to follow up on it. 23 Q. Yes. Effectively, I suppose the question is, what was 24 understood or would have been understood by 25 an indication of intention to retire in an employment Page 65	1 not too much longer. It might be useful just to 2 continue and then we could have the break to get the CP 3 questions? 4 THE CHAIR: Yes, I think it would be desirable unless, 5 Mrs Watson, you want to take a break? 6 A. No, that's okay. 7 MR DAWSON: I suspected Mrs Watson, after what she said 8 yesterday, might wish to just continue and try to get to 9 the end as quickly as possible, so if that's okay? 10 A. That's fine. 11 THE CHAIR: All right. 12 MR DAWSON: Thank you, sir. I appreciate it. So that's the 13 position as retirement is concerned. What about 14 resignation? So he intimates an intention to resign. 15 Is it possible for a health board in these circumstances 16 not to accept someone's resignation? 17 A. Not really. 18 Q. Because one of the consequences, it would appear from 19 the paperwork the fact that he had indicated this 20 intention to resign and retire, was that the 21 investigation, which by this stage I think was in its, 22 I think you said preliminary stages, was discontinued; 23 is that right? 24 A. So those are two separate things. Can we stop somebody 25 from retiring? No. Can we stop somebody from accessing Page 67
1 sense? 2 A. So that you'll no longer be employed by the employing 3 authority and you will access your pension. 4 Q. Yes. And so that would mean that -- I think what that 5 means, in essence is that you're not -- for example, if 6 you were moving to another hospital in another area or 7 something like that, would your pension be transferred 8 across? 9 A. No. If -- so if you did not access your pension then 10 you're not retiring. 11 Q. Yes, indeed. That's really what I'm getting at. 12 A. Yes. 13 Q. If you're working as a neurosurgeon in one hospital and 14 you thought: I'm going to move to Glasgow, or something 15 like that, you would transfer over to that hospital and 16 your pension would be transferred over? 17 A. Because it's an NHS Scotland pension scheme. 18 Q. So that's stopping working in Dundee, but it's not 19 retiring. If you're retiring it means you're stopping 20 working altogether; is that right? 21 A. Well, the reason I'm hesitating on that is not 22 necessarily. There could be the opportunity for you to 23 restart work. But as I say, I'm not sure about what the 24 provisions were for that at that time. 25 MR DAWSON: Okay. Sir, I have a little bit further to go, Page 66	1 their pension? No, we can't. But the decision not to 2 continue with the investigation, in my view, is 3 a separate issue. 4 Q. I see. So it doesn't follow automatically that because 5 someone says: I'm retiring and accessing my pension, 6 that any investigation would be brought to an end? 7 A. Absolutely not. 8 Q. But the two things do appear, from the narrative given 9 in the statement, to have been connected in the sense 10 that that was the consequence of the intimation that 11 Mr Eljamel wished to retire? 12 A. That was the -- sorry, I cut you off, I didn't mean to 13 do that. 14 Q. Go ahead. 15 A. That appears to be the decision that was made. 16 Q. But what I'm saying is that one doesn't necessarily 17 follow from the other; is that correct? 18 A. Absolutely not. 19 THE CHAIR: At that time, what was the age of the employee 20 required to be to access a full retirement pension? 21 A. 55. 22 THE CHAIR: 55. What age was Mr Eljamel, just remind me, at 23 that time? 24 A. I don't but I can get that information. 25 THE CHAIR: I have a feeling that I saw 1957 somewhere in Page 68

1 the papers, but anyway, maybe it doesn't matter. 2 MR DAWSON: If we could look, please, at NHST-01561. This 3 is the letter referred to in the passage we went to. 4 It's a letter from Mr McLoughlin to Mr Eljamel: 5 "Private and confidential. 6 "To be opened by addressee only." 7 Is that right? 8 A. Yes. 9 Q. Dated 20 February 2014, correct? 10 A. Yes. 11 Q. "Application to early retiral/investigatory process. 12 "I refer to my letter of 10 December 2013 confirming 13 details of your suspension from duty pending the outcome 14 of the GMC enquiry and the internal investigatory 15 process by NHS Tayside. However, I note that you have 16 now submitted an application indicating your intention 17 to retire from the employ of NHS Tayside on 31 May 2014. 18 Following consideration of this development, and in 19 agreement with Dr Andrew Russell, Medical Director it 20 has been determined not to proceed with the internal 21 investigation." 22 So I think that does indicate these are separate 23 decisions in the sense that that's been intimated, then 24 there's been a separate consideration of the 25 investigation by Dr Russell and Mr McLoughlin and Page 69	1 Q. Yes, I think that's what it says in the statement but 2 perhaps that was someone else who said that particular 3 thing. 4 Could we go to NHST-01562, please. This is a letter 5 from Mr Eljamel to an Alison Johnston in human resources 6 at Ninewells, dated December 27th. This was the letter 7 that was referred to as well that was an earlier one 8 that was also referred to in the statement. It says: 9 "Voluntary Early Retirement on reduced pension." 10 It says: 11 "Due to family reasons I am applying for voluntary 12 early retirement. Please find attached a completed 13 application form and I would be grateful if you could 14 fill the employer's section of the form and let me know 15 when you have send it off to SPAA ..." 16 It's SPPA, isn't it? 17 A. SPPA, yes. 18 Q. It says here "SPAA": 19 "My annual leave period begins on [October]9th each 20 year, please advise me how many days leave I am entitled 21 for. 22 "I have enjoyed my time at Ninewells and wish you 23 the best for the future." 24 So at this point Mr Eljamel is intimating that it's 25 for family reasons that he's intimating. Does it have Page 71
1 they've decided not to proceed with the investigation; 2 is that correct? 3 A. Correct. 4 Q. Why was it that the actual date of his leaving was so 5 far away from the time when he had intimated in December 6 that he intended to do so? 7 A. So there's a notice period that you have to give to the 8 Scottish Public Pensions Agency for them to be able to 9 process your pension application and there would 10 presumably be a -- not presumably. There will have been 11 a notice period in his contract of employment. 12 Q. I see and then -- so, as I think the letter goes on to 13 narrate, there was then a period -- because I think the 14 suspension had to be extended every four weeks, was it? 15 A. Yes. 16 Q. So there then had to be, in order to accommodate that, 17 a date agreed and effectively because in this letter 18 Mr McLoughlin says that it would be inappropriate for 19 him to return to work, the suspension was just continued 20 every four weeks up to the date of 31 May when he left; 21 is that what happened? 22 A. Correct. 23 Q. But over that period, he did not see or treat any 24 patients? 25 A. No. As far as I understand it. Page 70	1 any bearing on the right to retire at this stage, what 2 the reasons are? 3 A. No. 4 Q. That's not relevant? 5 A. No. 6 Q. Someone is entitled to make the decision themselves, as 7 you said? 8 A. Yes. Yes and maybe just to note, to the Chair in 9 response to the question you asked, yes, the earliest 10 age would be 55 but it wouldn't necessarily be on a full 11 pension if you didn't have the service. So he's 12 obviously decided to go with the reduced -- 13 THE CHAIR: And the commencement date, of course, would be 14 relevant to that? 15 A. Yes. 16 MR DAWSON: Can I just take you to something else which 17 I think is very much in the HR area. This is back to 18 NHST-04741, the HR file. Page 66, please. Although 19 actually we should probably maybe look at 61. So this 20 appears to be a form that's being filled in to access 21 the pension, is that right? 22 A. Correct. 23 Q. So let's go to 67, please. I think this is Mr Eljamel 24 filling this out. If you scroll down a bit, we see 25 a declaration, it's effectively the last page. His Page 72

1 signature is under there and it's dated 2 31 December 2013; is that right? 3 A. Yes. 4 Q. And could we look at 66, please. This is the thing 5 I was referring to earlier. If you go down to 6 section 8, please, it asks: 7 "Do you intend to continue in your current position 8 or take up further employment in the NHS?" 9 And it is ticked "no"; is that correct? 10 A. Yes. 11 Q. Is that provision to do with the thing we talked about 12 earlier, that the pensions authority would want to know 13 if you're continuing in the role because then the 14 pension would carry on, or going to another job within 15 the NHS, in which case it would normally be transferred 16 over? 17 A. Well, it's not so much that it's transferred over. Your 18 membership of the SPPA is not tied to whatever board you 19 work for. If you moved to another board, you don't have 20 to let the SPPA know because you're making your 21 contributions into SPPA. You would only fill in this 22 form and make application to SPPA if you want to access 23 your pension. 24 Q. I see. I see, but the question is to do with -- it says 25 there that it's to do with working after retirement? Page 73	1 the pension. Is that what that means? 2 A. Yes. 3 Q. So presumably, this must have been filled out by someone 4 within the HR department, I'm assuming? 5 A. Yes and it's got his year of birth there, so we can work 6 out how old he was. 7 Q. Indeed, so it was the understanding that he was retiring 8 voluntarily and early. Could I have a look, please, in 9 the file at page 115. So this is letter from 10 Mr McLoughlin to Mr Eljamel dated 27 February 2014. It 11 says: 12 "Dear Sam. 13 "I have learnt of your decision to take early 14 retirement as of 31 May 2014. While I don't think it is 15 appropriate that I comment on the decision, I do wish 16 you well for your years in retiral and I am guessing 17 that there will be a professional element contained 18 within these years." 19 Now, could you help us with what Mr McLoughlin might 20 be talking about that there could be a professional 21 element contained within these years, based on your 22 experience of, as you mentioned earlier, people ending 23 their work, by continuing with some sort of professional 24 activity beyond that? 25 A. Yes, it would be speculation, but outside of talking Page 75
1 A. Yes, and so at that time -- and remember there has been 2 significant changes in SPPA provisions since then, so 3 this is not -- what it was then is not an area of 4 expertise for me then, probably wouldn't even be now. 5 But yes, SPPA, at that time, there were limitations on 6 how much you could work for the NHS if you had accessed 7 your pension. And so they would want to know, and 8 you'll see they're asking employment type, et cetera. 9 There aren't those limitations any more. 10 Q. Okay. If we could go to 68, please, this is another 11 part of the form, I think. This is the employer part of 12 the form, I think, to be completed by the employing 13 authority. This is the page after where we saw the 14 signature. If you scroll down a bit, please. It 15 indicates the date there, that will be the retirement 16 date, if you like, and it says "retirement category" and 17 four different categories there. Could you help us with 18 "VERA", voluntary early retirement or something? 19 A. So I think that's indicating a reduced pension. 20 I couldn't tell you exact -- voluntary early retirement. 21 Q. Something? 22 A. Application. 23 Q. Yes, so it's to do what you told us about a moment ago 24 which is to say: I would like to access my pension but 25 it's not a full pension yet, so it's an early access to Page 74	1 about Mr Eljamel, it could have been in research, it 2 could have been any number of things. It could have 3 been work with Scottish Government, it could have been 4 any of those things. 5 Q. But it appears to indicate that Mr McLoughlin's 6 understanding is that, although as we've seen Mr Eljamel 7 would be retiring, as he had intimated apparently for 8 family reasons by this stage, from his work as 9 a consultant neurosurgeon which would enable him to 10 access his pension albeit early, that it was still 11 within certainly Mr McLoughlin's contemplation, that he 12 would continue on doing some sort of professional 13 activity, whatever that might have been? 14 A. It would appear so from the letter. 15 Q. Thank you. He goes on to say: 16 "While the end of May is a few months away, I have 17 been made aware that there are some research files in 18 your office that are needed to close out. I am sure 19 that you have other effects in your office also, and I 20 am happy for you to take back your office keys, return 21 any files that are necessary and keep those keys so that 22 you can clear out your office in an ordered and 23 unhurried fashion. 24 "Please let me know what arrangements you would like 25 to collect the office keys." Page 76

1 And there is another comment on that. So, there 2 does appear -- this is a sort of goodbye letter, but it 3 does contain a reference to the possibility there will 4 be further work. We have, I think, heard about some of 5 the research-related consequences which were taken up by 6 Professor Belch and others within the university and 7 some projects were carried on by some other people. So 8 we've already heard about that. 9 Could we look, please, at 37.3 in the statement. We 10 looked at this already, but it says: 11 "There is no available documentation or 12 organisational memory that explains the reason for the 13 decision not to continue with the internal investigation 14 following Mr Eljamel's communication of his intention to 15 retire. The Medical Director in post at the time may be 16 able to assist the Inquiry further in this regard." 17 What it appears to be, from the documentation, is 18 that that decision was taken by Dr Russell and 19 Mr McLoughlin; is that right? 20 A. Yes. 21 Q. So when you say there's "no documentation or 22 organisational memory" does that mean there's nothing 23 written down as to why they did that, other than the 24 letter that we looked at? 25 A. Correct. Page 77	1 recreating, based on your knowledge, what you think has 2 gone on, based on the paperwork, in some circumstances 3 it might be a lot easier just to ask the people who were 4 actually there? 5 A. That's exactly right. 6 Q. That's very helpful, thank you. So the letter that we 7 just looked at, the valedictory letter, if you like, was 8 in February 2014. Could we look, please, at -- I think 9 what it said, to recall, was that basically it was only 10 at that point that Mr McLoughlin had become aware this 11 was happening, although Mr Eljamel had intimated his 12 intention to retire and had discussed it with HR people 13 in December? 14 A. Yes. 15 Q. So if we can look at 38.2 of the statement, please. You 16 mention there that: 17 "A further letter to the GMC (noted as draft in the 18 file) dated 13 February 2014 [NHST-01565] advised the 19 GMC that Mr Eljamel had given notification of early 20 retiral and that as a result, the internal investigation 21 would no longer be pursued." 22 If we could look, please, at NHST-01566. 23 A. Do you mind if I make a comment on -- 24 Q. (Overspeaking) Absolutely, please go ahead. 25 A. A second thought, probably what I should've -- just in Page 79
1 Q. And as far as "organisational memory" is concerned, does 2 that just mean that those two have moved on so you can't 3 speak to them, is that right? 4 A. Yes, exactly. 5 Q. Yes, but they're the ones we would have to ask about 6 that? 7 A. Yes. 8 Q. I notice, by the way, that the phrase there being "no 9 organisational memory" is used all over the report. Is 10 that something that was deliberately synthesised with 11 others or is that something that's said within the NHS? 12 A. Yes, I mean obviously within reason in terms of the 13 questions that were being asked and who it would be best 14 to get answers from. There's a lot of people who have 15 worked in Tayside for a long time and so, for things 16 like what were the recruitment processes for clinical 17 lead at the time, there's organisational -- that's 18 probably where you were seeing the language around 19 organisational memory. So it's as straightforward as 20 that. 21 Q. I see. I'm not intending to be critical, I'm just 22 saying that it's a phrase that one sees a lot and what 23 it means is there are no people working there at the 24 moment that actually can remember this and although, of 25 course, you and your colleagues have tried to help us by Page 78	1 line with what we said earlier, it looks like that's 2 a connected decision. I should have made it clear that 3 a decision was taken not to pursue the investigation. 4 Do you get what I mean? 5 Q. Could you just explain that a little bit for me? 6 A. It's not up on my screen right now. If you don't mind 7 me going back to it. 8 Q. Do you want the document that was referred to in that 9 passage? 10 A. Yes, just that passage. I mean it's a minor point but 11 just given the specificity of what we're talking about. 12 Q. Could we go back to 38.2, please. 13 A. So you'll see how -- it's actually 38.3, isn't it? 14 Q. Yes. 15 A. Where I've said: 16 "... Mr Eljamel had given notification of early 17 [retirement] and that as a result, the internal 18 investigation would no longer pursued." 19 Re-reading that, that reads like that's an obvious 20 thing to happen given his decision to retire and it's 21 not. So I might have reworded that differently. 22 Q. Yes, you've refined your position on that I think, that 23 the two are not causally connected necessarily, is that 24 right? 25 A. Correct. Page 80

1 Q. Thank you. So if we can look at NHST-01566, please. 2 This is a letter where Dr Russell is writing to 3 Mr Paxton, who we know is the liaison individual at the 4 GMC. This was back in December, so it's before 5 certainly Mr McLoughlin becomes aware of the fact that 6 he's taking early retirement and it says: 7 "Following up our recent conversation with regard to 8 this doctor within NHS Tayside, who has been suspended 9 within the last two weeks. The suspension follows 10 an external review conducted by the Royal College of 11 Surgeons in England. I have enclosed a copy of the 12 report along with the documentation NHS Tayside 13 submitted to the review team. 14 "You will see [that] they have raised concerns with 15 regard to both probity and ongoing issues with wrong 16 site surgery. 17 "We are in the process of reviewing 18 Professor Eljamel's spinal surgery cases with a view to 19 deciding whether or not there are further wrong-level 20 surgeries that have not yet been identified. There are 21 150 patients in the cohort that we believe to be at high 22 risk. These are patients with spinal surgery and who 23 are also attending the local pain service. This initial 24 audit will be completed early in the New Year and we 25 will update on the outcome of that as soon as Page 81	1 Mr Eljamel was going to retire early. But in December 2 it was anticipated that the investigation would have 3 been available -- the initial audit would be completed 4 in the New Year. Was there evidence that that was 5 completed earlier in the New Year? 6 A. Okay, I understand. I was thinking you were meaning the 7 HR investigation, which never -- 8 Q. (Overspeaking) Sorry, no, the investigation into the 9 clinical -- 10 A. (Overspeaking) It was my confusion. It's clear in the 11 letter. No, there's no evidence that that was completed 12 but again, that's something that I think the medical 13 director will be able to provide some perspective on. 14 Q. Thank you. There's a couple of documents I wanted to 15 take you to as you're the HR file guru. It's back to 16 the HR file, NHST-04741 at page 59. This is 17 a "notification of termination" form. Is that something 18 you recognise? 19 A. Yes. 20 Q. This is a bit like another document we looked at, it's 21 very faint. I'm assuming, again, it was like this when 22 you first saw it? 23 A. It's actually a yellow form. It was written in pencil, 24 so that's why it's difficult to copy. 25 Q. I see. Maybe go to 58 then, which I think is the same Page 83
1 [possible]. 2 "We would be keen not to duplicate any investigatory 3 processes and would value your thoughts as to how you 4 would wish [us to] proceed [I think it means]." 5 So there's a suggestion there that this process of 6 investigation, to try to work out whether this is 7 a wider problem, would be concluded early in the 8 New Year. 9 A. Yes. 10 Q. In fact, was that not the case by early in the New Year? 11 A. Was what not the case, sorry? 12 Q. The completion of the intended investigation? 13 A. Sorry, I'm not following. 14 Q. Well, this is in December -- 15 A. Yes. 16 Q. -- when Dr Russell is saying: what we're planning on 17 doing is looking at 150 cases who may be affected by 18 this to see if we can find any other potential issues 19 that we probably need to address. And he is saying at 20 this stage that that should be completed early in the 21 New Year. Now, we've already looked at the 22 documentation which says that by February, Mr McLoughlin 23 and Dr Russell have decided to discontinue the 24 investigation because of the fact that -- or after 25 a discussion in which they had become aware that Page 82	1 thing and may be slightly easier to see. 2 A. Yes, the yellow. 3 Q. This is the yellow form. There is another copy on 59. 4 Can we go down about three quarters of the way down to 5 section 5. It says "Exit interview carried out?" And 6 "no" is ticked. Is that normal? 7 A. Exit interviews is a whole other discussion about how 8 many are done and in what circumstances. What I would 9 say, in these circumstances, the use of doing an exit 10 interview with what was going on and the decision that 11 they had made not to continue with the investigation, 12 whatever the assessment of that is, would probably 13 negate any purpose in doing an exit interview. 14 Q. So what would the purpose of an exit interview be, in 15 general? 16 A. To understand why someone is leaving, to get some 17 learnings if it's -- because, you know, unless they're 18 moving for a promoted position, most people leave 19 because they're not happy with something where they're 20 working. So if we can understand why and, you know, 21 learn from that, then everything that I talked about 22 around culture, that's an input to improving things for 23 employees. 24 Q. I see, but is it your evidence that you reasonably 25 suspect that the exit interview didn't take place Page 84

