

1 Tuesday, 29 September 2026 2 (10.00 am) 3 (Proceedings delayed) 4 (10.22 am) 5 THE CHAIR: Thank you. Good morning. Apologies to 6 everybody for the slight delay in starting. Technical 7 reasons have conspired against a prompt start, but 8 I think, Mr Dawson, are we ready to resume? 9 MR DAWSON: Certainly, sir. The witness for today is 10 James Cotton. 11 THE CHAIR: Thank you. 12 DR JAMES COTTON (sworn) 13 Questions by COUNSEL TO THE INQUIRY 14 MR DAWSON: Good morning, Dr Cotton. Apologies for the 15 delay. It was due to an administrative issue in the 16 background. You are James Cotton, is that correct? 17 A. That's correct. 18 Q. I understand that you are the executive medical director 19 of NHS Tayside; is that correct? 20 A. That's correct. 21 Q. And were you involved in the completion of a witness 22 statement for this Inquiry in response to a Rule 8 23 request which the Inquiry had sent to the board? 24 A. That's correct. 25 Q. Could we have a look, please, at NHST-04944. Page 1	1 right? 2 A. Yes. 3 Q. Why was that? 4 A. Because we understood that only one person from the 5 executive could sign it. 6 Q. And why was it you? 7 A. Because I was asked to be the executive lead on behalf 8 of NHS Tayside to co-ordinate the response to the 9 Rule 8. 10 Q. Right, so you co-ordinated it but you're not the chief 11 executive of the board are you? 12 A. No, I'm not. 13 Q. Was consideration given to it being signed by Ms Connor? 14 A. I don't recall that discussion. 15 Q. Okay. Dr Cotton, we've heard some evidence given on 16 behalf of the patients of Mr Eljamel that they consider 17 that the way in which NHS Tayside has dealt with matters 18 relating to Mr Eljamel and the systems around him amount 19 to a cover-up. Are you covered in a cover-up? 20 A. No. 21 Q. Are you sure? 22 A. Yes. 23 Q. Have you ever given any consideration as to whether you 24 might be? 25 A. No. Page 3
1 Is that the statement which was produced on behalf 2 of the board? 3 A. Yes, that is. 4 Q. And it runs in your name, isn't that right? 5 A. Yes. 6 Q. Could we have a look, please, at page 273. The 7 statement is dated 8 June 2026, is that right? 8 A. Yes. 9 Q. And it is signed by you, is that right? 10 A. Well, this doesn't have a signature on it, but, yes, it 11 was. 12 Q. But is the statement signed by you? 13 A. Yes, it was, yes. 14 Q. And as far as you are concerned are the contents of the 15 statement true? 16 A. Yes. 17 Q. I understand that the way in which the statement was 18 compiled -- we've heard from some of your colleagues, 19 that the statement was compiled by way of certain 20 contributions having been made by different people based 21 on an allocation of the appropriate questions to 22 appropriate people based on their responsibilities 23 within the executive team, is that right? 24 A. That's correct. 25 Q. But you were the one who signed the statement, is that Page 2	1 Q. You've never given that any consideration? 2 A. Sorry, could -- 3 Q. I asked you whether you'd ever given any consideration 4 to whether you might be involved in a cover-up? 5 A. No. 6 Q. In multiple places in your statement you decline to 7 answer questions and tell us that we would be better 8 posing them to other people, is that right? 9 A. Correct. 10 Q. And in multiple places you tell us that those questions 11 would be better posed to former members of staff of 12 NHS Tayside, is that right? 13 A. That's correct. 14 Q. And in multiple places you tell us that you cannot 15 answer questions because documents that might assist you 16 to do that are no longer available, is that right? 17 A. There's no evidence that would allow me to be able to 18 answer the question that I could see to be able to 19 provide an answer to the question. 20 Q. Yes and in multiple places you tell us that you can't 21 answer the question because documents which might help 22 you answer the question are not available to you, is 23 that right? 24 A. Correct. 25 Q. And in multiple places you tell us that documents which Page 4

1 might have been available at one stage are not available 2 because they've been destroyed in accordance with 3 document retention policies, is that right? 4 A. I believe so, yes. That's correct. 5 Q. And when you say you "believe so", do you know that they 6 were destroyed in accordance with the policies? 7 A. Sorry -- 8 Q. Just let me finish the question, please. Do you know 9 that they have been destroyed in accordance with the 10 policies or are you just assuming that that's the case? 11 A. So I only had the available documents to me that we had 12 retained. If they didn't exist then either they never 13 existed or they had been destroyed in accordance with 14 retention policies. 