1 because there had already been a decision not to have 2 an investigation? 3 A. I would suspect that that's the reason. 4 Q. Would that not be the reason to have an exit interview? 5 A. Yes. 6 Q. I mean, we went through in detail the letter from 7 24 June that described quite a lot of things that had 8 the potential to lead to learning in the organisation 9 because I think it fair to say, over the number of pages 10 that we read out, Mr Eljamel had some views on that? 11 A. I think that's reasonable but I'm speculating on why 12 that would have been the case. 13 Q. Another individual who was speaking largely in the 14 capacity of a representative of Dundee University, when 15 taken through some of the documentation and the lack of 16 intimation to that organisation in relation to various 17 matters, was of the view that there was someone within 18 the health board who wanted -- and I think these were 19 his words -- to close the book on the matter. Do you 20 think that the non-pursuit of the investigation, not 21 having an exit interview, would be consistent with his 22 testimony about what was going on over the period? 23 A. So I saw that evidence and I'm not sure of the inference 24 of that. So, with your permission, I'd prefer to give 25 my perspective on it as opposed to commenting on that Page 85	1 a good culture which appreciates and values learning? 2 A. No. And just to be really clear, I would have to have 3 it explained to me why there was a decision not to 4 continue with the investigation because I do not 5 understand it and from a professional perspective as 6 an HR professional, my advice, without somebody 7 explaining information that's not available to me, that 8 that should have continued to conclusion. 9 Q. And was there any evidence that either Mrs Fraser or 10 your immediate predecessor in the role at the time were 11 consulted about that? 12 A. No. 13 Q. Could I just look -- this is one aspect that was quite 14 difficult to follow, which comes in as slightly 15 illustrative. I have mentioned it before, but I wonder 16 if you might be able to help us with it, if you could. 17 Again, it's back in the file, NHST-04741, at page 154. 18 This is a series of correspondence. We're at the back, 19 but if you go through it, this is chronological. This 20 is an email from Lorraine Fraser to Andrew Russell, 21 Mr McLoughlin and Alison Johnston, who I think was one 22 of the HR people as well whom we saw, dated 31 December, 23 2013. So this is Mrs Fraser writing, saying: 24 "Hi Andrew. 25 "Following Professor Eljamel's suspension I have Page 87
1 evidence. 2 Q. Yes, yes. 3 A. Given what I know about how things were addressed at 4 that time -- and I spoke yesterday about the evolution 5 of people practices and people and culture versus 6 workforce -- I would suspect that the decision for 7 Mr Eljamel to retire and leave the organisation was seen 8 as a resolution to the problem. 9 Q. It was a resolution to the problem in the sense that he 10 left? 11 A. Yes. 12 Q. But there were also, it would appear from the evidence, 13 a lot of other problems which didn't leave, problems 14 that existed within the systems; is that correct? 15 A. I agree. 16 Q. And you gave evidence at the beginning, some time ago 17 now, where you told us that an important part of your 18 role within the board from 2023 onwards related to 19 trying to build a better culture, was that right? 20 A. Yes. 21 Q. And related, in particular, we talked about the learning 22 component to culture; is that correct? 23 A. Yes. 24 Q. And does this attitude towards accepting the retirement, 25 to put a full-stop on this episode, is it suggestive of Page 86	1 received notification from Alan Cook, who is the NHST 2 contact officer in this case, that we now have 3 confirmation of who is to represent Professor Eljamel. 4 In order to progress this matter we need to arrange 5 a Preliminary Investigation. Can you please advise who 6 will lead in regard to this process in order that I may 7 liaise with them. I have been appointed HR lead for 8 this case therefore I would be grateful if I could be 9 furnished with a copy of the report from the Royal 10 College of Surgeons." 11 And it also, I think, has another message to 12 Mr McLoughlin, which says: 13 "In light of the need to review the suspension every 14 4 weeks ..." 15 As we've said: 16 "... and that the first 4 weeks will be up in 17 6 January I will prepare a further communication to 18 Professor Eljamel confirming continuation of the 19 suspension for your signature." 20 So this appears to be that preliminary investigation 21 we talked about, is that right? 22 A. Yes. 23 Q. And if we go over the page, there are various other 24 emails about this and there is an email on page 153. If 25 we could just go down a bit. Yes, that one there. This Page 88

1 is from Tayside medical director, I think is Dr Russell, 2 is that right? 3 A. Yes. 4 Q. To a David Johnston within NHS Tayside: 5 "David. 6 "Are you able to take this on? 7 "[Best wishes] ... 8 "Andrew." 9 That was 6 January 2014 and then if we scroll up 10 a bit, the next day, David Johnston comes back and says: 11 "Hi. 12 "Should be ok. 13 "Can you give me more details about what is 14 required?" 15 And if we go to 152, we see this is from Dr Russell, 16 again to Mrs Fraser: 17 "Hi Lorraine. 18 "As you can see below David Johnston has agreed to 19 take this forward. Please can you contact him and give 20 more details." 21 Then at the top, we see Mrs Fraser taking that on, 22 and on 14 January: 23 "Hi David, 24 "I attach for your information a copy of the report 25 prepared by the Royal College of Surgeons. Can you let Page 89	1 investigation. Was there any procedure beyond this, as 2 far as we're aware? This was all I could find. 3 A. No, there's no evidence and yeah, there is a bit of 4 a crossover in the timelines. I picked that up as well. 5 And just because the clinical director didn't write to 6 Mr Eljamel until February doesn't mean that he didn't 7 know that he was retiring. It might be that he just 8 hadn't got round to sending a letter, based on the fact 9 that he wasn't actually leaving until the end of May. 10 That's a bit of speculation but I just know how these 11 things go in a busy office. It may be that Mrs Fraser 12 who, again, I know would be very particular in terms of 13 process being followed, a very experienced HR person, 14 maybe at that time was of the view that the 15 investigation should go ahead. 16 So even though Mr Eljamel had intimated his 17 intention, as I have said, and I would expect that HR 18 colleagues would be of a similar view that we need to 19 bring this to conclusion, the decision to do so may have 20 happened in that period. So there might have been a bit 21 of overlap in processes and discussions. 22 Q. Okay, I see. So it's possible that there was an earlier 23 decision, was there, to discontinue the investigation, 24 such that it came to an end at this point? 25 A. Yes. Page 91
1 me know when you have had a chance to read this and we 2 can arrange to meet to discuss what further information, 3 if any, is required to enable a report to be prepared 4 for submission to the Chairman to enable him to 5 determine whether there is a prima facie case." 6 I think we talked about this earlier. This is the 7 either Dr or Mr Johnston looking at the evidence to work 8 out whether an investigatory process needs to be taken 9 forward, is that right? 10 A. Correct. 11 Q. And then there are various other emails about details to 12 do with this which appear to come to an end, in this 13 chain, on 150. Where, broadly speaking, there's 14 a discussion about Mr or Dr Johnston coming to speak to 15 Mrs Fraser and them arranging an appointment in the HR 16 office on 20 January. Do we know, from the paperwork, 17 whether that went any further than that or is that the 18 end of it, because we know that at this stage, actually 19 Mr Eljamel had intimated his intention to Mrs Johnston, 20 I think in December, based on family reasons that he was 21 going to retire. It appeared that that hadn't 22 percolated through to Mr McLoughlin, Dr Russell until 23 the February, but in the meantime there was this ongoing 24 decision. Then by the February they found and 25 separately took the decision not to proceed with the Page 90	1 Q. Basically, did it get beyond this stage is really what 2 we're trying to work out? 3 A. Not that I can see. 4 THE CHAIR: There's no evidence that it did. 5 A. Correct. 6 MR DAWSON: But we have all the email exchanges about it and 7 then it seems to just jump to February where we learn 8 that their decision has been taken and doctor or 9 Mr Johnston's involvement on the paperwork doesn't seem 10 to be on this very preliminary discussion about things? 11 A. Yes. 12 Q. Thank you. So I just want to ask you about one area 13 which is a slightly later area but it does link into 14 what we've been looking at. If we go back to the 15 report, please, paragraph 38.1. So in question 38 you 16 were asked: 17 "Please explain the broad circumstances and 18 conditions of the removal of Mr Eljamel's name from the 19 GMC medical register, including the role which 20 NHS Tayside played in that event." 21 Now, in response to this question this is where we 22 see a number of pieces of the narrative. You pick up 23 the narrative slightly earlier in the period that we 24 were just discussing, December 2013. I'm not going to 25 read that out again. I just want to illustrate in Page 92

1 31.4 -- if we can scroll through, down to 38.4, you're 2 telling us what happened over that exact period that we 3 just discussed, December 2013 to 2014. This was 4 technically in response to a question about the removal 5 of the name from the register. 6 Then we jump in time quite a lot further forward, in 7 38.5. If we can have a look at that. You say: 8 "NHS Tayside was further notified by the GMC on 9 7 August 2015 that they would grant Mr Eljamel's 10 application for voluntary erasure, and that his name 11 would now be removed from the Medical Register. The 12 letter stated [that] Mr Eljamel's licence to practise 13 would be withdrawn, and he could not practise in the 14 UK ... A further check of the GMC register undertaken on 15 8 September 2016 showed that Mr Eljamel's registration 16 with the GMC was noted as relinquished from 17 10 August 2015 ..." 18 So I was trying to illustrate there the jump because 19 I think you're working on the basis of what is in the 20 file? 21 A. Yes. 22 Q. So would it be fair to deduce from that that there's 23 nothing on the HR file about questions relating to 24 erasure of his name from the medical register between 25 what we saw at -- in fact it's not related to that at Page 93	1 which is what this question was in relation to. 2 Q. Yes. So the other documentation that you're talking 3 about, we know that over this period there was 4 an ongoing investigation. Although the Tayside 5 investigation had been brought to an end -- we've 6 discussed that -- the GMC investigation continued. And 7 obviously they would need information to be able to do 8 that? 9 A. Correct. 10 Q. We know that there was ongoing correspondence, in 11 particular we understood that the way that that worked 12 was largely between the medical director and the liaison 13 person, Mr Paxton. Are you telling me that you're aware 14 that there is such correspondence but that was on 15 a different file, in a different place? 16 A. Yes. 17 Q. So it wasn't something that was being copied into the HR 18 system, it was being dealt with through some other 19 office or filing system? 20 A. Yes, the medical director's office. 21 Q. So again I suppose, one of the questions I've asked you 22 quite a lot, would you have expected there to have been 23 documentation about that on the HR file or because by 24 a certain point Mr Eljamel has left the employment, 25 technically if one says on 31 May 2014 would there be Page 95
1 all. 38.4, if we just scroll back to that, which is 2 basically the GMC saying in February these are the 3 restrictions we're placing on his practice and 2015 when 4 the board, according to the HR file or the documents you 5 saw, says his name has been removed? 6 A. Correct. So in the HR file there's no documentation but 7 I think there are letters within the medical director's 8 documentation that shows that there was some 9 communication back and forward with the GMC regarding 10 information that the GMC was looking for in terms of 11 their investigation which intimates that we were of the 12 understanding that that investigation was going to 13 continue. 14 Q. Yes. 15 A. But there's nothing in the file that suggests that 16 Tayside was advised that Mr Eljamel had made the request 17 for voluntary erasure. The letter that we have is 18 telling us that that decision has been made. 19 Q. So you're aware that there is some documentation, but as 20 far as the documentation you were focused on is 21 concerned, the HR file and other related files or 22 materials, you just didn't have access, so that's why we 23 jump from 38.4 to 38.5; is that right? 24 A. Yes, and the other documentation is in relation to the 25 GMC investigation, not about his voluntary erasure, Page 94	1 less of an expectation one would find there at that 2 stage? 3 A. No, so what -- you know, particularly with complex 4 situations there may be -- there's lots of documentation 5 and different offices may be dealing with it. And 6 through -- I know that you've heard evidence about the 7 ROAG that has been put in place now, the Responsible 8 Officer Advisory Group. What I would expect is at the 9 end of a process, that all of the documentation 10 pertaining to what happened in that circumstance is 11 pulled together and in the employee file so that we 12 don't find ourselves in the situation that we're 13 currently in where we're struggling to find 14 documentation. So that is something that the HR team 15 does and it would be at the end of -- usually at the end 16 of a process where all relevant documentation is 17 gathered. 18 Q. So there would be those exchanges largely between the 19 medical director and his office or her office and the 20 employment -- the liaison advisor of the GMC, Mr Paxton, 21 and then you would expect that to be occurring within 22 the medical director's office files and then at the end 23 of that, that it would be copied into the HR file so 24 that there's a comprehensive record of things relating 25 to a particular employee in one place, is that right? Page 96

1 A. Yes, so that would be my expectation of many years and 2 it would be my expectation now and it is what happens 3 now. 4 Q. Yes. 5 A. But bear in mind that the investigations around medical 6 staff, it's very much a collaboration now between the HR 7 office and the medical director's office. Others may 8 have different views on what should have happened in the 9 past in terms of that, but that's my professional view. 10 Q. So your professional view, just to be clear, was that 11 you think that while the investigation was going on, the 12 documentation was perfectly legitimately within the 13 medical director's files and his office dealing with it; 14 yes? 15 A. Yes. 16 Q. But that at the end of that process it should have been 17 copied over into the HR file and it appears not to have 18 been? 19 A. Yes. 20 Q. Because obviously one thing one can -- we've mentioned 21 this before -- one can see from the HR file is that 22 there is documentation relating to Mr Eljamel broadly 23 speaking subsequent to that, including, for example, 24 Police Scotland requesting information at a much later 25 date; isn't that right? Page 97	1 A. Correct. 2 Q. Sir, those are my questions for Mrs Watson. 3 At this stage, Mrs Watson, I always ask the 4 witnesses as to whether there is anything you would like 5 to add to the evidence you've already given? 6 A. So, no, not anything I would like to add. 7 I think what I would just like to say is, you know, 8 obviously I came into this situation when just before 9 the public inquiry was announced but have had the 10 opportunity to dig into the circumstances. I have 11 thought a lot about the impact that this must have had 12 and continues to have and the trauma that patients and 13 their families continue to experience and I really, 14 really hope that they get the answers that they need 15 from this process and the other processes that are 16 underway. 17 THE CHAIR: Thank you very much indeed. Mrs Watson, we 18 usually take a final break, just to ensure that there 19 are no further questions that our participants may wish 20 to have put that haven't been put already. So for one 21 final time, I'll ask you to go with Ms Miller to the 22 witness room and we'll get back to you shortly. 23 (12.06 pm) 24 (A short break) 25 (12.21 pm) Page 99
1 A. Yes. 2 Q. So it's not as if when someone leaves the HR file is 3 closed. Actually, far from it, it remains the 4 repository, if you like, of important information 5 relating to that person. Is that right? 6 A. Yes, and my position on it is there should be one file 7 that has everything pertaining to an employee -- key 8 information pertaining to an employee that is the 9 official record of that employee's time with 10 an organisation. It is often the case that what's 11 colloquially called "shadow files" that appear because 12 a manager may be working on something and the 13 information doesn't make its way. But personally 14 I would prefer information on me to be in my employee 15 file because we don't know what's happening with the 16 information that's not in the official record, and 17 I think that's a problem. 18 Q. Because if one wants to know what is going on with 19 an employee or what the situation is, one would like to 20 have one comprehensive place where all of that 21 information is stored, is that right? 22 A. Yes. 23 Q. That's as much as anything out of fairness to the 24 employee that a full picture of their position is 25 comprehensively in one place? Page 98	1 THE CHAIR: Yes, Mr Dawson. 2 MR DAWSON: Sir, I'm sure Mrs Watson may be delighted to 3 hear that I have no further questions. 4 THE CHAIR: Good. Thank you. 5 Mrs Watson, as you have heard, there are no further 6 questions. It's just possible that you may have 7 anticipated a shorter evidence session than has proved 8 to be the case but you've covered a great deal of ground 9 over the course of today and yesterday and for that the 10 Inquiry team and I are extremely grateful. 11 It's also evident from what you've been telling us 12 that in anticipation of giving evidence you and those 13 assisting you have obviously contributed a weight of 14 work to the process of preparing your section of the 15 statement but also the documents which have populated 16 that part of the statement and elsewhere. I don't 17 underestimate how much work is involved in that process, 18 and for that I am also extremely grateful to you. You 19 are free to go. 20 A. Thank you. Thank you. 21 (The witness withdrew) 22 MR DAWSON: Sir, we do have another witness but it might be 23 appropriate to break for lunch. 24 THE CHAIR: I think we will do that, yes. We haven't 25 obviously had a break. I think we'll just resume at the Page 100

1 normal time of 1.45, if that's convenient. 2 MR DAWSON: Yes, sir. 3 (12.23 pm) 4 (The short adjournment) 5 (1.51 pm) 6 THE CHAIR: Thank you. Yes. 7 MR DAWSON: Good afternoon, sir. The witness for this 8 afternoon is Ms Margaret Dunning. There is 9 an administrative matter that I just wanted to deal with 10 before we get the witness in. 11 THE CHAIR: Yes. 12 Housekeeping 13 MR DAWSON: As you are aware, sir, as I pointed out 14 yesterday and indeed on other occasions, the process by 15 which we go about intimating in a broad sense what broad 16 topics might be covered with a witness and what 17 documents may come up in the evidence is by means of 18 a document called an "evidence proposal" and the process 19 which we follow is that a draft document is sent out to 20 the core participant representatives on which they can 21 comment and contribute. 22 There were certain matters that were included within 23 the list of topics for Ms Dunning on the basis that we 24 had been led to believe by NHS Tayside that she answered 25 certain questions in the statement with which we are now Page 101	1 Question 103 related to how corporate or 2 administrative records insofar as relevant to Mr Eljamel 3 were generated, stored and processed within the board. 4 Question 104 related to, effectively, systems 5 relating to the accuracy of records within the board and 6 question 105 related to systems designed to ensure 7 accessibility of corporate and administrative records as 8 well as medical records and systems to try to ensure 9 that they were understandable. 10 So, these matters, in the evidence proposal for this 11 witness, they were listed as numbers 13 and 14, namely 12 administrative records managed within NHS Tayside and 13 accuracy and accessibility of records within 14 NHS Tayside. These were matters that were, for the 15 reasons I have explained, allocated to Ms Dunning's 16 evidence proposal which have been circulated amongst 17 other core participant groups and has led to certain 18 questions being proposed for Ms Dunning. 19 Questions 103 to 105 relating to the records are, in 20 fact, covered by another witness. The good fortune here 21 is that both of the witnesses are yet to come who speak 22 to this matters. That will be Sandra MacLeod who gives 23 evidence next Friday. 24 THE CHAIR: I was going to ask you. So the position is that 25 certain questions have been proposed. It's not that Page 103
1 familiar. 2 On Monday evening the representatives of NHS Tayside 3 told us that there had in fact been a slight error in 4 the allocation of certain answers to certain individuals 5 and the result of that is that there are certain matters 6 which appear within the evidence proposal and I can say 7 in relation to which certain core participants have 8 submitted questions in advance in accordance with our 9 procedures that will, in fact, not be covered with 10 Ms Dunning but will be able to be covered with other 11 witnesses. So if I could just clarify that because 12 these, I think are, because I've seen questions 13 submitted in connection with these topics, ones in which 14 certain core participants have a particular interest and 15 wish questions to be asked. 16 So I'll just be clear. The questions which were 17 allocated in the statement, if I could put it that way, 18 to Ms Dunning which in fact she was not primarily 19 responsible for answering are questions 102-105. 20 Question 102 related to what types of corporate or 21 administrative records existed within the board relating 22 to the professional practice of Mr Eljamel. 23 I understand that that question was, in fact, answered 24 by Dr Cotton who gives evidence towards the beginning of 25 next week. Page 102	1 they won't be answered, they just won't be answered by 2 this witness, but they will be answered during the 3 process of this section of the hearings? 4 MR DAWSON: That is absolutely correct and insofar as the 5 questions which have been produced for Ms Dunning, 6 totally understandably by other core participants in 7 accordance with the process, might be more applicable to 8 other witnesses, I can make sure that they are 9 considered for those witnesses in due course. 10 And it may be that today we run into some difficulty 11 in defining the precise boundary. So if I ask questions 12 today and Ms Dunning says that will be for someone else, 13 then that will be fine, but I think there are areas of 14 responsibility of these executives that perhaps overlap 15 to an extent with each other, or at least touch on each 16 other. So it might be slightly difficult to work out 17 who should answer what. 18 But I think procedurally, that's where we are. It's 19 important, I think, to point that out just to make sure 20 that core participants who have seen the evidence 21 proposal may be expecting aspects of the statement 22 relating to those matters to be covered this afternoon. 23 They will likely not be covered with Ms Dunning but the 24 positive news, if I can put it that way, is that the 25 questions have in fact been answered by witnesses who Page 104

1 are still to come. So we can cover those sorts of 2 questions later. 3 THE CHAIR: All right, that's helpful. I'm sure that will 4 be taken into account, but thank you for that update. 5 Can we have the witness then. 6 MR DAWSON: Thank you very much. 7 MS MARGARET DUNNING (sworn) 8 Questions by COUNSEL TO THE INQUIRY 9 THE CHAIR: Ms Dunning, I'm going to ask you, if you will, 10 so that everybody can pick up what you have to tell us, 11 to speak into the microphones. They will illuminate to 12 show that they're alive and well for that purpose, but 13 if you just particularly bear that in mind, Mr Dawson 14 will ask you some questions. 15 MR DAWSON: Thank you, sir. You are Margaret Dunning? 16 A. I am. 17 Q. I believe, Ms Dunning, that you contributed to 18 a statement which was produced to the Inquiry on behalf 19 of NHS Tayside, is that right? 20 A. Yes, that is right. 21 Q. Could we have a look, please, at NHST-04944. This 22 statement runs in the name of Dr James Cotton who 23 I understand is the executive medical director of 24 NHS Tayside, is that right? 25 A. Yes, that is correct. Page 105	1 NHS Fife and NHS Tayside. What roles did you hold 2 within NHS Fife? 3 A. So I started my health service career in NHS Fife in 4 1984 as an assistant domestic services manager and it 5 was at the time of the internal market within the NHS 6 but I did progress to domestic services manager and then 7 we were in the contracting sort of phase of the internal 8 market and through working with the contracts, I became 9 a monitoring officer, so monitoring the contracts. 10 I didn't particularly enjoy that job because it was like 11 that monitoring job and I really did like the work 12 within the hospital. So that's the point that I chose 13 to take a career change and that's when I moved to 14 Tayside. 15 Q. Okay, so was that from 1984 to 1994 then? 16 A. I think it was to 1990, I came to Tayside. 17 Q. And you tell us that you took up the role as the 18 corporate services manager for Dundee Healthcare NHS 19 Trust in October 1994, is that right? 20 A. Yes. So there was a period before that which I didn't 21 go into all the detail within the short paragraph but 22 that's when I took the career change and went into 23 hospital administration and hospital management. So 24 I did that for four years before becoming the corporate 25 services manager in Dundee Healthcare NHS Trust. Page 107
1 Q. And is that the first page of the statement? 2 A. That is the first page of the statement. 3 Q. If we go to page 273, please, we see there a blanked out 4 square, but as far as you understand it, is Dr Cotton's 5 signature in that position? 6 A. Yes, I'm aware that's where Dr Cotton signed the 7 statement. 8 Q. Thank you and is the statement dated 8 June 2026? 9 A. It is. 10 Q. And as far as you are concerned, in particular in 11 relation to matters which you contributed to the 12 statement, is the statement of truth there, that you 13 believe the facts stated in this written statement to be 14 true, your position? 15 A. Yes, I do. 16 Q. Thank you very much. Could we go, please, to 17 paragraph 2.14 of the statement. This is the section 18 where you set out your role, background and 19 qualifications, is that right? 20 A. That's correct. 21 Q. And it says here that you are the board secretary for 22 NHS Tayside, is that right? 23 A. Yes, that is correct. 24 Q. You list various roles that you've held in the past. In 25 particular, you mention that you've worked in both Page 106	1 Q. Okay, we'll get into the subject of the different trusts 2 and what they did in due course because that's one of 3 the subjects you've helped us with in the statement. 4 You say that that role is corporate services manager and 5 involved responsibility for corporate governance and 6 corporate communications. Could you tell us broadly 7 what your responsibilities were? 8 A. So it is obviously a little while ago but very similar 9 to the board secretary role today, responsible to the 10 chair and chief executive of the trust, for providing 11 advice and guidance regarding corporate governance 12 matters and putting in place the systems and processes 13 for corporate governance. 14 We didn't have the "blueprint for good governance" 15 back in the day, we had an NHS circular. So making sure 16 that the details in the circulars were upheld and 17 adhered to by the trust. 18 Q. What's the blueprint for good governance? 19 A. So the blueprint for good governance is a recent 20 publication. It was published in 2019 and it's now in 21 its second version published in May 2022 and it was the 22 first substantive update to corporate governance 23 guidance within the NHS and Scotland since the circular 24 of 1994. 25 Q. Right, and is that a government publication? Page 108

1 A. It is. 2 Q. So it's Scottish Government giving some instruction to 3 health boards effectively as to how they should manage 4 their corporate governance? 5 A. Yes, to make sure there's consistency across the NHS in 6 Scotland. 7 Q. Right, and would that include information about the way 8 in which different levels of governance should work and 9 who should report to whom and all that sort of thing? 10 A. It's really focused on the board governance level as -- 11 not sort of management, it is about the board governance 12 as opposed to the all of the whole of the organisation 13 if that makes sense. It doesn't -- 14 Q. Right, so does it relate more to what we would call 15 Tayside Health Board and the chair and that sort of 16 group of people? 17 A. That's correct, yes. 18 Q. Rather than the executive side? 19 A. It does refer to the executive but it doesn't give 20 detail around executive. 21 Q. I see and as far as decision-making around the way in 22 which the executive side of a health board is run, is 23 that a matter which is dictated by the Scottish 24 Government or is it a matter which the health board can 25 decide itself as to how they want to go about that? Page 109	1 of the chief executive of the particular board, 2 depending on the geographical location of the board and 3 the functions that the board covers, who and what they 4 should have in their executive leadership team. So they 5 do vary from board to board, but the core members will 6 be those executives that are board members as well. 7 Q. I see, so -- 8 THE CHAIR: Sorry, I'm just going to interrupt a minute. 9 I should have pointed out at the outset that these 10 proceedings, as well as being recorded, are taken down 11 by a stenographer. And it would be very helpful -- it's 12 very natural to want to speak quickly, but if you could 13 maybe slow down a bit. 14 A. I will do. 15 MR DAWSON: Thank you very much. So just talking about the 16 way in which the executive side of the operation is put 17 together. So then there are certain key individuals 18 identified within the government guidance who are 19 identified as: these are people that will work on the 20 executive side. They will also be members of the board, 21 is that right? 22 A. Correct. 23 Q. But beyond that, you say it would be conditioned by what 24 the chief executive thinks is the best way to run the 25 executive operation. You mentioned geographical factors Page 111
1 A. So in the blueprint it does say that the board shouldn't 2 concern itself with the day-to-day operational matters, 3 that is a matter for the executive leadership team. So 4 the accountable officer of the board is the chief 5 executive. So the chief executive, it's in their gift 6 about how they actually construct their executive team 7 to carry out the functions that are set to them 8 through -- by the Scottish Government. 9 Q. Okay, so the government guidance says: there will be 10 a board, there will be a chair and a vice chair and that 11 sort of thing, and the executive operation of the health 12 board should be run by a separate group of people and 13 that there should be a chief executive. But beyond 14 that, is it a matter for the chief executive to decide 15 exactly who fills what roles, how the executive function 16 will be carried out and is there any element of guidance 17 on that given by government? 18 A. So within the blueprint of good governance it says there 19 should be certain executives. So part of the executive 20 team is made up of board executive directors. So for 21 example, the chief executive is an executive director, 22 as is the director of finance, director of public 23 health, executive nurse director and the executive 24 medical director. So those would be a core part of the 25 executive leadership team and then it's within the gift Page 110	1 but there might be a multitude of different things? 2 A. Yes. 3 Q. For example, what services, medical services that board 4 actually happens to offer, perhaps policy directives 5 that need a specific person to manage, that sort of 6 thing; would that be fair? 7 A. Yes, I think you could take myself for example, as board 8 secretary I am part of NHS Tayside's executive 9 leadership team, but that is not the same in all boards. 10 So that is an example of how NHS Tayside has, you know, 11 decided to construct its executive leadership team. 12 Q. So you are part of the board, I think, but maybe 13 a non-executive capacity? 14 A. No, I'm not an executive nor a non-executive. I attend 15 the board meeting in my role is board secretary. 16 Q. I see and has that always been the case throughout your 17 time as board secretary? 18 A. Yes, I have. 19 Q. And what's the thinking behind that? 20 A. That the board secretary is not a board member? 21 Q. Yes. 22 A. Yes. So it can provide independent advice. So I am 23 independent of the board and meant to be seen as 24 a source of advice to the board chair and chief 25 executive and board members. Page 112

1 Q. Okay, thank you. You mention there that -- I think you 2 said that the 2009 blueprint for governance was the 3 first government guidance on that for some time? 4 A. Yes, 2019. Yes, that is correct. 5 Q. And when had been the last time? I think you mentioned 6 a date. 7 A. Yes, I think it was 1994, the circular. 8 Q. 1994, okay. And so in the intervening period, what 9 you've talked about so far is what the blueprint says 10 the broad structure should be, but as far as what 11 existed in the period before, insofar as your experience 12 goes, but I know you've been in the position for a long 13 time. So was the regime that was put forward by 14 government something similar in the period between 1994 15 and 2019 or did it work differently? 16 A. It was less prescriptive. The blueprint is more 17 detailed, it has principles of governance, it explains 18 how the governance processes should work. The previous 19 guidance didn't really, it just sort of highlighted 20 a number of committees, for example, the requirement to 21 have an audit committee and a remuneration committee. 22 So it was much lighter in its guidance than the 23 blueprint is. 24 Q. I think we might see this in due course but the broad, 25 structural, legal position behind all of this is that Page 113	1 prescriptive and it allows either government or a health 2 board or an executive to decide the way they want to run 3 things in order to achieve the principles to which they 4 are committed, is that broadly right? 5 A. That is correct and I should probably add as well is 6 that main circular from 1994, over time, government 7 issues directions to sort of boards through circulars. 8 So I think there has been reference already made to the 9 circular that brought in clinical governance to the NHS 10 in Scotland. So you have to look at that original 11 circular and then the subsequent circulars around 12 specific topics to get the whole picture. 13 Q. Yes, we might have a look at that today as well because 14 that's one of the things you mention in your sections 15 I think. You mention also that you then went on to 16 become corporate services manager in something called 17 Tayside Primary Care Trust. Was that broadly the same 18 function you had in the Dundee Healthcare NHS Trust 19 before that? 20 A. Yes, there was a merger within Tayside of the trusts, 21 the four trusts merged into two trusts. So there was 22 a process, obviously similar to what the health service 23 will be going through with the recent announcements, but 24 yes, there had to be re-organisation and people 25 reallocated jobs within that and I successfully moved Page 115
1 there is an Act of Parliament that effectively creates 2 the health service and governs, in a broad sense, the 3 way that the National Health Service works and is 4 delivered in Scotland; is that correct? 5 A. That's correct, yes. 6 Q. And the current Act is the NHS Act from 1978; is that 7 right? 8 A. I think that's correct, yes. 9 Q. Yes, we'll have a look at some details of that in due 10 course, I won't quiz you on it without going to the 11 document. But I think we'll see this, that that sets 12 out that -- it says in the Act the Secretary of State, 13 but basically the government has a certain role with 14 regard to the provision of NHS services, is that right? 15 A. That's correct. 16 Q. It also creates health boards and says: this is broadly 17 what health boards is going to do; is that right? 18 A. That's correct. 19 Q. And then it also has a number of other provisions in it, 20 which say that the features of the way that NHS work 21 will have certain things. So it talks about medical 22 directors and it talks about certain committees; is that 23 broadly right? 24 A. That's correct, yes. 25 Q. And then I think beyond that, the Act is not so Page 114	1 into that role at that time. 2 Q. And as we will get to some of the trusts that are more 3 relevant to the sort of things that we are looking at, 4 hospital care, but the primary care trust at the time 5 when you were working there, that was a trust that dealt 6 with primary care rather than hospital care; is that 7 right? 8 A. Yes and also the mental health service as well which is 9 not really reflected in its name but it did deal with 10 mental health as well for Tayside. 11 Q. Yes. So we'll come to this in due course but 12 effectively there have been, as you are contemplating 13 about to happen imminently, there have been a number of 14 restructurings of the way that healthcare has been 15 delivered within NHS in Scotland; is that correct? 16 A. That is correct, yes. 17 Q. And we'll see, in the period that we are interest in 18 which I know you know from the Rule 8 request that we 19 sent you which is from 1995 to 2015, there were such 20 restructurings. And we'll look at that in more detail 21 in due course. You arrived, I think, at NHS Tayside in 22 2002 as the head of corporate communications, is that 23 right? 24 A. That is correct, yes. 25 Q. And you tell us that that post involved responsibility Page 116

1 for internal and external corporate communications; is 2 that right? 3 A. That is correct, yes. 4 Q. Is that similar to the post held now by one of your 5 colleagues, Jane Duncan? 6 A. Yes, it is. 7 Q. Yes, and could you tell us a little bit about what that 8 role involves? What does a communications role for 9 a health board look like? 10 A. So, as you've said, it deals with internal and external 11 communications. So internal communications is really 12 about providing sort of conduits across the organisation 13 for messages to be distributed to sort of staff, around 14 business critical information, or celebrations of 15 success, you know, if people have won awards or have 16 done something outstanding. So there's different 17 channels used within the organisation to communicate 18 that information to staff. 19 It also provides advice to managers and team leaders 20 and things about how they might want to communicate with 21 their staff, the kind of processes they could put in 22 place. 23 Externally, it's dealing with requests from the 24 media. Quite a lot of it is obviously responding to 25 sort of media requests. Page 117	1 Q. But before that, do you know would it have been email 2 before then or would it have been other sorts of 3 communication? The period we're interested in obviously 4 goes back to 1995. You weren't there at that time but 5 do you know anything about that? What was there 6 immediately before you arrived in 2002? 7 A. So it would have been much more difficult probably prior 8 to that until obviously there was access to, you know, 9 PCs and electronic communications to get that consistent 10 message out across the organisation. So it did rely on 11 communications going out to departments, department 12 heads, managers, and asking them to cascade the 13 information to their teams. And that's why it's 14 important obviously for those areas to consider how they 15 do that because some areas are obviously easier. If 16 they're all geographically based and they have team 17 meetings, then it's easier to impart that knowledge but 18 for the services that were geographically dispersed, 19 then managers will have to think: how am I going to 20 communicate this important advice to staff? So that was 21 part of internal communications, helping managers to 22 understand how they may communicate with their staff. 23 So prior to, as you say, electronic communications 24 it was mainly by word of mouth or written, hard-copy 25 information. So notice boards, for example, were used Page 119
1 Q. As far as the internal communications are concerned, we 2 heard in some earlier evidence from one of your 3 colleagues, in fact from more than one of your 4 colleagues, that there were ways of communicating 5 nowadays to all of the staff that were involved, that 6 needed to get a message about something. Something was 7 mentioned called a Vital Signs email. Is that something 8 you're familiar with? 9 A. Yes, very familiar with, yes. 10 Q. Was that a method of communication of that sort of 11 information, things that everybody needed to know about. 12 Perhaps in the more important area of, you know: this is 13 a new policy or this is something you need to take 14 account of, was that sort of system in existence when 15 you were in corporate communications between 2002 and 16 2004? 17 A. That is correct. I think it probably started around 18 about that time 2002, 2003, but yes, it has been in 19 place all that time. 20 Q. So was it called Vital Signs then, or was it just 21 an email -- 22 A. It was called Vital Signs then, yes. 23 Q. Right, yes. So the Vital Signs system has been around 24 since then? 25 A. Yes. Page 118	1 a lot more probably in the past. 2 Q. Okay, because it's obviously important that these 3 mechanisms are effective, isn't that right? 4 A. Totally, yes. 5 Q. And it's important that, for a start I suppose, that 6 staff know they exist? 7 A. Exactly, yes. 8 Q. And that there are systems for trying to make sure that 9 they fulfil their purpose? 10 A. Yes. 11 Q. And their purpose -- it might be, as you say, 12 communicating social information or something but it 13 might also be a means of communicating quite fundamental 14 changes to the way in which the governance of the 15 organisation wishes the operation of the organisation to 16 run? 17 A. That's absolutely correct, yes. 18 Q. So if there is a new policy or something that you felt 19 people needed to know about, perhaps a policy that 20 applied across the whole of the board, it would be 21 important there would be systems that would make sure 22 that that policy, first of all, got to the people it 23 needed to get to? 24 A. Yes, and that they actually had read and they understood 25 it as well. Page 120