15 Q. But do you know that they were destroyed in accordance 16 with the policies or are you just assuming, based on the 17 fact that such policies exist, that that's the case? 18 A. In some cases I think it would be a reasonable 19 assumption. 20 Q. But you are assuming that? 21 A. There will be an assumption in there, yes. 22 Q. Thank you. And you repeat in the questions that you 23 answered -- which in particular relate to investigations 24 that happened in the past, you repeat the positions that 25 NHS Tayside has adopted in the past, is that right, in Page 5	1 Q. Why would a cover-up be unacceptable? 2 A. Because it's fundamentally against the -- well, (a) the 3 duties of a doctor, the principles of that, and 4 transparency and public life, against the 5 Nolan Principles that would be fundamentally 6 unacceptable. 7 Q. So from whom would it be unacceptable to cover up 8 information? 9 A. The public. The people that we look after and serve. 10 Q. Yes, so the public in the area that you serve in 11 Tayside? 12 A. No, the public. 13 Q. The general public? 14 A. Absolutely. 15 Q. Okay. And the obligation not to cover up information to 16 be open, as you've said, I think you're telling us, 17 derives at least from two sources, as far as you're 18 concerned. I think you're telling us about the 19 Nolan Principles, so it derives from -- those are 20 principles I think that relate to the way in which 21 people who are in public office should conduct 22 themselves, is that right? 23 A. Correct. 24 Q. And you told us, for you at least although perhaps not 25 for some others, there are also similar principles which Page 7
1 places? 2 A. In places, yes. 3 Q. And you sometimes repeat the positions of NHS Tayside in 4 the past which emanate from investigations which have 5 been criticised as flawed, is that right? 6 A. Yes. 7 Q. Is it possible, do you think, Dr Cotton, that by 8 approaching the answers to the questions that you 9 addressed in that way, that you're merely repeating the 10 mistakes of the past and sustaining what some patients 11 at least describe as a cover-up? 12 A. Sorry, can you repeat that question? 13 Q. Certainly. Is it possible that by approaching the 14 Inquiry in this way you are merely repeating the 15 mistakes of the past and sustaining what some patients 16 at least describe as a cover-up? 17 A. So the answers were provided against the available 18 evidence that we had, so that was the only -- best way 19 of answering the question. 20 Q. Okay. And if the Chair of the Inquiry were to decide 21 that predecessors of yours and other predecessors from 22 the executive team were involved in a cover-up you would 23 merely, by adopting the approach that you have adopted, 24 be sustaining that cover up, wouldn't you? 25 A. Well, a cover-up would be unacceptable. Page 6	1 derive from your professional obligations as a doctor? 2 A. Correct. 3 Q. Do you know what "obfuscation" is? 4 A. It would be helpful if you could explain that to me. 5 Q. Obfuscation is the action of making something obscure, 6 unclear or unintelligible. Do you understand? 7 A. Yes, I understand that, yes. 8 Q. Are the positions of NHS Tayside on matters which fall 9 within the remit of this Inquiry in the statement always 10 clear? 11 A. I believe they're as clear as they could be. 12 Q. Sorry, carry on. 13 A. No. 14 Q. Are they always intelligible? 15 A. I believe there's an attempt to make them as 16 intelligible as possible. 17 Q. Are they obscure? 18 A. I believe they're not intended to be obscure. 19 Q. If it were concluded that they were obscure, unclear, or 20 unintelligible it would be reasonable to conclude that 21 there may be obfuscation going on, is that fair? 22 A. That's the definition that you've given to me. 23 Q. Is there obfuscation going on? 24 A. I think, based on my previous answers, no. 25 Q. Thank you. Could we have a look, please, at the Page 8

1 statement at paragraph 2.4. I think, as I understand it 2 from other witnesses, the passages that are here were 3 prepared by the individual to whom they relate, is that 4 right? 5 A. Correct. 6 Q. So you provided some information about your own 7 background and your role and that sort of thing? 8 A. Yes. 9 Q. You say here: 10 "I am Dr James Cotton, MBChB, FRCP ..." 11 We've come across these initials before with 12 a number of other people: 13 "I am the Executive Medical Director for 14 NHS Tayside, Responsible Officer ... and an executive 15 member of NHS Tayside Board. I qualified from the 16 University of Dundee in 1996. I was appointed 17 a Consultant Gastroenterologist in 2006 within 18 NHS Tayside. I have been the Executive Medical 19 Director, [responsible officer], and executive board 20 member for NHS Tayside since 2024. 21 "I do not and have never practised clinically within 22 the neurosurgical department within NHS Tayside. 