1 Q. Absolutely, and have there been, since your time 2 involved in that -- were you responsible in that role 3 for instituting systems to try to make sure that all of 4 those objectives that you've mentioned were actually 5 being achieved? 6 A. Yes. So I have done that in different guises within my 7 career. So when I was hospital administrator, for 8 example, I was responsible for policies within like 9 a hospital environment and did very much, at the time, 10 have to have those paper sort of records and had to seek 11 assurance from different department heads that they'd 12 actually cascaded the information and sought assurance. 13 But as I moved into the role in 2002, we were 14 obviously using email at that point and that's why Vital 15 Signs was sort of developed. But then when I moved on 16 in my role as board secretary, one of the things that we 17 did was introduce an electronic document store for the 18 capture of policies as a repository for policies and 19 also to ensure that we could use that for communicating 20 policies as well. 21 Q. Is it possible, within these Vital Signs systems, to 22 audit just that first stage of making sure that people 23 are receiving and opening important emails? Can that be 24 done? 25 A. No, not through the email system. It does rely on the Page 121	1 A. That is correct because not every policy is applicable 2 to every member of staff, so that the managers have to 3 sort of translate what policies are important for their 4 groups of staff depending on the functions that they are 5 carrying out within NHS Tayside and ensure that those 6 policies are made available to the staff. 7 Q. And again, just to understand in the Vital Signs 8 context, the context in which we've been discussing 9 these things have been always related to things that 10 will be going out to everyone in the health board. Is 11 that what Vital Signs is? It sends it to everyone and 12 then there's a decision made by the middle managers, if 13 I can put it that way, as to which of those things need 14 to be considered by their own teams, or is that 15 considered at the top level? 16 A. So, A bit of both. If I can use an example I'm familiar 17 with. So the code of corporate governance is within my 18 remit, I'm responsible for keeping that up to date and 19 there's a number of sections within the corporate code 20 of governance. So when we send out a Vital Signs 21 highlighting there has been an update to the code of 22 corporate governance, we highlight in the Vital Signs 23 who should look at what sections. So section A is 24 virtually the standing orders of the organisation, so 25 not every member of staff requires to understand the Page 123
1 cascade as well. So individuals would get the email 2 delivered to their email, but the managers would have to 3 check to ensure that it had been received, it had been 4 read and it had been understood. 5 Q. I see. 6 THE CHAIR: Does the old-fashioned notice board still have 7 a place to play in all of that? 8 A. I think in some areas they do. Some areas also, 9 I think, use their team meetings, their management 10 meetings. Some also I think have communication books as 11 well. So I think there's still a plethora of ways of 12 communicating in place today. 13 MR DAWSON: So, in the chain of trying to make sure that 14 something is received, read, understood, and 15 implemented, are those responsibilities then -- without 16 going into the structure, too complicated, of the sort 17 of middle managers who would be making sure -- is that 18 what you mean "cascading"? 19 A. That's correct. 20 Q. The policy might be set at the top, a document might be 21 put together and run through various different people, 22 a policy decision is made that: this is what we want to 23 send out to people, it gets sent out. And then there's 24 a reliance on managers to make sure that their own 25 groups whom they manage are doing all those things? Page 122	1 standing orders. But there is a section around the code 2 of business conduct. So it's highlighted there that all 3 staff should be aware of the code of business conduct 4 and especially if they're involved in sort of decisions 5 regarding sort of finance or contracting. So we 6 actually help managers understand which of their staff 7 should be directed to which sections. 8 Q. I see. So you say who would direct that? 9 A. Sorry? 10 Q. Who would direct which staff would see which -- 11 A. (Overspeaking) So, because I'm responsible for the code 12 of corporate governance, I would write the Vital Signs 13 for that. So the communications team don't write the 14 individual Vital Signs, it's the managers use that 15 channel to get the message out about what they're trying 16 to communicate. So the communication team facilitate 17 that but every policy has a policy owner and a policy 18 manager. So they're responsible for actually putting in 19 place the communication and who needs to see it and read 20 it and understand it. 21 Q. Right, so for the corporate governance area you're 22 talking about, you're the policy manager? 23 A. That's correct. 24 Q. Understood. Because of course, it's important, in 25 trying to achieve those very steps that we were talking Page 124

1 about that you identified, it's an important component 2 of that, in order to try to maximise the possibility 3 that the right people will be reading, understanding and 4 implementing documentation, that they are only sent the 5 amount of documentation that they really need to be 6 looking at. Because if you get sent 100 emails, you 7 might not read any of them and five might have been very 8 important for you to see, but if you get 100 it's quite 9 difficult to see the wood for the trees, isn't it? 10 A. That's correct. So that's why it's important, in the 11 Vital Signs, to actually direct who it is applicable 12 for. 13 Q. And that will be done by the policy lead in any given 14 area? 15 A. Correct. 16 Q. That's very helpful, thank you. You mentioned corporate 17 governance. Could you just broadly tell us the policies 18 you're putting out. You've talked about some aspects 19 already, but what sorts of things would that cover, 20 what's the extent to corporate governance? 21 A. So corporate governance is the framework really, that 22 brings together all of the elements of governance within 23 the organisation. So financial governance is an obvious 24 one, but for example clinical governance is another, 25 staff governance, information governance, and that links Page 125	1 given the portfolio for risk. Resilience planning I've 2 had for a number of years and that involves -- complies 3 with the Civil Contingencies Act and ensuring we have 4 business continuity plans in place and also emergency 5 planning as well. 6 So working quite closely with other public sector 7 colleagues regarding NHS Tayside's plans and processes 8 and how they're aligned to our local authority 9 colleagues, for example. 10 Q. I see. Does risk involve clinical risk or does that sit 11 somewhere else within the system? 12 A. So my sort of portfolio now, from 1 April, will involve 13 ensuring that all teams in NHS Tayside understand the 14 responsibilities around identifying and mitigating sort 15 of risks and that will include clinical risk. But 16 I'm not responsible for the actual mitigations, 17 I'm responsible to ensure that there are sound systems 18 and processes that people that have to manage those 19 risks can actually use. 20 Q. Right. So we looked, with Mr Dunn for example, at the 21 adverse incident management policies. That sits, 22 I think, within his remit? 23 A. That's correct. 24 Q. That's within the clinical governance structure? 25 A. That's correct. Page 127
1 as well to performance management and risk management. 2 So all of that together gives you the corporate 3 governance framework for the organisation, but those 4 distinct areas are led by the executive. So the 5 financial governance is set by the executive finance 6 director and similarly, I think Simon Dunn spoke about 7 clinical governance. He's the executive lead for that 8 along with our medical director. 9 Q. Yes. Where would professional governance sit in, is 10 that part of clinical governance? 11 A. That's part of clinical governance and down through the 12 medical and nurse directors. 13 Q. Understood, thank you. And one of the other aspects 14 that you tell us in the statement that you are 15 responsible for is providing strategic and professional 16 leadership for risk and resilience planning. What does 17 that cover? 18 A. So risk has been, from the 1 April this year. Previous 19 to that I had responsibility for strategic risk, so that 20 was maintaining the board's strategic risk register. 21 But from 1 April this year that has been for the whole 22 system of risk because it was recognised that it is 23 a whole system and the blueprint for good governance 24 recognises that as well, so we were realigning 25 portfolios. So part of realigning portfolios, I was Page 126	1 Q. So what would you do, connected to that? 2 A. So what -- I think you've mentioned about sort of Datix 3 as well. So we would work with teams to make sure that 4 they know how to identify risks and once they've 5 identified risks, that those risks are recorded on sort 6 of Datix and in putting in place mitigations. And one 7 of the things that we're working on is how we're going 8 to provide the assurance to the executive leadership 9 team and then up to the board that actual risks are 10 being identified and when they're actually identified, 11 they are being mitigated and managed. So that we can 12 actually ensure that there is a system from the board to 13 the ward areas, the department areas, that there is 14 active risk, not only as I say identification, but 15 management as well as and mitigation. 16 Q. Right, so as I understood it, Mr Dunn was in charge of 17 the operation of the policy then; is that how it works? 18 A. So I might be helpful to talk about what we understand 19 as the three lines of assurance within the NHS and 20 within governance. So the first line of assurance is 21 actually the services, carrying out their work and 22 putting in place all the mitigations. 23 Second line of assurance is, for example, the risk 24 team that I now sort of manage, actually checking up to 25 make sure that the teams are doing exactly what they're Page 128

1 meant to be doing and then providing that information 2 through performance management system, that people like 3 the medical director and the nurse director can take 4 some independent assurance from the actual line 5 management. 6 And then the third line of assurance is from 7 external sources, for example, our internal audit team 8 or our external audit team and any of the inspections 9 that are undertaken by, for example, NHS Health 10 Improvement Scotland. 11 Q. I see. So Mr Dunn's role would fall into the first 12 category, would it, in this regard? 13 A. Yes, his teams -- 14 Q. Your team, if you like, would have a role in checking 15 that what his operation says it's doing it is actually 16 doing? 17 A. Yes, checking and assurance, yes. 18 Q. Understood. And then does your team then do that across 19 all the divisions? 20 A. Yes. 21 Q. Right, understood. 22 THE CHAIR: In terms of having a risk register, you have 23 mentioned that a couple of times and we've heard it 24 elsewhere. In the context of what's just been 25 discussed, is that something that you and those who Page 129	1 Q. And why did that happen? 2 A. So, as you asked earlier on about the make-up of the 3 executive leadership team, it is within the gift of the 4 chief executive and we were, as an executive team, 5 obviously reviewing functions and portfolios. And in 6 discussion with the chief executive who is my line 7 manager, it was agreed at that point that I would take 8 responsibility for risk along with the resilience 9 planning portfolio. But a new post of director of 10 corporate affairs had been created and it was felt that 11 that would be better aligned to the information 12 governance function to give it more dedicated time and 13 that was agreed as part of those changes. 14 Q. Yes, okay. Was that because it was thought that, as we 15 discussed earlier, within that ability of a chief 16 executive to take those sorts of decisions, it was 17 thought that you had too many things on your plate, 18 effectively? 19 A. -Poss -- yes, because obviously I was getting risk as 20 well. So it seemed a sensible time to make that sort of 21 change and it give it, yes, more focus than what I would 22 have been able to give it. 23 Q. Yes, because there's a number of other functions which 24 I think you no longer do now but you did at the time of 25 the statement. So for example, you said you provided Page 131
1 support you are responsible for maintaining and is that 2 the process by which you, as it were, assess the 3 performance or compliance with whatever risks have 4 previously been identified, or is that done further 5 down, if you like? 6 A. Yes, so it's done at all levels. There should be risk 7 registers at all level. So departments or functions 8 should have their own sort of risk register, they should 9 have a good understanding of the risks that they're 10 actually managing. Any projects that are started, part 11 of the fundamental governance that should be put in 12 place around a project is actually the creation of 13 a risk register for that project. And then there is 14 obviously the strategic risks that NHS Tayside board 15 manages. So the board has its own strategic risk 16 register around its activities. 17 THE CHAIR: Thank you. 18 MR DAWSON: I think you mentioned that some of the roles 19 that you've listed in the statement, I think you told us 20 in the statement, prospectively you knew that was going 21 to happen, would be taken off your plate, if you like, 22 on 1 April? 23 A. That's correct, yes. 24 Q. And that happened, I'm assuming? 25 A. That is correct, yes. Page 130	1 strategic and professional leadership for information 2 governance and cyber assurance and that you were, I 3 think connected to that, you were NHS Tayside's senior 4 information risk owner, which the acronym is SIRO, is 5 that right? 6 A. That's correct. 7 Q. And I think you mention information governance. Is that 8 now part of the role of the director of corporate 9 affairs? 10 A. So, no, the chief executive decided to strengthen even 11 further, so I was, as I say, the head of the department 12 of information governance the cyber assurance and also 13 the senior information risk owner, but the changes that 14 were put in place was that the director of corporate 15 affairs would assume responsibility for the information 16 governance and cyber assurance team. And the role of 17 senior information risk owner was allocated to our 18 director of finance and there was also a deputy senior 19 information risk owner created as well and a deputy 20 Caldicott guardian. So there was a number of actions 21 taken at that time. 22 Q. What's a Caldicott guardian? 23 A. So the Caldicott guardian is our medical director and 24 they have specific responsibility regarding 25 patient-related information and health records. Page 132

1 Q. I think it's about trying to promote the application of 2 important principles related to the security of 3 patient-related information, is that broadly what -- 4 A. (Overspeaking) That's correct, yes. I think there was 5 a report a number of years ago and that created the role 6 of Caldicott guardians. I can't exactly remember what 7 year that was created, but all boards must have 8 Caldicott guardians and they're all undertaken by the 9 medical director because, as you say, of the 10 responsibility for patient information. 11 Q. So information governance and risk -- sorry, cyber 12 assurance is now with the director of corporate affairs? 13 A. That's correct, from 1 April. 14 Q. Yes, and does that cover everything to do with 15 information, like does it cover data protection, does it 16 cover freedom of information, does it cover records, 17 storage and management? 18 A. That is correct. Similar to what you were talking about 19 regarding policy management, there is the overarching 20 sort of framework sort of put in place, but individual 21 managers, team leaders, all have a responsibility 22 regarding information governance and records management 23 at different levels within the organisation. So you 24 can't just sort of point to one person, it's made up of 25 a framework of responsibilities. Page 133	1 objectives are managed by an executive or lead by 2 an executive director or a member of the executive 3 leadership team, to be more correct. And 4 a non-executive is aligned to those as well. 5 So, recognising the importance of sort of 6 information governance and the creation of that 7 corporate objective, the chief executive, as I say, 8 looking at her executive team, there was a number of 9 sort of changes but we've just been focusing on this. 10 But that is one of the reasons for the change in 11 portfolio, was to ensure that it did have the time 12 because it was an area that is growing with more, 13 obviously, electronic sort of communication. 14 Q. Yes, and so the split there of the roles between 15 information governance on the one hand and information 16 risk on the other, we've talked about the governance 17 side. What does the SIRO do? 18 A. So they're responsible ensuring the systems and 19 processes are in place and highlighting if there is 20 information risks and actually seeking assurance that 21 they being sort of mitigated. So having it separate 22 actually gives you, probably a check and balance in the 23 system where before, with it all being within my remit, 24 we didn't have that. So having the independence of the 25 director of finance carrying out that role I think gives Page 135
1 Q. So that person would sit at the top? 2 A. Correct. 3 Q. But also with individual teams, people would have to 4 take responsibilities for the individual data that 5 exists within their own teams? 6 A. That's correct. 7 Q. You can't have one person responsible for the entirety 8 of NHS Tayside, can you? 9 A. Yes. 10 Q. Okay. Other than taking things off your plate, were 11 there other reasons for the reallocation of these 12 responsibilities elsewhere? For example, I think we 13 mentioned earlier responsibilities might be reallocated 14 because of policies or a particular work-stream becoming 15 more burdensome than it used to be. Are these sorts of 16 areas, for example to do with information governance and 17 cyber assurance, creating more work or is there a policy 18 to give it more attention or something? 19 A. Yes, so one of the main areas is around the way -- so 20 NHS Tayside has corporate objectives. So the board 21 agrees the areas of work that it wants to give focus to. 22 So we have 15 corporate objectives for this year and one 23 of them is around information governance because the 24 board had acknowledged that this was an area that they 25 wanted to give specific focus to. So each of those Page 134	1 you a checks and balance. 2 Q. So previously with the role being with one person, that 3 might have meant that one person was in charge of 4 managing documents and information and things on 5 computers and then they would also be responsible for 6 assessing the risks of that. And that person might not 7 think what they have done is risky, but someone else 8 might; is that the theory? 9 A. Yes. 10 Q. So was that part of the thinking in splitting the roles? 11 A. Yes. 12 Q. Understood. One other thing that I think you were 13 responsible for you and you don't now do -- please 14 correct me if I'm wrong -- is leadership for the patient 15 liaison response team; is that right? 16 A. That's correct, yes. 17 Q. Where has that gone now, if I'm right that you don't do 18 that anymore? 19 A. So it has gone to Simon Dunn within his portfolio. It 20 has been aligned to the nursing directorate. I assumed 21 responsibility for the patient liaison response team 22 when the associate medical director left in 2024 because 23 it was a corporate sort of team. But over time because 24 my role is not sort of patient facing and this role is 25 very much patient facing, again, when we were looking at Page 136

1 portfolios and how best they should be discharged, it 2 was felt that this team, who is truly patient facing, 3 should be within the nursing directorate and they work 4 now quite closely with the patient experience team but 5 they are separate from it. But they are, as I say, part 6 of Simon Dunn's portfolio. 7 Q. Thank you. And we discussed that team a little bit with 8 Ms Connor when she came to give evidence. Am I correct 9 in thinking that that team was something that came out 10 of the due diligence review into the Eljamel -- 11 A. (Overspeaking) That's correct, yes. 12 Q. -- in 2023. I think we discussed, to an extent, the 13 findings of that review and in particular what had been 14 done subsequently with her and she identified this as 15 one of the steps that had been taken. And I think my 16 recollection was that it was because that review had 17 found that there had been poor triangulation of 18 information and communication with patients, such that 19 a dedicated team to do that needed to be set up; was 20 that right? 21 A. That is correct, yes. At that time, the medical 22 director, Pam Johnston, wanted to ensure that any sort 23 of patients that wanted to make contact with NHS Tayside 24 and may have lost sort of trust in the systems and 25 processes they had been using at that point, had another Page 137	1 Q. Yes, that makes sense. And the other role that you 2 point out was the public inquiry support across 3 NHS Tayside. Is that something you still do? 4 A. That is correct, yes. 5 Q. Yes, you still do that. So insofar as there are public 6 inquiries that involve Tayside, like this one, for 7 example -- 8 A. Predominantly this one, yes. 9 Q. -- you might have some involvement in others, but it's 10 not as focused on you, if I can put it that way? 11 A. No, in this context, it is this Inquiry. 12 Q. Understood. Obviously you've been working within 13 NHS Tayside back into -- a number of other -- your 14 colleagues who have come have been much more recent. 15 Some have come and gone quite quickly actually, but 16 you've been in NHS Tayside for a long time. You make 17 clear in your statement that you didn't have any 18 involvement in the matters that we are looking at, which 19 would make sense because you don't have a patient-facing 20 role, but did you have any engagement around the time 21 when Mr Eljamel was working there with any issues 22 relating to his practice? We've heard, for example, 23 about a number of reviews and that sort of thing that 24 one might have expected would be elevated up to 25 a different level beyond the medical director. Page 139
1 route into the organisation. And it was important as 2 well that they had trauma-informed training as well and 3 had time and the ability to actually be able to spend 4 with the patients that may have -- or be unaware of how 5 to actually navigate the complexity of the NHS. 6 Q. So it was designed to be a dedicated place where people 7 could go. Because again, I think one of the problems 8 that have been identified was that there were lots of 9 different places a patient might need to go to get the 10 information they needed, which was a daunting and 11 difficult thing to do, whereas concentrating it all in 12 one place with hopefully good signposting to where that 13 existed was designed to make it easier. And then 14 presumably, if information needed to be gathered from 15 the team from different places, it would be done by the 16 team rather than by the patient having to run around to 17 lots of different places. Was that the theory behind 18 it? 19 A. Yes, but they would have to possibly signpost to 20 other -- for example, there is a process around freedom 21 of information. So the patient liaison response team 22 would not take -- they would not undertake the role of 23 the team that has responsibility for a freedom of 24 information, but they would be able to get information, 25 if that makes sense. Page 138	1 A. So my first awareness that there was any issues was when 2 it was reported to the board in 2014. So by that time 3 Mr Eljamel had been sort of suspended and there was 4 a report to the board regarding suspensions and it was 5 in that and the medical director at the same time 6 brought a separate report detailing the background 7 circumstances. So that was the first -- I mean, 8 obviously I was aware of the name, Mr Eljamel, 9 Professor Eljamel, working within the Tayside system. 10 But I had actually never had engaged with him sort of 11 directly and as I say, the first time it was brought to 12 the board's attention was in 2014. 13 Q. And did you say that was at the time that Mr Eljamel was 14 suspended? 15 A. It was February 2014 that the board received a report. 16 Q. Right, so he was actually suspended 10 December 2013, 17 but that was when the medical director, I think it was 18 Dr Russell at the time -- 19 A. That's correct. 20 Q. -- brought it to the board at that time? 21 A. So our board meetings are -- and have been for a number 22 of years -- every two months. So our board meeting 23 would have been in February, so that would have been the 24 first opportunity after the suspension. So it 25 would've been reported to the next board meeting after Page 140

1 the suspension. 2 Q. Yes, and in those sorts of circumstances would that have 3 been the normal thing to have happened, when 4 a consultant was suspended that would get reported to 5 the board? 6 A. So at that time, yes, there was a period of time that 7 there was a report required to come to the board. At 8 the present day, suspensions aren't reported to the 9 board. 10 Q. Right, and why was it at that time that they needed to 11 be reported to the board? 12 A. There was a circular. So I think within the report, the 13 circular -- I can't recall the detail of the circular's 14 number but there was a circular that required -- so 15 required the boards to be notified of suspensions of 16 consultants. 17 Q. But rather than just the process which required it, what 18 was the thinking? Did the board have to do anything 19 about it? 20 A. No, just note it, yes. 21 Q. And is that what happened? 22 A. So there was two reports that came. So the first report 23 where Mr Eljamel was mentioned was the report on 24 suspensions, which had other suspensions, other than his 25 suspension. Page 141	1 Q. Okay. So, in terms of any decision-making that we might 2 have heard about, from that point on or indeed before 3 that, that was all in the province of the medical 4 director? 5 A. Correct. 6 Q. The board wasn't being asked to authorise anything or 7 make any decisions about Mr Eljamel or anything to do 8 with his practice? 9 A. Nor did the board seek to ask for further information to 10 come back from the medical director, which they could 11 have at the time. 12 Q. But if there was a report made about things like 13 capacity, that -- obviously clinical matters would be 14 for the medical director to deal with predominantly but 15 if there was a report, as you said, raising issues about 16 things like capacity, would that not be something the 17 board would be interested in, to the extent that, you 18 know, if by "capacity" you mean capacity of the 19 neurosurgical service to deliver the services that it 20 needs? 21 A. Yes, and to meet sort of things like waiting times, yes, 22 yes. I would have -- you know, reflecting back -- I was 23 obviously there at the time, but reflecting back now, 24 I think that if we were to receive the same report today 25 then the board would be asking those assurance Page 143
1 Q. Yes. 2 A. And then the second report was a report from the medical 3 director. And on reviewing it -- I didn't put it in the 4 evidence pack, one of my colleagues did -- but on 5 reviewing it in preparation for today, there is no 6 action required of the board. And the subsequent minute 7 of that meeting doesn't have the board asking for any 8 further information or follow-up. 9 Q. I see, so the follow-up wouldn't be part of the 10 suspension, it would be the intimation of the 11 suspension. And obviously, it sounds from what you're 12 saying, the medical director could have said: I think 13 there's some more stuff I need to discuss with the 14 board. But that didn't happen in this? 15 A. Well, he did bring a separate report which actually gave 16 more of the detail and the background leading to the 17 suspension and the issues that that was then causing the 18 board regarding sort of capacity and which, I think, 19 you've already sort of touched on. But it didn't ask 20 the board to do anything, it was really just a statement 21 around the facts and the information at the time. 22 Q. Do you know when it was that that second report was made 23 available to the board? 24 A. They came both to the same meeting, so the 25 February 2014. Page 142	1 questions, which is -- yes, which I think is different 2 to back in 2014. 3 Q. You're the expert in the corporate governance side, so 4 just to understand how that would work. Hypothesising 5 that the board did say: well, hang on a sec, there's 6 some aspects of that report that take an interest and 7 we're worried about that. What would be the mechanism 8 then by which they could effect something being gone 9 about it, effectively asking the medical director under 10 the chief executive: okay, this is concerning, what plan 11 have you got to try to address these issues? 12 A. That's correct. Today, they would probably ask to see 13 that sort of plan or certainly ask for a report to come 14 back and they would probably ask for it to come back 15 within a certain period of time as well. And then we 16 would track that through the administration of the 17 board. It would go into our kind of action tracker to 18 ensure that that did sort of come back. So yes, the 19 board would set the parameters today around what they 20 require and when they require it. 21 Q. Because, as you say, there were reports -- we've looked 22 at it with some other witnesses -- of what one might 23 describe as worrying, systemic aspects surrounding the 24 more individual, clinical professional issues to do with 25 Mr Eljamel, including the capacity of the service to Page 144

1 deliver the sorts of medical services it was purporting 2 to do, the ability, as you say, to meet waiting time 3 targets, which no doubt were important, and therefore -- 4 I think you may have already said this -- but do you 5 consider it surprising that there wasn't further 6 follow-up involving the board at that time? 7 A. I think, with hindsight looking back now and applying 8 kind of the standards we would have today, yes, it does 9 seem surprising. But then -- and you do have to reflect 10 back, it was in 2014 and we have had, you know, 11 substantial sort of changes around -- obviously around 12 the blueprint of governance and, yes, the way actually 13 the organisation operates today. 14 Q. Are you aware, whether through information that you had 15 at the time as being someone who attends the board, or 16 in any other way, what steps if any were taken to 17 address those systemic issues to do with things like 18 capacity, waiting time? Obviously the fact that 19 Mr Eljamel left would also have created a gap in terms 20 of the provision. All those things would presumably 21 have been difficult matters to face for the service. 22 Are you aware of what steps were taken to deal with any 23 of those matters in the aftermath? 24 A. I can't recall, and as I say, obviously the construct of 25 NHS Tayside then is different to sort of today as well. Page 145	1 Q. Okay, was it Mr Marr who was the chief executive at that 2 time? 3 A. Not in 2014. 4 Q. Sorry, it was someone else. 5 A. It was Lesley McLay in 2014. Mr Marr left 6 in December 2013. 7 Q. Yes, we'll actually come to look at that, in fact. 8 Okay, just in terms of -- I have asked some other 9 witnesses this question the way in which you went about 10 answering the questions that were allocated to you. 11 I was wondering what sources of information were 12 available to you. With Mrs Watson this morning, she was 13 obviously talking to aspects to do with human resources 14 and she was able to send us a very bulky human resources 15 file. And she also told us that she was able to draw on 16 other repositories of information that contain things 17 that were relevant to the questions she was asked. So 18 I was interested in understanding the process that you 19 went through to gather some of the documents that you've 20 provided to us. Where did you go to find those 21 documents? 22 A. So as you know, there was two trusts, Tayside University 23 Hospitals Trust and Tayside Teaching Hospitals Trust. 24 Their corporate records of their trust board and the 25 committees that were in place at that time had to be Page 147
1 Q. Yes, but I'm interested predominantly in the way it 2 worked at the time because you, unlike some other 3 witnesses, were actually there? 4 A. So I have no recollection of this being discussed as 5 part of the executive or senior management leadership 6 team at the time. 7 Q. But it could have been -- because obviously you're kind 8 part of both teams, as it were, it could have within 9 pursued by the board saying: we're more interested in 10 this, is that right? 11 A. That's correct, yes. The board could have sought 12 assurance that this was being given due attention by the 13 executive leadership team and asked for a report. So 14 they could have tracked to see -- by asking for 15 a follow-up. But the executive leadership team could 16 have also decided to actually ask for reports as well to 17 be considered at the executive leadership team. 18 Q. Indeed, I think you're also saying as parts of the 19 executive leadership team you're in the aware of 20 anything happening with this, whether the board was 21 involved or not? 22 A. No, I'm not aware, but it's not something that I have 23 delved into and looked at the records around that. So 24 it might be that's something you might want to pick up 25 with others. Page 146	1 preserved, so they were in archive storage. So we 2 retrieved all of the hard-copy files and we engaged 3 a number of individuals, we gave them the search 4 criteria and they virtually -- well, they did. They 5 went through each individual box, each individual file, 6 each individual page, using the search criteria to look 7 for information. And then some other teams came along 8 and looked as well. So for example, Simon Dunn's 9 clinical governance team, they availed themselves 10 because they were looking for maybe different specific 11 things other than what I had actually asked staff to do. 12 So we actually did all of that prior to submitting the 13 Rule 8. 14 We've since now obviously converted all those to 15 sort of digital, just so we have them in digital storage 16 as well for preservation as well. 17 Q. Okay. Was that -- you started to mention there, there 18 are two trusts involved here. This is an area that you 19 cover helpfully for us in the statement. So there was 20 a trust effectively in charge of the service that we're 21 interested in, the neurosurgical, called Dundee 22 University Hospitals NHS Trust? 23 A. Yes. Before, it was Dundee Teaching Hospitals Trust 24 which was really just Ninewells, Kings Cross, and DRI, 25 obviously at the time because it was still open and Page 148

1 I think the limb fitting centre, because there were 2 other trusts in Tayside at the time, Angus NHS Trust and 3 Perth and Kinross NHS Trust. So they managed -- so, for 4 example, Angus had Stracathro Hospital and Perth Trust 5 had PRI, but when they merged into Tayside University 6 Hospitals Trust, that saw that trust managing all of the 7 acute hospitals. So that's when it expanded to be Perth 8 PRI, Stracathro and the Dundee hospitals as well. 9 Q. So just to be clear, because we're looking from 1995, 10 the first trust that had operational control of the 11 neurosurgical service from 1995 was Dundee University 12 Hospitals -- 13 A. No, Dundee Teaching Hospitals -- 14 Q. Teaching Hospitals NHS Trust? 15 A. Yes. 16 Q. Was that from 1995? 17 A. That's correct. 18 Q. Right, and then there was, I think, another change in 19 1999? 20 A. Yes, 1999. 21 Q. 1999 is when the next one took over which was 22 a different Trust with different responsibilities, which 23 was Tayside University Hospitals NHS Trust; is that 24 right? 25 A. Yes, I think the thinking back in the day was, there was Page 149	1 that basically a policy has been announced they were 2 going to have a radical change in the number of health 3 boards and I think her position was there would now be 4 a process of reflecting on how best to deliver that. 5 It does look a little bit like that's sort of 6 putting the cart before the horse, doesn't it, because 7 if ultimately, the objective here is to try to obviously 8 operate more efficiently, but operate in a way which 9 improves patient safety, those sorts of things, one 10 would imagine, would have had to have been worked out 11 before the announcement was made? 12 A. Yes, correct. I mean, certainly since our chief 13 executive was here, there has been a further 14 announcement to say that there are going to be two 15 health boards within Scotland, one for the East and one 16 for the West. So I think that there probably is plans 17 in place, it's just that they are just being announced. 18 So there has been sort of work being undertaken 19 I'm aware and obviously our colleagues from the Scottish 20 Government will be able to answer to that. So I think 21 there is plans that just obviously we're just becoming 22 aware of what those are. 23 Q. Right. Well, maybe we'll ask some of them what the 24 plans are. It sounded like Ms Connor was keen to find 25 out. The position then with the trusts is that we had Page 151
1 a number of trusts and similar to the changes in the NHS 2 now, there was economies of scale by bringing the trust 3 together, so through trust mergers it was called. So 4 that saw the creation of two trusts where before there 5 had been four in Tayside. So instead of having four 6 trust boards and all the governance around four 7 individual organisations, it created two new corporate 8 organisations. 9 Q. I see. You mentioned there economies of scale. Are 10 these -- you're absolutely right, there are lots of 11 re-organisations and changes that you've helped us with 12 and indeed, there's a proposal that there will be 13 a re-organisation of the way health boards work on the 14 table right now. Are these changes based on economy? 15 A. Well, I think that one would hope that they would help 16 redirect resources to the front line. So, as opposed to 17 actually creating savings and seeing the money coming 18 out of the health, you would hope that the 19 re-organisation would then see more money available to 20 provide the services to the patients. 21 Q. Because if one were to look, for example, at the 22 proposals relating to the way in which health boards are 23 to be re-organised, I asked Ms Connor about whether she 24 knew anything about that and she effectively didn't, 25 other than what people know from the press and in effect Page 150	1 the trusts, from 1995 the period we're interested in, 2 there was a change in 1999 and I think there was another 3 change in around 2004, is that right? 4 A. That's correct. Well, prior to that, there was a change 5 in which brought in what they called the "Unified Board" 6 in about 2001 I think it was, but trusts still existed. 7 So there was a change, but trusts were still there until 8 2004. 9 Q. So just to be clear, in the period where trusts were 10 involved, what was happening was there was still 11 a health board always throughout this period, is that 12 right? 13 A. Yes. 14 Q. And the health board is something, as we discussed 15 earlier, that is created by statute effectively; is that 16 right? 17 A. Yes. 18 Q. And then there was a certain period where a decision was 19 made that it would be better to have healthcare services 20 deliver via separate entities called trusts, is that 21 right? 22 A. Yes. 23 Q. And then, by I think around 2004, the position reverted 24 to the operational side also being run by the health 25 board, is that right? Page 152

1 A. That's correct, yes. Prior to that, it was through 2 contracts through -- it was called the kind of 3 purchaser-provider split. The trusts were the provider 4 and the health boards were the purchaser and it was that 5 kind of language that was used and contracting was 6 a function at the time. 7 Q. If I could just combine the two -- you tell us all about 8 this in the statement. 9 THE CHAIR: I don't want to lose the thread, but am I right 10 in thinking then, because you referenced the unified 11 board in 2001, is the situation in summary that in 1995 12 there was the Dundee Teaching Hospitals NHS Trust, 13 within which there were four trust boards, is that 14 right? 15 A. Yes, Dundee Teaching Hospitals was one of four, yes. 16 THE CHAIR: One of four. And then 1999, there was Tayside 17 University Hospitals NHS Trust, was that one of two? 18 A. That's correct, yes. 19 THE CHAIR: And then the two became one in 2001? 20 A. No, 2004. So the board's role changed in 2001 but the 21 trusts still remained. 22 THE CHAIR: Well, maybe I'll leave that with you, but it was 23 the use of the expression "unified board" suggested that 24 if previously there had been two, it became one. But 25 that's not -- Page 153	1 care. So they very much sort of followed kind of what 2 had been in place for the trusts. 3 Q. So what it looked like -- and I think you've checked 4 some of the people involved -- it looks like some of the 5 key people involved who worked for the trust, they just 6 move over to different place called an operational 7 unit -- 8 A. That's correct. 9 Q. -- within the board, but they are effectively doing the 10 same jobs as they did the day before the switchover, is 11 that right? 12 A. That's correct. 13 Q. I don't think that's in every case, actually, but in 14 many key positions that appears to be the case? 15 A. Yes, for example the chair, I think the chair of the 16 trust became the chair of the delivery unit -- 17 Q. (Overspeaking) Indeed. So, broadly speaking -- that's 18 right and just to put into the picture as well, another 19 important change that we've discussed with one of your 20 colleagues this morning in relation to the provision of 21 neurosurgical services, which needs to be factored in, 22 if you like, is the movement of the hospital? 23 A. Yes. 24 Q. So in amongst all of these changes with trusts and 25 boards, the hospital, through which neurosurgical Page 155
1 A. (Overspeaking) Yes, it talked, I think, unified in that 2 the board and the trusts were working more together in 3 a unified way as opposed to the purchaser-provider 4 split. 5 THE CHAIR: I follow you, yes. Thank you. 6 MR DAWSON: I wasn't really sure, for our purposes, whether 7 the talk of what happened in 2001 and the unified board 8 actually changed the picture, but let's just clarify 9 that. My understanding was in 1995 it was run by one 10 trust, 1999 another trust and then in 2004, it was run 11 by the health board. Is that -- 12 A. That's correct, yes. 13 Q. Thank you. And I think also, not wishing to confuse 14 matters at all, you've provided for us a very detailed 15 breakdown of the identities of all of the people over 16 the years that we're looking at, both insofar as there 17 was a board and a trust on the trust side and on the 18 board side, but you also -- I think around 2004, there 19 is something that emerges. There are two different 20 entities that appear to emerge as the way in which the 21 board delivers operational services, an operational unit 22 is mentioned? 23 A. That's correct, yes. The trust ceased to exist in 2004 24 but then two operational units were created and they 25 still had the division around acute services and primary Page 154	1 services are delivered in Tayside, changes from our 2 period starting in 1995 from Dundee Royal Infirmary and 3 in 1998, there's a move into Ninewells, is that right? 4 A. That's correct. 5 Q. And we've seen some evidence of that having been 6 a project that was in train for quite a while. In fact, 7 when Mr Eljamel was appointed to his post, the plan to 8 move to Ninewells was already on the table, it was part 9 of the job application materials. And I think the idea 10 was it was moving to a better, bigger, more modern unit; 11 was that the idea? 12 A. I believe so. I wasn't around -- well, I was in Tayside 13 at the time, but I wasn't in the service. 14 Q. Understood. And just so I understand as well, another 15 thing that you've helped us with which is of 16 significance in our understanding of these services, is 17 that I think you've told us that the way in which 18 healthcare services are delivered, effectively the 19 geographical area that's covered by NHS Tayside, 20 NHS Tayside in general -- we'll get to neurosurgery in 21 a moment -- basically delivers healthcare services to 22 three council areas in the Tayside area; is that 23 correct? 24 A. Yes and also to North-east Fife as well. 25 Q. Well, is that the case for all of NHS Tayside or only Page 156