23 However, as Executive Medical Director and RO, I do hold 24 overall responsibility for the clinical practice of 25 doctors working within the Neurosurgery department Page 9	1 cover the services offered in the hospital, is that 2 right? 3 A. Yes. I can explain that, if that will be helpful. 4 Q. That will be helpful. 5 A. So in a healthcare system as it currently stands there 6 are different parts of the system, so you will -- so 7 there are community-based services, so general practice, 8 community mental health services, et cetera, all sit 9 within the community. 10 Acute services is the hospital-based services 11 predominantly around acute admissions so patients who 12 are acutely unwell but also patients who will have care 13 that will be from a primary care clinician into 14 secondary care for secondary care treatment, for 15 example, elective surgery or diagnostics or other 16 specialist opinion. So as a gastroenterologist I would 17 receive referrals from, predominantly a general 18 practitioner but other health professionals, seeking 19 a professional opinion. I would see a patient and then 20 formulate a treatment plan with that patient and it may 21 be that I continue follow-up for a patient within 22 a hospital specialty service or I might discharge them 23 back to their general practitioner. 24 Q. Okay. We were given, by our expert neurosurgical group, 25 a list of all of the different types of medical Page 11
1 within NHS Tayside." 2 And then you set out the various questions to which 3 you've responded, as others have too. So you tell us 4 that you're a consultant gastroenterologist, is that 5 right? 6 A. That's correct. 7 Q. And you have that since 2006? 8 A. That's correct. 9 Q. Could you tell us -- you provide some evidence and 10 others have given us quite detailed evidence of the 11 various structures, in particular where neurosurgical 12 services fit within those structures. We've heard, for 13 example, about concepts such as acute services, 14 specialist services. Could you tell us where 15 gastroenterology fits in with all of that, if that's 16 possible? 17 A. Yes, I can. So gastroenterology is the practice of 18 medicine relating to the digestive system and in terms 19 of where it sits structurally, I'm a physician so I sit 20 within the medicine division of acute services. So 21 I work within a hospital environment and my -- yeah. 22 Q. Acute services is something that I think we are still 23 struggling with. It may well be -- we have one of your 24 colleagues, Lynn Smith, coming tomorrow who I know is 25 someone who can speak to that but does it effectively Page 10	1 specialties with which neurosurgeons may come into 2 contact and it rather looked like almost every clinical 3 specialty one could imagine but it did not include 4 gastroenterology. Do you, in your gastroenterological 5 practice, ever involve yourself with neurosurgeons? 6 A. I can't recall a time. So disorder of the gut in 7 a neurosurgical practice, I can't ever recall a time 8 that I have worked with a neurosurgeon. 9 Q. I wondered if you might then be able to help us with one 10 aspect of your role as executive medical director which 11 I think you tell us involves having clinical 12 responsibility for everyone who works within the 13 service. How do you go about dealing with situations 14 which arise with clinicians in fields with which you, as 15 a clinician, are not as familiar as others, if I can put 16 it that way? 17 A. I think it's a reasonable question and I think you'll 18 probably recognise that in Scotland the executive 19 medical director will come from different backgrounds, 20 general practitioners, renal physicians, surgeons, 21 et cetera. So you're never subject matter expert in 22 everything. So in order to help discharge my 23 responsibility, I have a professional leadership 24 structure of -- so I have a medical director for acute 25 services, which I have them for the health and social Page 12

1 care partnership, so I have a direct line structure but 2 within those there will be professional structures that 3 will be based on the expertise of the different areas. 4 So for example, we'll have somebody that manages 5 a division of surgery which is a large chunk of 6 different specialty services and then clinical directors 7 who will look after groups of services and then clinical 8 leads who will look after individual specialties and 9 from that you can draw professional opinion. 10 As an executive medical director you also have the 11 opportunities, when you don't feel you have sufficient 12 expertise internally, you can seek to colleagues and 13 other health boards and other places to seek expert 14 advice, you can ask colleges, you can ask specialty 15 advisors et cetera. So there's different ways of 16 seeking your professional advice. 17 So, no, you can't know everything as a medical 18 director but you have a structure in order to be able to 19 obtain that professional advice. 20 Q. Okay, so just to be clear, we're talking about your role 21 as medical director and responsible officer, I think 22 here, is that right? 23 A. So there are two distinct functions. I'm the executive 24 medical director NHS Tayside board, a member of the 25 executive team and my role obviously is fundamentally Page 13	1 A. They fundamentally have to work hand-in-glove. 2 Q. Understood. You tell us you graduated from the 3 University of Dundee in 1996, is that right? 4 A. That's correct, yes. 5 Q. Did you do your professional training in Dundee as well? 6 A. I did my physician training, yes, I was a physician. So 7 I did my house jobs in Dundee and then went on to 8 medical rotation, did a period of research and then 9 undertook my professional registrar training in 10 gastroenterology in Dundee. 11 Q. Right, so all based in Ninewells? Is the 12 gastroenterology based in Ninewells? 13 A. No. 14 Q. Is it not? Is it a different hospital? 15 A. No, so gastroenterology training we deliver services in 16 Ninewells Hospital, Perth Royal Infirmary and we also, 17 for a period of time, delivered some endoscopic 18 surgeries in Stracathro Hospital. We no longer do that. 19 Q. Right. You arrived in your current role, the one we've 20 been describing, medical director and responsible 21 officer, in 2024 as I understand it? 22 A. Yes. 23 Q. And when you arrived in that role what information were 24 you given about what I might broadly call the Eljamel 25 saga? Page 15
1 around clinical governance and professional governance 2 and patient safety as the executive medical director. 3 The role of responsible officer does not necessarily 4 need to be held by the medical director, although in 5 Scotland all the executive medical directors are the 6 responsible officers and that, I believe you've heard 7 evidence already -- 8 Q. We have. 9 A. -- around that role. That role is a statutory role 10 introduced I think around 2012 and that is around 11 ensuring you've got the appropriate governance around 12 the management of the fitness to practise for doctors' 13 appraisal and revalidation and oversight of that. So 14 there are two distinct functions, however, in Scotland 15 they're held by a single person. 16 Q. It makes sense, does it not, for those two functions to 17 be held by a single person because there's a close 18 association between the professional governance 19 framework that you've set out and the clinical 20 governance responsibilities of the medical director? 21 A. Yes, how those functions work can function well together 22 with a single person, although they can function well as 23 in other parts of the United Kingdom with two different 24 people holding that. 25 Q. And working closely together, presumably? Page 14	1 A. I don't believe I was given information. I was aware of 2 the report that my predecessor, Pamela Johnston, had 3 taken to board in 2023. I was broadly aware of the 4 circumstances and of the issues. 5 Q. Was that just based on your roles previously and the 6 fact you were working in the area? 7 A. Awareness, really -- there wasn't a specific handover, 8 if that's the question? 9 Q. Yes, it is. 10 A. Yes, there wasn't a specific handover of something to 11 something. 12 Q. And I think you mentioned a moment ago that you've taken 13 something of a leadership role relating to the 14 interaction with the Inquiry and co-ordinating matters 15 and that's why you've signed the statement, is that 16 right? 17 A. Correct and also recognition that there was a need to 18 co-ordinate with the ICR and the police investigation, 19 Operation Stringent. So there were three threads of 20 investigation each seeking information from NHS Tayside 21 all at around a similar time. 22 Q. Presumably you have a lot of other responsibilities as 23 medical director and responsible officer? 24 A. Yes. 25 Q. And why was it thought that you should take on that Page 16