1 acute services? 2 A. Acute services. 3 Q. Yes, so if we just talk about NHS Tayside, there are 4 three council areas, which are? 5 A. Correct. Angus, Dundee and Perth and Kinross. 6 Q. Okay, so part of its catchment area/geographical area is 7 that? 8 A. Yes. 9 Q. And there's also something called acute services? 10 A. That's correct. 11 Q. Could you tell us what that is? 12 A. So, acute services are all the services that are not 13 primary care. So it's predominantly around the 14 hospitals, the secondary -- what we sort of -- acute 15 services call it "secondary care", so Ninewells, PRI, 16 Stracathro. 17 Q. And as far as acute services are concerned, which 18 I think includes neurosurgery, is that right? 19 A. Correct, yes. 20 Q. That service is also delivered to the council area of 21 North-east Fife, is that right? 22 A. Yes. 23 Q. So as far as acute services are concerned, but not other 24 services, four council areas covered by NHS Tayside? 25 A. That's right, yes. I think the proximity of Page 157	1 in the period we're interested in, trusts, boards, that 2 sort of thing and the move of the neurosurgical service 3 being predominantly delivered from Dundee Royal 4 Infirmary to Ninewells in 1998 and the important changes 5 in the way the service is delivered. 6 I wanted to ask you some questions -- various 7 different places you used terms which are no doubt 8 completely normal to use while one works within the 9 health board, but are ones with which I think maybe 10 we're not familiar. 11 In particular, you mention -- I don't know whether 12 there is a historical phenomenon, but you mention at 13 paragraph 4(b).2 that: 14 "Dundee Teaching Hospitals NHS Trust had operational 15 responsibility for the provision and delivery of 16 neurosurgery which was part of the Neurosciences 17 Directorate." 18 And that the directorate was: 19 "... transferred from DRI to Ninewells ... in 20 1998 ..." 21 You say, at paragraph 6.5: 22 "The operational delivery structure during the 23 relevant period broadly followed a divisional model." 24 You say that: 25 "Acute services were organised into divisions, Page 159
1 North-east Fife to Ninewells as opposed to other 2 hospitals in Mid Fife is the reason why they are within 3 that catchment area. 4 Q. Understood. And so for other aspects of healthcare 5 provision that aren't part of acute services, is that 6 only delivered to the three council areas? 7 A. Correct. 8 Q. Thank you. 9 MR DAWSON: Sir, that would be a convenient moment for 10 a break. 11 THE CHAIR: Ms Dunning, we're going to take a 15-minute 12 break, if that's convenient. Just before Miss Miller 13 takes you to the witness room, can I mention something 14 I say to any witness in your situation: you've started 15 but not finished giving your evidence. So to keep 16 matters regular, we ask that you don't discuss your 17 evidence during the break. Thank you. 18 A. Okay. 19 THE CHAIR: Thank you. 20 (3.02 pm) 21 (A short break) 22 (3.17 pm) 23 THE CHAIR: Thank you, we're ready to resume. Mr Dawson. 24 MR DAWSON: Ms Dunning, we were talking about the way in 25 which the various structures had changed over the years Page 158	1 within which sat clinical care groups, and 2 individualised speciality services such as 3 Neurosurgery." 4 Now, I'm interested to try and work out a sort of 5 hierarchy, if you like, or how it breaks down. There 6 may be differences over different time periods but you 7 mentioned there a neurosciences directorate, acute 8 services that would be organised into divisions, 9 clinical care groups and individual speciality services. 10 So I wonder if you could just set out for us how all 11 these things fit together in the delivery of 12 neurosurgery, broadly? 13 A. So the information that obviously I put into the Rule 8 14 came from the records that we reviewed at the time. So 15 I'm probably not the best person. I think you have 16 Lynn Smith, our acute services chief operating officer, 17 next week and Lynn might be able to give you the exact 18 sort of detail. But I think it's a clinical sort of 19 group and then it goes into kind of a directorate and 20 then the directorate is within acute sort of services, 21 so there is different levels. 22 And we took some of the information from the minutes 23 and reports and also the year book and sometimes the 24 terminology was slightly different but usually there is 25 the sort of care group and then a directorate and then Page 160

1 the acute unit or operating division. 2 Q. Okay, so if we take acute services as being the top 3 level -- 4 A. That is correct, yes. 5 Q. -- which, as you defined earlier, is the body through 6 which acute services is delivered, you then said there 7 were divisions below that. So if we're looking at 8 neurosurgery, what would the division be that would be 9 relevant? 10 A. So I think there were divisions and then they probably 11 went to directorate. So the division would be 12 neurosurgery or neurosciences or specialist services, 13 for example. So I think that specialist services is 14 a term that I think you were discussing with 15 Elaine Watson. 16 Q. Yes, that's right. 17 A. And that's certainly what we recognise today, but 18 I think that in the yearbook when Mr Varma is mentioned, 19 they talk about neurosciences -- 20 Q. Directorate. 21 A. Directorate, yes. So I think it's a passage of time, 22 there's different terminology used. So I think that 23 Lynn Smith would be able to give you more clarity 24 regarding that. 25 Q. But perhaps for present purposes, we have acute services Page 161	1 know about, may have affected the way the service 2 operated. But I think the change of hospital appears to 3 be the main change in relation to neurosurgery. These 4 corporate level changes were, for the reasons we 5 discussed about economies of scale and that sort of 6 thing, but it's not clear that they really had much of 7 an effect on the way neurosurgery would actually be 8 delivered, is that fair? 9 A. Well, I suppose because trusts and the board operating 10 in that purchaser-provider split and there was sort of 11 contracts and I think you picked up with Elaine Watson 12 as well around waiting times and targets and things. So 13 in the purchaser-provider split of the health service, 14 it was driven through those contracts. So when that was 15 removed, that element sort of went as well. So I think 16 patient-facing services would probably see no 17 difference, but there would be teams of people that were 18 no longer doing the function, that you would not need 19 people to draw up contracts and people to monitor 20 contracts. So there would be impact but not at the 21 patient-facing side of the services. 22 Q. I see, yes. So the changes which have been driven to 23 try to make the system more efficient might have meant 24 that the money available for running the health service 25 in Tayside may have -- if the system improved, there may Page 163
1 and below that would be either specialist services unit 2 or it might have been called neurosciences directorate, 3 at one point? 4 A. That's correct. 5 Q. And then below that, you say clinical care groups and 6 below that neurosurgery. What would the clinical care 7 group be, do you think? 8 A. So I think a clinical care group would be neurosurgery 9 for example, yes, uh-huh. 10 Q. I see. So clinical care would be neurosurgery. There 11 wouldn't be another level below that? 12 A. No, it would probably be like wards, departments, 13 outpatients, yep. 14 Q. Absolutely, I'm with you. That's helpful. Other than 15 the move of the hospital, my impression was that all of 16 these various structural trusts type changes didn't 17 really affect the delivery of the neurosurgical service 18 at all. In fact, the changes appeared relatively 19 administrative at the top and quite often, really, one 20 day one had a trust, the next one had a board and it was 21 exactly the same people delivering the service; is that 22 right, broadly? 23 A. Broadly, yes, uh-huh. 24 Q. Because obviously we're interested in the extent to 25 which any of these changes, which are interesting to Page 162	1 be more money and the system therefore may be able to 2 work better, but it didn't mean that all of a sudden you 3 had different people working in the wards or anything 4 like that? 5 A. No. 6 Q. You also say in the statement, at paragraph 3.8, in 7 relation to this change of hospital, that neurosurgical 8 care in Tayside was not routinely delivered over than at 9 Dundee Royal Infirmary or at Ninewells. Again, this may 10 more of a question for Lynn Smith, but when you say "not 11 routinely delivered", we saw some evidence in the HR 12 paperwork that Mr Eljamel was at times listed as 13 delivering some sort of service at Perth Royal 14 Infirmary, for example. Did your investigations help 15 with the question as to why you say it was not routinely 16 delivered, which tends to suggest it was delivered in 17 some other places at some point? 18 A. So I think there was some evidence, as you came across 19 with Elaine Watson, that other establishments were 20 mentioned and it would be probably for the purpose of 21 outpatient clinics or possibly patients were sent for 22 some diagnostic, maybe to PRI maybe for, I don't know, 23 x-rays or other diagnostics, but the actual neurosurgery 24 theatre and service was at Ninewells. 25 Q. Thank you. Just to focus in on something that we Page 164

1 discussed earlier, at the point where the service 2 changed in 2004 to be delivered by the board, we were 3 talking about the operating -- it was the acute 4 operating division, I think, operated for a period of 5 time. 6 A. Yes. 7 Q. And in the tables you provided, one can see, effectively 8 at that point, you stop having a table of important 9 people from the trust and a table of important people 10 from the board, but then from 2004 onwards, the tables 11 start to show a table of important people from the board 12 and a table of important people from the acute operating 13 division -- 14 A. Yes. 15 Q. -- which is the operational wing of the board, is that 16 right? 17 A. Yes. 18 Q. And I think, as I mentioned earlier, it was in 2006 that 19 something happened whereby it amalgamated into a single 20 delivery unit. And I think from that point on, you 21 basically just see the board with some executive people 22 in it? 23 A. Yes, so you had two operational units up until that 24 point, the primary care and acute. So the single 25 delivery unit was the merger of both of those together. Page 165	1 which was if we look page 15, please. So this is 2001 2 to 2002, you have there organisation -- this is still in 3 the period between 2004 before it becomes the health 4 board. We notice there on the Tayside University 5 Hospitals NHS Trust board members, if we go over the 6 page, one sees, at the top under box 6, that 7 between April and August of that year, the trust's chief 8 executive was a Mr P White and then the chief executive 9 in August 2001 becomes a Mr G Marr. Now, Mr G Marr is 10 that Gerry Marr? 11 A. That's correct, yes. 12 Q. He then holds, through the various iterations as 13 I understand it, the role of chief executive for 14 a number of years up to 2013, is that right? 15 A. Yes, but when he's listed there, in 2001 to 2002, 16 I think he's chief executive of the trust at the time, 17 and then he subsequently becomes chief executive of the 18 board. 19 Q. Yes, that's correct. So basically he performs the role 20 of the chief executive in whatever is the operational 21 vehicle that's delivering the service; is that correct? 22 A. That is correct, yes. 23 Q. So the changes go on around him, but as we said earlier, 24 some people effectively remain in the same role; is that 25 correct? Page 167
1 So that's still the operational focus of the 2 organisation through the single delivery unit. 3 Q. Understood, thank you. If I -- as I say, you've sent us 4 a very helpful breakdown of the various different people 5 and that's to be found in appendix 2 to the statement. 6 A. Yes. 7 Q. We've gone through these and worked out some of the 8 things that we've talked about already, the fact that 9 certain people remain in post when there are changes, 10 who the main people appear to be. There were a couple 11 of things that I wanted to ask you about more 12 specifically. If we could have a look, please, at 13 NHST-04945. Page 20. If you look at table 21, this is 14 you telling us who were the board members of Tayside 15 health board between 1 April 2003 and 31 March 2004. If 16 we go over the page, please, at the top in box 21, is 17 that you? 18 A. Yes, it is. Yes. 19 Q. Yes, I'm glad I worked that out because I was trying to 20 find your name, but that's your maiden name 21 I'm assuming? 22 A. That's correct, yes. Sorry, it was my previous married 23 name, sorry. 24 Q. And I also wanted to point out another reference -- or 25 I'll ask you a question about one aspect of things, Page 166	1 A. That's correct, yes. 2 Q. One thing that I'd like to point out as well is, if you 3 go over the page, you see, at page 17, this is the board 4 in the year 2001 to 2002, if you scroll down a bit 5 further you see in box 13 that Mr Marr, who is the chief 6 executive of the trust, also sits as an executive member 7 of the board, is that right? 8 A. That is correct, yes. 9 Q. Yes, and does that continue through into effectively the 10 whole way through? Is the person who is the chief 11 executive of the operational vehicle also an executive 12 member of the board? 13 A. Yes, until he becomes the chief executive, yes. 14 Q. Yes, indeed because I think you told us earlier that the 15 model is that the government blueprint tells you how the 16 board is going to operate. It doesn't tell you the 17 details of how the executive side is going to operate, 18 but it does tell you that some of the executives will 19 sit on the board? 20 A. So the blueprint was obviously published in 2019 and it 21 now does specify those executive directors of the board, 22 but at the time, you'll see that there is no nurse 23 director there and the nurse director -- there is, 24 I think, a circular that then sort of dictates there 25 should be a nurse director on the board. Page 168

1 Q. Yes, I wonder if we could look at page 38, please. So 2 this is further on in time. If we go to 37 actually 3 please. This is the year 2013, 2014, by which point we 4 just have Tayside NHS board. 5 A. Yes. 6 Q. And you see all of the various people there, 7 chairperson, vice chairperson, et cetera. If we go over 8 the page to 38, you actually see, at 27, that's where 9 you become Ms Dunning, I think? 10 A. Yes. 11 Q. And if we look at box 21 you see that from 1 April 2013 12 to 1 December 2013 Mr Marr is the chief executive, who 13 is the same person we saw a moment ago? 14 A. That's correct, yes. 15 Q. But then he's replaced during that year by a Ms L McLay, 16 is that right? 17 A. That is correct, that's Lesley McLay. 18 Q. And the information that you've produced here suggests 19 that Mr Marr left on 1 December 2013 and Ms McLay 20 started on the 16th, is that right? 21 A. That is correct, yes. 22 Q. And so there appears to have been a period when there 23 was no chief executive between 2 December 2013 and 24 15 December 2013? 25 A. That's correct and in compiling this, I reminded myself Page 169	1 A. Yes. 2 THE CHAIR: All right, thank you. 3 MR DAWSON: That may be a period in which we have 4 a particular interest for various reasons that I don't 5 need to get into with you. Could I just ask 6 a question -- I asked this of another witness, but we 7 struggled to get to the answer, you might be able to 8 help us with it. 9 When we're referring to the health board, if you 10 like, which is created under section 2 of the 1970 Act, 11 or regulations that are announced by the Secretary of 12 State under section 2, is that something different from 13 NHS Tayside, or is it the same thing? 14 A. I think it is. Tayside NHS Board is Tayside Health 15 Board. "Tayside NHS Board" is the common name, the 16 legal name is still "Tayside Health Board", but when we 17 talk about NHS Tayside, we do talk about the system, the 18 whole system. And NHS Tayside wasn't really a term 19 probably used until the 2000s. When the trusts were 20 there, it was very much Tayside Health Board and the NHS 21 Trusts and then, when the health board became Tayside 22 NHS Board, I think in 2001, and then that's when the 23 term "NHS Tayside" started to be used. And then 24 obviously, when we moved to single delivery unit and 25 then obviously not having a delivery unit, the Page 171
1 by looking at the accountable officer circular which is 2 issued by the Scottish Government because I wondered if 3 we had somebody acting in that period, but the circular 4 dictates that you only have to replace the accountable 5 officer after four weeks of absence. So at the point 6 that Gerry Marr left, the recruitment had taken place 7 regarding Lesley McLay and Caroline Selkirk, who is not 8 mentioned there, she was in the acting capacity. 9 Q. But there was no chief executive at that time? 10 A. No, not under the accountable officer circular. 11 Q. Right, but the person you just mentioned was the 12 acting -- 13 A. (Overspeaking) Was acting, yes. 14 Q. -- for the two-week period that there was no cover? 15 A. That's correct. 16 THE CHAIR: Could I assume -- you may not know the answer to 17 this, in which case just say -- that the recruitment 18 process which resulted in Ms McLay's appointment as 19 chief executive was restricted to that two-week period, 20 or would it be reasonable to assume that it had 21 commenced before then, or do you just not know? 22 A. I don't know but I could find out, but I do know that 23 within that period of two weeks, that the recruitment 24 process -- the interviews took place. 25 THE CHAIR: In that period? Page 170	1 amalgamation of all the services is commonly known as 2 NHS Tayside. But Tayside NHS Board is the board, the 3 legal sort of corporate entity. 4 Q. So is NHS Tayside more a sort of operational name, is it 5 the operational side? 6 A. Yes, yes. 7 Q. Yes. Okay, right. Because obviously it gets quite 8 confusing when you start to talk about people who sit on 9 the board and that's not the board of NHS Tayside, 10 really. The board of NHS Tayside is really the 11 executive side, is that right? 12 A. No, the Tayside NHS Board is the corporate body and it's 13 made up of executives and non-executives. 14 Q. That's not what I said. I said the board of 15 NHS Tayside, which would be the executives. Would that 16 not be -- or is that not a concept that -- 17 A. (Overspeaking) No, we talk about the executive 18 leadership team being below -- so we talk about the 19 board being the board of governance and then the 20 strategic or the executive leadership. But we don't 21 refer to that as a board. 22 Q. Okay, thank you. We can put that away just now. You 23 also answered questions helpfully for us relating to -- 24 we were looking for information about basically 25 corporate structures, groups, committees, working Page 172

1 groups, specialist bodies and other investigatory or 2 decision-making bodies with responsibilities, in 3 particular related to matters of interest to the 4 Inquiry. 5 You've provided some information about some 6 committees effectively that exist and you've provided 7 some details as to what their role is. One body that 8 you told us about was the clinical governance committee 9 and I wonder if you could tell us, the clinical 10 governance committee, what role the committee itself has 11 in the operation of the clinical governance systems that 12 exist within NHS Tayside? 13 A. Okay. So the clinical governance committee's name has 14 changed I think over the period as well. It's often 15 referred to the improvement quality committee and the 16 care governance committee and then again I think the 17 clinical governance committee. So it specifically looks 18 at the governance of the clinical or the patient-facing 19 sort of services. So the board delegates 20 responsibilities to a number of standing committees. So 21 the clinical governance committee is a standing 22 committee of the board, alongside audit and risk, 23 performance and resources, staff governance and the 24 population health committee. So it will concern itself, 25 for example, looking at the clinical sort of risks, Page 173	1 A. Yes. 2 Q. Now, I think one might think that that was coincident 3 with devolution but in fact, I don't think it was. 4 A. No. 5 Q. I think it was the UK Government, the Labour government 6 that decided there would be something called "clinical 7 governance" and as it happens, devolution happened at 8 about the same time, is that right? 9 A. Yes. 10 Q. And I think you told us a moment ago that one of the 11 component parts of this new thing called clinical 12 governance was that effectively that meant that health 13 boards would have a clinical governance committee? 14 A. That is correct, yes. 15 Q. Right, and before that, you've told us, and you've 16 helped us with some documentation from the time, that 17 there were mechanisms which existed before to try to 18 deal with the same sort of territory, if I can put it 19 that way, but they tended to be called quality -- the 20 word "quality" appears in them? 21 A. Yes. 22 Q. There's "quality of care" and that sort of thing. But 23 clinical governance was a new concept that came in at 24 that time and again, it's not connected with the trust 25 system changing or anything at that time? Page 175
1 patient complaints. 2 Q. Right. So I suppose what I'm trying to understand, it 3 has changed in its sort of role over the years? 4 A. It has. 5 Q. I think, broadly, what you told us in the statement was 6 that there was a significant change which took place in 7 around 1999. One might think that that was connected to 8 devolution, but I don't think it actually was connected 9 to devolution. You produced a document to us which 10 shows, effectively, the launch of something called 11 "clinical governance"? 12 A. Yes, that is correct. I think, having worked in the 13 health service prior to that, "clinical governance" 14 wasn't a term sort of used. People talked about quality 15 possibly and quality of services but then that circular 16 introduced the term "clinical governance". Up until 17 that time, the committees had really been around audit 18 and finance and this sort of signal to boards they 19 should be looking at the clinical services equally as 20 that they are looking at the audit and the finances of 21 the organisation. So it made them put into place 22 a governance structure that had a sub-committee 23 dedicated to clinical governance. 24 Q. And that was the result of the 1999 changes that I have 25 just mentioned? Page 174	1 A. No. 2 Q. It's something that was from a UK government policy, as 3 I understand? 4 A. That's correct, yes. 5 Q. So the clinical governance committee, I just want to 6 understand, we've heard that there are -- certainly, in 7 more modern parlance, there are certain people who have 8 responsibility for clinical governance within a system. 9 For example, this came in later but something called 10 a responsible officer which tends to be the medical 11 director in a health board has responsibility for the 12 clinical governance system and we also have heard that, 13 within the system within NHS Tayside, there would be 14 something within -- if we go down the rung to a lower 15 department, say, in the neurosurgery unit, there would 16 be someone who would be in charge called the clinical 17 lead who would be responsible for clinical governance 18 within the unit and would liaise with the responsible 19 officer to make that work. 20 Is that broadly your understanding of how it would 21 work? 22 A. Yes. 23 Q. Because what I'm interested in, is the question of how 24 it is that the clinical governance committee fits in 25 with those individual responsibilities? Page 176