1 extra responsibility of dealing with all of these three 2 areas as well? 3 A. I think probably there's a recognition that this Inquiry 4 is fundamentally about the practice of a doctor, the 5 professional governance of doctors and the clinical 6 governance of a doctor. I think it was probably felt it 7 was appropriate that I, as the executive medical 8 director, held that. What I don't recall is any lengthy 9 discussion of being appointed into that role. 10 Q. Do you mean it sort of evolved over time, or ..? 11 A. As many things do. 12 Q. Right. You mentioned that one of the things that this 13 Inquiry is to do with is the professional practice of 14 a doctor; is that correct? 15 A. Correct, yeah. 16 Q. This Inquiry is predominantly to do with the systems 17 around the professional practice of doctors, isn't it? 18 A. Yes. Yes, I accept that. 19 Q. Is there a feeling within NHS Tayside that this is all 20 about the professional practice of a doctor and not 21 about the systems around him? 22 A. No. No. No, I agree this is about the governance 23 arrangements and the system and the environment, 24 actually probably broader than just what happened in 25 NHS Tayside, around the role of other bodies. And Page 17	1 Q. I wonder if you could help us, please, we've seen some 2 evidence when we heard from the chief executive, 3 Ms Connor, about the way in which NHS Tayside had gone 4 about creating systems to interact with the Inquiry and 5 to respond to matters that the Inquiry needed help with 6 and one aspect that I think she did try to help us with 7 but she wasn't too sure, which she deferred to you, was 8 something called "Eljamel huddles". They seem to arise 9 in given contexts, but I wonder if you could tell us 10 what that means? 11 A. Yes, I will do my best to do that. So I think you've 12 heard me reference that we had an ongoing police 13 investigation, there'd been an announcement of the 14 Independent Clinical Review and the Inquiry chaired by 15 Lord Weir was being announced and being established and 16 I think during 2024, 2025, you were building your 17 protocols and how you work. 18 We were very aware that the police were requesting 19 significant volumes of case records as were the ICR and 20 trying to recognise that there were multiple points of 21 entry for information relating to requests from these 22 three bodies. And I think it must have been towards the 23 end of 2024, we just put in place a weekly touch-point 24 which was called "the huddle", recognising there wasn't 25 a formal governance structure in place at that time, to Page 19
1 obviously I recognise you're hearing evidence from 2 others as well. 3 Q. Absolutely. Because it would be wrong, wouldn't it, to 4 think this is just about Mr Eljamel? It's really about 5 the systems around his practice, isn't it? 6 A. Correct and where they can be strengthened. 7 Q. One aspect of the way in which evidence has been 8 presented by some of your colleagues so far is that they 9 have, on occasion, deferred to you in certain areas when 10 they've been asked questions which have arisen out of 11 questions that they have answered themselves. Do you 12 know why they've done that? 13 A. I think they believe I'll be the best person to give the 14 Inquiry the best answer to those questions. 15 Q. But if the questions relate to matters that they 16 answered, why would you come to that conclusion? 17 A. Well, I think, as you'll probably recognise, within the 18 Rule 8 there's quite a lot of overlap and I think 19 Mrs Watson also highlighted that. Certainly around the 20 employment piece and the professional governance, 21 there's probably areas of overlap. So I suspect that's 22 why they've come to that conclusion. 23 Q. Has a decision been taken that people should defer to 24 you in certain areas? 25 A. No. Page 18	1 be able to have a co-ordinated response, so that we were 2 recognising that we had allocated the appropriate 3 resources where they were required to be able to respond 4 in a timely fashion, to make sure that we were providing 5 the best information that we could, et cetera. 6 So that was the huddle part of that. 7 What evolved through 2025 and really the first 8 quarter, maybe the first two quarters, is that we 9 required to build an infrastructure, a project or 10 programme management type function, to be able to 11 respond to all of these requests and to put a team in 12 place to be able to do that. The board secretary sought 13 support from NSS and we got two project support 14 officers -- sorry, I get the language "project" and 15 "programme" mixed up. So people that are skilled in 16 running complex programmes together to help set up and 17 establish a governance structure and then, to put that 18 in place at the beginning of 2024 whilst we recruited 19 staff or seconded staff from other areas, to build 20 a capacity up and a programme management office to be 21 able to respond. So that was, I guess, the governance 22 journey in doing that during the end of 2024 to 2025. 23 And that's what we have in place today. 24 Q. Thank you. "NSS" is that National Services Scotland? 25 A. Yes. Page 20