1 A. So the board's clinical governance committee doesn't 2 concern itself with the operational day-to-day. So 3 there's no direct line to that front line, it goes up 4 through the clinical governance structure, through the 5 executive lead for clinical governance which is the 6 medical and the nurse director. So the operational -- 7 the acute services, the operational services, they're 8 responsible for the safe and effective running of their 9 service, and the board is responsible for seeking 10 assurance regarding how that actually happens. So the 11 board isn't managing those services, but they're seeking 12 assurance that they are being managed appropriately and 13 effectively and safely. 14 Q. And there are responsibilities, as I've said, with these 15 individuals. I think my understanding is that, if we 16 look at it from today's position, it would be the 17 medical director and the nursing director. Are they 18 involved in this clinical governance committee? 19 A. Yes. 20 Q. Are they in charge of it? 21 A. Yes. 22 Q. And they report to the board about clinical governance 23 matters and do they use other members on the clinical 24 governance committee to help them make decisions and run 25 that side of the operation? Page 177	1 actual organisation is being run effectively by the 2 executive team. So that's where -- I know it seems 3 complicated, but I think we understand it because we 4 live and breathe it all of the time, but the board is 5 a board of governance and it is around seeking assurance 6 that the service has been run effectively through the 7 chief executive and the chief executive leadership team. 8 Q. As far as the internal workings are concerned, is it 9 always clear what people are doing in this regard? It 10 does sound complicated, but I'm interested in 11 understanding whether that might mean that it doesn't 12 work very well. 13 A. No, I think that -- we have spent a left time under the 14 leadership of our new chief executive actually looking 15 at those functions and defining them and that's 16 obviously led to what we were talking about earlier, you 17 know, the redefining of portfolios to ensure that that 18 is clear and that there is accountability from the chief 19 executive, through her executive leadership team, to the 20 delivery of those services. 21 So, I mean, sometimes I explain it to people you 22 should actually be able to remove the board and the 23 organisation should still be able to operate fully and 24 effectively and safely. The board is there to actually 25 check up to ensure that that is actually happening and Page 179
1 A. So, the committee doesn't run -- so, they're personally 2 responsible and they report to the clinical governance 3 committee. So that's why it's important that everyone 4 at every level of the organisation is part of that 5 process up until the executive level. And then the 6 executive level is reporting to the board and providing 7 assurance. So the board's job is to seek assurance and 8 the executive is to provide the assurance. 9 Q. Who sits on the committee then? 10 A. So the committee is made up of executive -- the nurse 11 director and the medical director and the non-executive 12 members who just recently done an exercise looking at 13 the membership of the committees and that does change 14 from time to time, but basically it's executive 15 directors and the non-executives that are members of the 16 committee because they are board members. 17 Q. And if the medical director and nursing director report 18 to the committee, is that right? 19 A. That's correct. 20 Q. And does the committee then report to the chief 21 executive? 22 A. No, the committee reports to the board. So -- yeah. So 23 we talk about above-the-line governance and 24 below-the-line executive leadership and accountability. 25 So the board is therefore seeking assurance that the Page 178	1 then provide the assurance to the Scottish Government. 2 Q. Yes, I haven't asked you anything about the board. 3 I understand the board's role. What I'm trying to 4 understand is how clinical governance is delivered and 5 the responsibilities of the various people for 6 delivering that on the executive side. We know that the 7 responsible officer, who is the medical director, for 8 example, has certain responsibilities in that role which 9 derive from the law? 10 A. Yes. 11 Q. And there is a committee, as we understand it, that has 12 two executive members and the non-executive members and 13 they have some sort of a role in it. And I'm trying to 14 work -- 15 A. (Overspeaking) Yes, that is a board committee. So -- 16 that is a board committee. So the nurse director and 17 the medical director will have their executive committee 18 as well. So they'll have the means, through their 19 committee, to actually seek the assurance within the 20 organisation to then they can report to the board 21 committee. 22 Q. I understand. So they will have an executive committee 23 involved in clinical governance as well, which is to do 24 with the operation of the system? 25 A. That's correct. Sorry, I didn't make that clear. Page 180

1 Q. So that will have the sorts of people I envisaged, who 2 would be put on that executive committee and would be 3 able to help them and advise them and to work out 4 whether the system is working or not and ultimately, the 5 two that are responsible for this, the nursing director 6 and the medical director, then report to the clinical 7 governance committee which is a board committee? 8 A. That's correct. 9 Q. And in effect, what they are doing there is reporting to 10 the board which is consistent with the general 11 obligation of the executives to report to the board 12 about everything? 13 A. That is correct, yes. 14 Q. And there's no role there for the chief executive, is 15 that right? 16 A. The chief executive delegates to her members of her 17 executive team to take on these functions. I should say 18 the medical director has that responsible officer status 19 which goes with being the medical director and the 20 director of finance will have specific responsibilities 21 regarding his role as well. But ultimately, the chief 22 executive is the accountable officer and discharges that 23 function through her executive leadership team. 24 Q. Okay, the medical director is a creation of statute, 25 I think, from the 1978 Act? Page 181	1 very well. You've answered by telling me about recent 2 changes to try to make it work better. Should we deduce 3 from that that it didn't work very well before? 4 A. I think everything is in context at the time. I think 5 that now there is greater clarity and you can see the 6 line, the direct line from the chief executive through 7 the members of the executive team. Prior to the 8 changes, our executive team was made up of individuals 9 that were direct reports to the chief executive and 10 others. So at times it often was confusing exactly who 11 was accountable. Now there's absolute clarity who is 12 responsible and accountable because of the work we've 13 done around that. 14 Q. Like some of your colleagues, when I ask a question 15 about the way things worked in the past -- and that 16 seems so me to be a legitimate question to you because 17 you have been part of this system, unlike some other who 18 are telling me what they understood the position to be 19 before -- you were keen to try to emphasise the position 20 now. But what I'm trying to understand really is how it 21 worked before that. And if changes have been made for 22 the positive, that's obviously a good thing, but what 23 I'm trying to understand is if there were issues -- and 24 you're telling me, I think, that there were issues 25 around who was accountable so there needed to be extra Page 183
1 A. Yes. 2 Q. And the medical director, I think, acquires responsible 3 officer status through a different legal mechanism, but 4 also a creation effectively of the law? 5 A. Yes. 6 Q. Right, so it would make sense for the medical director 7 to be doing that role because he already has certain 8 responsibilities, so therefore that's why the medical 9 director who is responsible officer gets put in that 10 position, is that right? 11 A. Yeah, but we've also chosen to have the nurse director 12 have responsibilities as well. 13 Q. Yes, because that would be the sort of thing that we 14 discussed earlier as being an executive decision of the 15 chief executive, to think: this would actually be 16 a better way of doing it, so we'll have the nurse 17 director as well. Even though the nurse director does 18 not have those legal responsibilities as responsible 19 officer? 20 A. Yes, because they have other professional 21 responsibilities and accountabilities. 22 Q. Indeed. Does the fact, as you've said there, that there 23 have been changes of portfolios -- I was trying to work 24 out -- I was asking you whether there was a lack of 25 clarity around how all this works and whether it works Page 182	1 clarity put into the system; is that correct? 2 A. That's definitely what we've done, yes. 3 Q. Yes, and that relates to clinical governance as it does 4 to some of the other areas that you've told me about. 5 In particular, areas that have been moved around that 6 used to be part of your portfolio? 7 A. Yes. 8 Q. Understood. What mechanisms existed for monitoring 9 compliance with clinical governance requirements over 10 the period that we are looking at? Was there 11 an evolution of that through the quality system into the 12 clinical governance system into what you now think are 13 the clear accounting systems that exist? 14 A. Yes, you might want to pursue this more with our medical 15 director, but there has always been, I think since the 16 circular came along, clinical governance committees at 17 the operational sort of frontline service, where you've 18 talked about specialist services. So I'm not sure if 19 the clinical governance committee was for specialist 20 services or whether it was for neurosurgery. I think it 21 was probably at the specialist services, so Lynn Smith 22 or James Cotton might be able to help you. 23 But there obviously has been an infrastructure 24 within the operational area where they are actually 25 looking at the risks that they are managing, I would Page 184

1 presume complaints, other information at that level and 2 then that's reported up to the acute services, first of 3 all, operational unit and then to the single delivery 4 unit, and then onwards to the board. So there has been 5 all these layers that that has gone through. 6 Q. And when you're talking there about clinical governance 7 within specialist services, is that the operational side 8 rather than the clinical governance board or committee 9 that we're talking about a moment ago? 10 A. Well, I think the information all generates -- the 11 information that ends up at the board comes from the 12 front line, it's just looked at through different lenses 13 in the organisation, but it is the same information just 14 looked at in different ways for different reasons. 15 Q. Okay, and as far as the remit -- let's stick with the 16 clinical governance committee that you told us about. 17 As far as clinical governance is concerned, what aspects 18 of the operation -- you've mentioned a couple already. 19 For example, would complaints sit within the remit of 20 what it is that they are considering? 21 A. Yes, so again, I think over time they've probably had 22 different sort of focus on what the clinical governance 23 committee has, you know, sort of looked at. So, as 24 I said, it was clinical governance went to improvement 25 and quality committee, and then care governance Page 185	1 as well. 2 Q. Okay. One matter that you helped us with was -- I think 3 you sort of excluded its importance was something to do 4 with local healthcare co-operatives? 5 A. That's correct, yes. 6 Q. What were they, or what was their function? 7 A. So, we were talking about the times of the NHS sort of 8 trust and the purchaser-provider. We also had GP 9 fund-holding services as well, as part of the NHS in 10 Scotland and local healthcare co-operatives were the 11 groups of the GPs coming together. So in Tayside we 12 actually had four, we had one for Dundee, one for Angus 13 and one for Perth and Kinross. And Arbroath and 14 Friockheim decided to also have their own local 15 healthcare co-operative. So it was within the gift of 16 the GPs, how they organised themselves. But it was 17 really a collective of GPs that were involved in GP 18 fundholding at the time. 19 Q. Okay, and given that that was a different area of 20 medicine, your position I think was that this didn't 21 have anything to do with the Inquiry, is that right? 22 A. That's correct. 23 Q. I suppose it could have something to do the Inquiry on 24 the basis that it could be a mechanism through which, 25 for example, issues with neurosurgical services that had Page 187
1 committee and now clinical governance. So the focus on 2 what the committee is looking at is very much dictated 3 at the time by actually the members of that sort of 4 committee. 5 Q. But fundamentally, they're all just the clinical 6 governance committee which is a recognised thing that 7 exists, that came from the 1999 period. They're calling 8 themselves different things but they have the same 9 responsibilities, broadly, don't they? 10 A. Yes, but I think that probably over the time there's 11 been maybe different emphasis of what they've maybe 12 spent their time doing and looking at and paying due 13 attention to. 14 Q. So there's not a set list of things that the clinical 15 governance committee needs to keep its eye on? 16 A. Not like a tick list. They're broadly the areas that 17 should be looked at. 18 Q. So do they look at complaints? 19 A. Yes. 20 Q. Do they look at the risk management, the adverse 21 incident management systems we discussed earlier? 22 A. Yes, but you are probably better pursuing this more with 23 our medical director because I'm having difficulty 24 recalling the exact reports that come. So from over the 25 period of time, the reporting mechanism sort of changed Page 186	1 been encountered by the GPs may have been discussed? 2 A. Yes, I think so. I think you're probably right in 3 picking that out because, in looking at I think the 4 structures at the time, there was a number of key 5 individuals I think within acute services that liaised 6 with the local healthcare co-operative. So that would 7 be a conduit that would allow the GPs to have the direct 8 contact with somebody from acute services to talk about 9 issues that they were having if they wished. 10 Q. Yes, because I think you mentioned the NHS Tayside LHCC 11 liaison directorate, is that what you are just 12 mentioning there? 13 A. I don't think there was such a directorate as such, as 14 individuals within the directorates had responsibilities 15 for liaising with the different LHCCs. So I think, for 16 example, in some of the information I looked at there 17 was a Dr Mike Jones and I think he liaised with one of 18 the LHCCs and then somebody with another, but obviously 19 it did give the conduit for acute services to actually 20 be able to be asked about acute services by GPs that 21 were involved in GP fundholding. 22 Q. So it could have been a mechanism by which -- because 23 obviously there would be situation where is people would 24 be referred. We looked at something this morning 25 actually where Mr Eljamel was complaining about the Page 188

1 system whereby GPs could get access to radiology, decide 2 what they thought was going wrong in a neurosurgical 3 sense and effectively refer people on, having made 4 an initial diagnosis. So people would end up at the 5 hospital for neurosurgical service through GPs. So 6 therefore these GPs, through these local committees, may 7 have been in a position to be able to report issues that 8 their patients had experienced with that service and 9 that would go to acute services? 10 A. Yes, I think back in the time that would have been the 11 case through GP fundholding. 12 Q. Understood. You also helped us with some information 13 about NHS Tayside medical ethics committee and told us 14 about the fact that it was a committee which looked at 15 ethical issues arising relating to research, clinical 16 trials, that sort of thing; is that right? 17 A. That's correct, yes. 18 Q. You managed to find out for us that Mr Eljamel himself 19 had been a member of -- I think you told us that there 20 were, at one stage, two committees; is that right? 21 A. Yes, it's quite complicated, I think, what happened 22 around the medical research ethics. But I think it was 23 in line with wider, national governance arrangements. 24 But the committees did then -- I think there was two 25 committees and then they went into one committee and Page 189	1 Q. Was that because there was a conflict of interest? 2 A. That is correct, yes. 3 Q. So he had applied to the committee of which he was 4 a member and then somehow someone had noticed and they 5 said: oh, it would be better to go to the other 6 committee; is that right? 7 A. Yes, I think he would have made the application, 8 somebody probably allocated it to the committee and then 9 they realised there was a conflict and that was dealt 10 with and reassigned. 11 Q. I see. Are there any issues that you can think of to do 12 with people sitting on an ethics approval committee who 13 are, as frequently as someone as Mr Eljamel, who is 14 obviously involved in quite a lot of research projects, 15 making applications to them? 16 A. I think not as long as the good governance is being 17 observed which we have an example there that there 18 wasn't a conflict of interest. I think it probably can 19 help by having front-line clinicians on these committees 20 because they can bring the reality and they can take 21 learning back to the workplace as well. So as long as 22 the good governance is observed then I don't see 23 an issue. And that demonstrates it was at that time. 24 Q. But these are committees that are involved in making 25 quite important decisions about effectively experimental Page 191
1 then it went into kind of consortium basis as well. But 2 for a time he was a member of one of the medical 3 research ethics committees. 4 Q. I think you told us he was that between July 2009 5 and July 2013, is that right? 6 A. I think that's correct, yes. 7 Q. Was there any information as to why he left the 8 committee? 9 A. No. 10 Q. You also told us about the fact -- you gave us 11 information actually about a number of applications that 12 had been made by Mr Eljamel himself in connection with 13 projects that he was to be involved in, I think usually 14 as the principal investigator or whatever it was called. 15 And he was making an application to the ethics committee 16 for ethics approval, is that right? 17 A. That's correct. 18 Q. You've actually given us a table, I think? 19 A. Yes, some was before he was a member, and some was at 20 the time he was a member. 21 Q. Indeed, and one particular application you told us about 22 that was initially submitted to the committee of which 23 he was a member but then was moved to the other 24 committee's responsibility, is that right? 25 A. That's correct. Page 190	1 or potentially sometimes quite dangerous areas of 2 medicine, is that right? 3 A. I think it's looking to make sure the ethics -- it's not 4 actually deciding whether the research should go ahead 5 or not, it's actually making sure, where there's 6 patients involved, that all the ethical obligations have 7 been undergone. So it's not actually approving whether 8 something will happen or not, it's actually looking at 9 the impact on the patients and making sure that all of 10 the patient-related aspects have been dealt with. 11 Q. But the ethical side of things that one is looking at 12 relates to making sure that all of the high standards 13 are maintained? 14 A. Yes. 15 Q. So effectively those high standards are about trying to 16 make sure all the various rules are followed, patients 17 know exactly what's going on, that they're told they're 18 allowed to withdraw and all that kind of thing? 19 A. Yes. Regarding patients. 20 Q. So therefore, there is an element of approval to the 21 extent the ethics committee sets down this is what the 22 rules have to be to do this. 23 A. Yes. 24 Q. They're very stringent and make sure they're followed 25 properly, is that right? Page 192