1 Q. So that's another part of NHS Scotland effectively, is 2 that right? 3 A. Yes and they had resource that was available for us to 4 draw down on. 5 Q. Thank you. And -- 6 A. A skill set that we didn't have. 7 Q. Okay, and I think you've mentioned the governance 8 journey. I think we heard some evidence about something 9 called an "oversight group" coming into -- or a more 10 formal group coming into existence, is that right? Is 11 that what you were talking about when something more 12 formal came in? 13 A. Yes, so we had a co-ordination group, a doing group, and 14 then an oversight group that really allows us to hear 15 requests from different people and make sure that we've 16 got the right systems and processes to respond. 17 Q. So there's two groups, a co-ordinating group and 18 an oversight group, is that right? 19 A. That's correct. 20 Q. Which ones are you involved in? 21 A. So I chair the oversight group and the co-ordination 22 group is chaired by the director of pharmacy. 23 Q. Okay. I'd like to ask you some questions about some of 24 the information that you've provided to us about 25 predecessors in your role as medical director. In Page 21	1 Q. And if we could look at page 19, please. So that is the 2 medical director in the trust, if we could scroll just 3 a little bit further down. This is a table which tells 4 us about who is on the board at this time and it appears 5 that the medical director at that time was an executive 6 member of the trust but not of the board; is that 7 correct? 8 A. That's how I would read that, yes. 9 Q. I think we'll find that that changes or other roles come 10 in. Do you have any insight into why that was at that 11 time, maybe based on your recollection of being involved 12 in this? 13 A. No, so I would have been a very junior doctor in 2002. 14 Q. Yes, but your researches into the role haven't given us 15 any further insight? 16 A. I still find it confusing about the different structures 17 that were in place. 18 Q. If we go further down to page 19, please, again, this is 19 the next year for the trust. If we carry on into 20 page 20, Mr Lyall still there. A bit further down, we 21 have there executives, executive members of the board. 22 And the medical director in the year 2003, 2004 does 23 become a member of the board. Any insight into why that 24 is? 25 A. No. But that reflects the current board membership of Page 23
1 particular, if we could look, please, at NHST-04945. 2 Could we look at page 18, please. 3 These are tables provided by Ms Dunning setting out 4 a good deal of information by various people who held 5 various positions over time. And she's explained to us 6 there were various different corporate entities involved 7 in the running of health services in Tayside, in 8 particular that there was a particular trust that was 9 involved in the operation which, we're looking at the 10 period from 1995, so 1995-1999 there was a particular 11 trust, which I think was called "Dundee Teaching 12 Hospitals NHS Trust", is that your understanding? 13 A. Yes, it is. I mean, as you've heard from me, I worked 14 within the system at that time and even looking back 15 now, I find it confusing. 16 Q. We're trying to get on top of it ourselves, doctor, so 17 I think you might be able to help us with certain 18 aspects that fall within your remit. I think then there 19 was another trust which came along in 1999 called the 20 "Tayside University Hospitals NHS Trust" and you can see 21 a reference to that there, is that right? 22 A. Yes. 23 Q. And we see that, at that time in box 5, the medical 24 director was a Mr Lyall, is that right? 25 A. Correct, yes. Page 22	1 today, where there are five executive directors that are 2 also board members. 3 Q. We heard some evidence from some of your colleagues 4 about this, in particular from Ms Dunning, who told us 5 that I think the position -- please correct me if 6 I'm wrong -- is the situation, I think from this point 7 on as you've identified and certainly the situation now, 8 is that there are certain executive individuals who sit 9 on the board as executive board members and that's 10 basically prescribed by government, is that right? 11 A. Correct. 12 Q. And then beyond that, what she said was the way in which 13 the executive structure of the board is run is really 14 a matter for the chief executive to decide and in fact 15 she told us about the fact there had been significant 16 recent re-organisations of various roles in accordance 17 with the priorities which the chief executive is wishing 18 to pursue; is that correct? 19 A. Correct yes. 20 Q. And if we look, please, at page 26. We see here, this 21 is the year 2006-2007, the medical director changed at 22 that point to a Dr B Mutch, is that right? 23 A. Yes, that was Bill Mutch. 24 Q. And if we look to page 27, please. We see here, on the 25 board if we keep going down. Keep going down. Keep Page 24