1 A. That is correct, yes. 2 Q. And so in these sorts of circumstances, might it be said 3 that there is potential issues around having someone on 4 a committee, albeit there are two committees, on 5 broadly, the ethics committee who is making so many 6 applications because it might be suggested they have 7 a conflict relating to their interest in trying to get 8 the project up and running, as against the fundamental 9 purpose of the committee which is to make sure that 10 everything is done correctly? 11 A. Well, they wouldn't be looking at their own application. 12 They would be applying the due diligence to other 13 applications along with the other members of the medical 14 research things committee who -- I don't have the 15 membership in front of me, but does come from a number 16 of different backgrounds. And I think it's probably 17 important to always have somebody from the front-line 18 clinical services, so that they can bring the reality 19 maybe of some of the issues that have to be sort of 20 dealt with. And I think as long as that committee isn't 21 dealing with those applications regarding that 22 clinician, then it should be making safe decisions. 23 Q. Okay. Could I ask you -- could we go to paragraph 20.1 24 of the statement, please. We asked the question: 25 "What questions, if any, were raised about the Page 193	1 provide that information to the Inquiry if you so wish. 2 So there was a predecessor group prior to this final 3 report group that I have subsequently found. 4 Q. Where did you look for documentation relating to this 5 question? 6 A. So in this question I looked within the organisational 7 memory of the organisation and then did actually some 8 online searching and it was actually in preparation for 9 today, again, going online, that I came across that 10 there had been a needs assessment. But it wasn't within 11 the records that we held within the organisation. 12 Q. I'm not sure I really understand what you mean when you 13 looked into the organisational memory. I mean 14 physically, where did you look? 15 A. Sorry, within the records of the two trusts and the 16 board. So into the physical records from the two trusts 17 and into the electronic documents store. 18 Q. Okay, and so you say that have now found a previous 19 report to do with a needs assessment, is that right? 20 A. Yes. 21 Q. So could you tell us a little bit about what the format 22 of that is -- just before we do that, it might be useful 23 to say you've directed us towards a report from around 24 2008 which is the document that's numbered there, 25 NHST-04433. That report, as I understand it, is to do Page 195
1 viability of maintaining a neurosurgical unit within 2 NHS Tayside in the context of a re-structuring of 3 neurosurgical services in Scotland over the relevant 4 period?" 5 And you answered this question, I think, and said: 6 "NHS Tayside does not have any organisational 7 memory, evidence or documentation to provide a response 8 to the above question. However, NHS Tayside are aware 9 of a report titled 'Final Report of the Neuroscience 10 Implementation Group' authored by the Neuroscience 11 Implementation Group, which was chaired by 12 Mr John Glennie Chief Executive, NHS borders (as at the 13 time of the report's publication in around 2008). The 14 Inquiry may wish to core this report and its findings in 15 relation to this question ..." 16 Why did you answer this question? 17 A. I think because, again, none of my colleagues were 18 around at the time and we had to look into the 19 organisational memory of the organisation which is the 20 records that the organisation holds. In re-looking at 21 this in preparation for today, I have come across that 22 prior to this final report, there was actually a needs 23 assessment that was undertaken and I think John Glennie 24 was involved in this needs assessment and actually 25 Mr Eljamel was involved in that group as well. So I can Page 194	1 with what ultimately led to something called the managed 2 service network for neurosurgery? 3 A. That is correct. 4 Q. Which we discussed actually earlier today. Effectively 5 it's people getting around and not actually defining 6 what the problems with neurosurgery are, but deciding it 7 would be better to have one service, which I think came 8 in around 2009, 2010, which was involved in trying to 9 standardise and, I think ultimately improve, 10 neurosurgical services. What it doesn't tell us is why 11 they're doing that. Does the needs assessment tell us 12 that? 13 A. So the needs assessment looks, I think, at the actual 14 services and what the state of those services were. So 15 it provides, I think, the evidence for this group to 16 properly come to their conclusions. 17 Q. Well, the answer to the question is we would very much 18 like to see that and, in fact, that sort of information 19 is precisely what the question was directed at because 20 we looked at some information this morning, at least it 21 was a written account from Mr Eljamel himself, that 22 outlined the fact that the provision of neurosurgical 23 services in Tayside had, since he arrived in 1995, been 24 in what might reasonably describe as a powerless state. 25 And we were interested in understanding, when asking Page 196

1 this question, why it was that, for example, the managed 2 service network came in. In the document you've just 3 told me about for the first time, will we find in that 4 document an analysis of how powerless a state the 5 neurosurgical service in Tayside was? 6 A. I'm not sure you'll find that information in that 7 detail. I think what you'll find is across -- I think 8 it's across the whole of sort of Scotland, the kind of 9 the service provision. But it probably doesn't come to 10 that detail necessarily around Tayside, but I would have 11 to check that totally for you. 12 Q. And there is no other documentation that you were able 13 to find which explained or set out any issues that 14 existed with regard to the viability of the 15 neurosurgical service in Tayside over the period in 16 which we're interested? 17 A. Not within the physical documents that we looked at and 18 in our electronic document store and the searches that 19 we did. This is what we came up and, as I say, it was 20 only by re-looking at this again that I found that 21 previous report. 22 Q. Are there other people that might know more about this, 23 for example, maybe Mr Marr who was the chief executive 24 at the time? 25 A. I think that that would -- you know, individuals that Page 197	1 Were others not looking in the historical records? 2 A. Yes, they were but I took on to do this question as 3 somebody earlier talked about the division of labour. 4 So I said I was happy to do that. 5 Q. Yes, okay. It sort of stood out as one that didn't seem 6 to fit in with the other questions you were answering. 7 Would it not have been more for Lynn Smith as the head 8 of acute services to cover this? 9 A. Possibly, possibly. 10 Q. Because she provides evidence about the neurosurgical 11 service. All the questions she's answered are to do 12 with that. 13 A. Yes, and she was also in the organisation at the time, 14 so that's somebody else you may wish to speak to about 15 this. 16 Q. But as far as being in the organisation at the time is 17 concerned, you were in the organisation at the time we 18 were looking at, at least from 2002 I think. 19 A. Yes. 20 Q. But you've told us that you don't actually have any 21 direct involvement in any of this. So you'd be no 22 advantage to anybody in searching the materials, would 23 you? 24 A. That's a good observation. 25 Q. Yes, I'm just slightly -- Page 199
1 were in key positions within NHS Tayside or NHS Scotland 2 at the time would be able to give you more detail 3 regarding this certainly. 4 Q. Okay, the medical director of the time might well know 5 about it because, as I understand it, the person that 6 you would go to if, like Mr Eljamel, you were 7 considering that the service you were providing with as 8 in a powerless state, to try and improve it by, for 9 example getting more staff or better facilities, would 10 be the medical director, is that right? 11 A. That is correct. I think in the time of the 12 purchaser-provider split, when we had trusts and we had 13 the board, some of those conversations would have been 14 through the contracting process, where the board were 15 saying to the trust: this is what we want you to provide 16 and the trust were agreeing, whether or not they could 17 actually provide what the board was -- so, the board was 18 planning the services for the population of Tayside and 19 the trusts were actually providing, responding to what 20 the board was looking for. But, as I say, obviously 21 those contracting processes ceased with the internal 22 market. 23 Q. Okay. I wondered why -- again, so your answer as to why 24 you answered this question was because of the fact that 25 you were looking in some of the historical records. Page 198	1 THE CHAIR: (Microphone off) Except that (inaudible) to do 2 so. 3 MR DAWSON: I'm just slightly concerned, how was it that 4 this needs assessment came to light? 5 A. I can't answer that question. I think it was 6 obviously -- it's a very specialist area, isn't it, 7 neurosurgery, so -- 8 Q. No, sorry, I mean you told us that you had found it 9 subsequent to answering the question. How did you find 10 it? Where did it come from? 11 A. I can't actually remember, to tell you the truth, sorry. 12 Q. Right, did you undertake some further search? 13 A. Oh, the needs assessment, yes. Sorry, the needs 14 assessment, yes. As I was refreshing myself around -- 15 about coming here today, that I went online and did some 16 searching and that's when I came along the needs 17 assessment. 18 Q. Right, so it's publicly available? 19 A. Yes. 20 Q. Right, so there haven't been any further searches 21 amongst the Tayside paperwork or anything like that? 22 A. No. Because at the time it was quite extensive, so 23 yeah. 24 Q. Okay. You also answered questions that we asked about 25 the data protection systems. Page 200

1 A. That's correct. 2 Q. I think that, as it happens, you've now moved on from 3 that role, is that right? 4 A. That's correct, yes. 5 Q. So that's been taken on by, was it the -- 6 A. Director of corporate affairs. 7 Q. Director of corporate affairs, rather than the director 8 of finance who had the risk-related role? 9 A. That's correct. 10 Q. That's helpful, thank you. So the data protection 11 regime obviously involves there being a number of 12 obligations on organisations like NHS Tayside to comply 13 with the various legal provisions to do with data 14 protection, is that right? 15 A. That's correct. 16 Q. And just to understand, obviously if things have changed 17 slightly recently, we may need to work out who does 18 this. But what was your responsibility for that, when 19 you were in the previous role a few months ago? 20 A. So I was responsible for the policy framework, to ensure 21 that NHS Tayside had a policy to comply with the Data 22 Protection Act. Also responsible for the information 23 governance team which dealt with non-clinical subject 24 access requests, so any sort of patient health 25 record-related subject access requests would go through Page 201	1 they've been changed from time to time to do with 2 changes in the law, for example the Data Protection Act, 3 coming in more recently 2018, GDPR and that sort of 4 thing? 5 A. Yes, there have been a number of changes to the data 6 protection policy during the relevant period, as you 7 say, in line with the changes around the legislation in 8 that area. 9 Q. And broadly the way that the system works, I think, is 10 that organisations have to have systems in place in 11 order to be able to comply with various principles that 12 exist within the data protection law, is that right? 13 A. That's correct. And another responsibility of the 14 information governance team is that's where the 15 organisation's data protection officer sits. So we have 16 to have a recognised data protection officer and the 17 organisation also provides the data protection advice to 18 GPs as well. GPs are their own individual data 19 controllers, but the organisation provides the GPs with 20 that advice that they require. 21 Q. Right, and so who is the data protection officer then? 22 A. For NHS Tayside? 23 Q. Yes. 24 A. At the moment it's our head of information governance 25 and cyber assurance -- Page 203
1 the health records team, but any that weren't 2 specifically regarding health records would come to the 3 information governance team. 4 Q. Again, this is difficult to follow if you go through the 5 process of trying to work out who answered which 6 question. 7 A. Correct. 8 Q. Because this appears to be split amongst various 9 different people. Somebody else answered the questions 10 about subject access requests, for example? 11 A. That's correct because the majority of subject access 12 requests within the organisation do come in through the 13 health records department. 14 Q. Right, so there at least was a split between 15 responsibility for data protection issues on the 16 corporate records side and then the medical records 17 side, is that right? 18 A. Yes. So my responsibility was to ensure that there was 19 a policy and a framework in place and then the 20 individual teams were responsible for enacting that. So 21 the health records team would be responsible for 22 answering the subject access requests in line with the 23 principles set out in the Data Protection Act. 24 Q. And you set out various documents which cover the 25 policies in this area and I think you tell us that Page 202	1 Q. Right, so does that sit under the -- which -- 2 A. So now it's a direct report of our director of corporate 3 affairs. It was my direct report previously, yes. 4 Q. I see, and the data protection officer is a recognised 5 statutory function that requires to do various things? 6 A. That's correct, yes. 7 Q. Yes. So as far as these principles are concerned, these 8 principles and systems which serve them require to do 9 things like organisations like NHS Tayside making sure 10 that data, i.e. information that they hold, is accurate 11 and up to date, that's one of them? 12 A. That is correct. 13 Q. And one of them is that data must be held on the basis 14 of specific -- for a specific purpose that's recognised 15 in law? 16 A. That is correct. 17 Q. And one of the principles is called the data 18 minimisation principle which I think means that you must 19 hold and process data only insofar as necessary? 20 A. That is correct. 21 Q. So that would mean, I think, that if you have data 22 contained within paperwork or something, only the people 23 that need to see that data and use that data see it but 24 other people do not? 25 A. That's correct, yes. Page 204

1 Q. Yes, and there are other things that are included within 2 it. For example, there's a principle to do with storage 3 limitation which is you shouldn't keep it longer than is 4 necessary? 5 A. Yes. 6 Q. And there are also provisions relating to having to have 7 systems which maintain the integrity and confidentiality 8 of data? 9 A. Yes, and security, yes. 10 Q. Yes, indeed. And one of the other important principles, 11 in particular for organisations like NHS Tayside, is 12 that they have to be accountable for the systems that 13 they have, is that right? 14 A. Correct. 15 Q. And if things go wrong with these systems, that can be 16 called a data breach, is that right? 17 A. That is correct. 18 Q. And I think ultimately, the information commissioner can 19 become involved if there are problems in that regard, if 20 things go wrong? 21 A. That's correct and there is an obligation to report to 22 the information commissioner as well. There's 23 a threshold for reporting. 24 Q. Yes, the threshold, I think, is to do with how 25 significant the breach has been? Page 205	1 right, so corporate information? 2 A. That is correct. 3 Q. So you weren't responsible for those data breaches or 4 dealing with them, somebody else was? 5 A. Well, the information governance team is responsible for 6 putting in place the information governance framework 7 for the organisation. So I did take responsibility for 8 that, yes, and looked at the causes of that. 9 Q. Yes, because one of the things that there is an interest 10 in and I think it relates to -- my interpretation is it 11 relates to the data minimisation principle, is the 12 possibility that medical records of patients, in 13 particular Eljamel patients, have been accessed by 14 people within the board for effectively the board's 15 purposes without telling the patients that they have 16 been accessed. So for example, for examining records to 17 do with particular discrete aspects of care or something 18 like that in order to be able to provide responses to 19 inquiries or in other investigations, effectively whole 20 sets of medical records have been sent to executives. 21 Is that something that should happen, given of 22 course, that someone's medical records, whether that's 23 now a physical bundle or an electronic bundle, will 24 include an awful lot of things, other care they've had 25 in other areas not related to neurosurgery, for example, Page 207
1 A. Yes, I think the information commissioner provides 2 a tool to allow organisations to be able to assess data 3 breaches, to see if they're reportable. 4 Q. Yes, and so there's a point at which a data breach, when 5 it gets over that threshold, becomes reportable. Would 6 that, from the corporate side, have been the sort of 7 thing that you would have had to have become involved 8 in? 9 A. That is correct, yes. 10 Q. We've heard evidence and we're aware of the fact that 11 there have been a significant number of well publicised 12 data breaches within NHS Tayside. I think most of those 13 have been more on the other side of the fence from where 14 you were, is that right, to do with patient medical 15 records and information, that sort of thing? Have I got 16 right, just where the responsibility sits? 17 A. Yes. There were data breaches involving patient 18 identifiable information. 19 Q. Indeed. 20 A. And the numbers of the patients involved as well made 21 them significant, yes. 22 Q. Yes, but I'm just trying to understand, in terms of the 23 responsibility for those as I understood it, you've now 24 moved on from that role but your responsibility was in 25 relation to non-medical record information, is that Page 206	1 which would not be necessary for that person to look at 2 the neurosurgical care? 3 A. I am not aware of that happening and I wouldn't have 4 expected that to happen. There should be a legitimate 5 reason for somebody to access records, you know. So if 6 somebody was investigating a complaint or something that 7 had sort of gone wrong, then there would be legitimate 8 reasons for doing that, but that would be within 9 probably the clinical services. I wouldn't have 10 expected records to have gone to individuals that have 11 no reason to have them. 12 Q. So, to be clear, I'm talking about records going to 13 people at the executive level rather than a complaints 14 department or something. Can you imagine why that would 15 be necessary? 16 A. No, I cannot. 17 Q. And even if it were going to someone in the complaints 18 department, in accordance with the data minimisation 19 principle, would it not be the case that the person 20 would have to look at only the records that were 21 relevant to the complaint or the matter that was being 22 looked at? 23 A. You would need to probably take this up with somebody 24 that deals with the complaints department but I wouldn't 25 have even have thought that the complaints department Page 208

1 would need to actually see the records either because 2 they are actually administering the process of getting 3 a response to the complaint and making sure that that is 4 in order. They're not actually writing the response. 5 Q. Thank you very much, that's helpful. Just to be clear, 6 so I have the right people, are these aspects we 7 discussed at the beginning before you came in that some 8 of the questions had in fact been answered by you 9 originally, or we thought had been answered by you but 10 in fact were answered by Sandra MacLeod, is this an area 11 that's really your area to talk about or is this an area 12 that she also can talk about? 13 A. I think probably she can also talk about it. So my 14 role, up until 1 April, was about ensuring that there 15 was a policy framework across the whole organisation 16 relating to how we manage records and information, but 17 the specifics regarding health records or medical 18 records are completely separate. So there is a specific 19 health records policy regarding how health records, 20 medical records are sometimes called case notes -- they 21 have different terms -- are managed. So that's where 22 the split of the responsibility is. 23 Q. I see and so the overall policy would have been 24 previously for you, but there are specific rules 25 relating to health records that would be Page 209	1 THE CHAIR: Thank you, Ms Dunning. We take, at this point 2 in time, one final break and the reason for that is just 3 to check that there aren't any further questions that 4 other participants may wish to have put through Counsel 5 to the Inquiry. So if you could just bear with us, 6 we'll be ready to resume again shortly. 7 A. Yes, thank you. 8 THE CHAIR: Okay. 9 (4.24 pm) 10 (A short break) 11 (4.39 pm) 12 MR DAWSON: Nothing further, sir. 13 THE CHAIR: Nothing further. 14 Well, Ms Dunning, you'll have gathered that that now 15 brings your evidence session to an end. There are no 16 further questions. Just before Miss Miller takes you 17 out of the hearing room though, I'd like to thank you, 18 if I may, for your attendance here this afternoon, for 19 sharing your insights and reflections and your evidence 20 generally on the matters which you were asked about. 21 As I've said to other witnesses, I'm also conscious 22 that giving evidence at the hearing is only part of what 23 we asked you to do and that means that I would also like 24 to extend the thanks of the Inquiry and indeed my 25 personal thanks for the efforts you've made to Page 211
1 Sandra MacLeod's area, is that right? 2 A. That's correct, yes. 3 MR DAWSON: I understand, that's very helpful. Sir, I have 4 no further questions. At this stage I always invite the 5 witness, is there anything further you would like to add 6 to the evidence you've already given? 7 A. Obviously working in NHS Tayside as long as I have, this 8 has been a really significant sort of issue for us and 9 I know that behind all of our discussions today and all 10 the work that we have done, that there is patients and 11 families that have been profoundly affected sort of by 12 this. I recognise the role of the Inquiry to seek to 13 find out what has happened and for us to be able to take 14 those findings and to learn lessons for the future. And 15 I just want to make a commitment to all of the patients 16 and their families and to the Inquiry that if I can help 17 in any further way, that I will do so and just thank 18 you. 19 MR DAWSON: Thank you very much. Just on that point, the 20 matter we discussed earlier about the needs assessment 21 that you helpfully found for us online, it would be 22 extremely interesting for us to see that, so if you 23 could submit that through the normal channels, that 24 would be very much appreciated. Thank you. 25 A. Thank you. Page 210	1 contribute to those parts of the statement for which you 2 assumed responsibility and for looking out the 3 associated documents. So with all of that, and with my 4 thanks, you're free to go. 5 A. Thank you, sir. Thank you. 6 Housekeeping 7 MR DAWSON: Sir, there's just one further administrative 8 matter relating to the evidence for next week. 9 Obviously, we had scheduled to hear from 10 Ms Caroline Lamb to speak on behalf of the Scottish 11 Ministers yesterday afternoon, but there was 12 insufficient time to do so. There have been some 13 discussions that have taken place in the background and 14 I understand that Ms Lamb has kindly made herself 15 available to come and give evidence on Wednesday 16 afternoon next week. That's something that's already 17 been communicated to core participants but obviously, as 18 there are people who take an interest in our proceedings 19 beyond the core participant group, that is an update 20 which may interest some people who are interested in her 21 evidence, which will be heard on Wednesday afternoon 22 next week. 23 There may be minor, consequent changes to the 24 programming, but core participants will be updated as 25 soon as decisions are made in that regard. Page 212

1 THE CHAIR: All right. And of course, for the benefit of 2 all, we're not, of course, sitting at any point on 3 Monday. So I will look forward to seeing you all again 4 on Tuesday at 10 o'clock. I wish you a good weekend in 5 the meantime. Thank you. 6 (4.41 pm) 7 (The hearing adjourned until Tuesday, 8 29 September 2026 at 10.00 am) 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 213	
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