1 going down. 27, please, at the top. So we saw in the 2 previous one, 2006, 2007, Dr Mutch takes over, who 3 I think you're aware of. And then this is something 4 called the delivery unit at that time and you can see 5 there that there is a different medical director, 6 a Professor Forsyth, is that right? 7 A. So I think what is being described -- 8 THE CHAIR: Is that number 14? 9 MR DAWSON: That's number 14, sir, yes. 10 A. Sorry, I think what's being described and I think this 11 is the language that's being used here is -- the 12 delivery unit is what I think would be referred to as 13 acute services. So the delivery unit would be the 14 hospitals. So I think Professor Stewart Forsyth would 15 have been the medical director for, if I put it into 16 today's language, acute services and Dr Bill Mutch would 17 have been -- 18 Q. The equivalent of you? 19 A. That's how I interpret that document, yes. 20 Q. That does make sense I think. And you explained 21 earlier, when I asked you questions about the extent to 22 which you would know about things that happened in 23 certain aspects of acute services, you would have other 24 people to help you. Is that, to some extent, what's 25 going on here? You have an overall medical director and Page 25	1 would have been -- ultimately yes, you're asking me the 2 question am I responsible for clinical governance in 3 NHS Tayside? Yes, I devolve that responsibility down 4 and I have oversight of it because I cannot do it all. 5 So I have a structure that enables me to deliver that in 6 a governance structure that supports the clinicians in 7 doing that. 8 Q. And it looks like something broadly similar was in place 9 at the time, although the structures were different? 10 A. I think so. I think that's a fair assessment of what 11 you're reading. 12 Q. Thank you, that's helpful. 13 THE CHAIR: Dr Cotton, this may seem a very obvious question 14 but I'll ask it anyway. As the executive medical 15 director but also as a consultant gastroenterologist, do 16 you still do any of the latter or are you fundamentally 17 full-time involved in the former? 18 A. As in practising as a doctor? 19 THE CHAIR: Yes. 20 A. Yes, I have patients booked for tomorrow afternoon and 21 Friday afternoon. Yes, I'm very much clinically active 22 and still teach as well. 23 THE CHAIR: That was the point I wanted to clarify. 24 MR DAWSON: Could we look at page 32, please. If we go back 25 to page 31 for the sake of clarity. Just stop there. Page 27
1 someone who sits as a medical director slightly below 2 that? 3 A. Yes. 4 Q. Within a division, if you like? 5 A. Well, not -- I wouldn't use the language "division", 6 I would call it acute services. I think this is the 7 medical director for the hospital element of 8 NHS Tayside. I have one -- today, I have a medical 9 director for acute services who has responsibility for 10 all of acute services. 11 Q. Because the health board has responsibility beyond the 12 hospital side, into primary care and the likes? 13 A. Absolutely. My role covers the delivery of health for 14 the population of NHS Tayside no matter what operational 15 structure it is. 16 Q. But at this time, the response -- I mean, I think 17 medical director is something that exists under statute 18 originally but there are various responsibilities that 19 come with the role and they have changed over the years, 20 as you've already told us. But just to understand, the 21 responsibilities of the medical director as being the 22 person who is overall responsible for clinical 23 governance even at this time, that would attach to the 24 medical director of the board, is that right? 25 A. Yes and I believe though, I guess that's -- yes, it Page 26	1 This is the board in the year 2009-2010. If we go to 2 32, please. We can see there that Dr Mutch is being 3 replaced as the medical director by Dr Russell, is that 4 right? 5 A. Yes. 6 Q. One thing that some of your colleagues helped us with 7 that you did not was specifying the particular aspects 8 of particular roles in connection of matters that fall 9 within the Inquiry's Terms of Reference. Now, I think 10 Dr Russell is someone that did certain important things 11 relating to the Eljamel affair in particular, as 12 I understand it, he was the one that ordered the review 13 from the Royal College of Surgeons in 2013, is that 14 right? 15 A. Yes, he commissioned that review. 16 Q. Thank you. I wonder if you could help us with 17 understanding, because you don't go on to tell us who 18 the holders of the posts were subsequent to this in the 19 list that you gave us, but you do mention them 20 throughout the statement. If you could help us with who 21 the medical directors were subsequent to Dr Russell and 22 in particular, if you could help us with what particular 23 important aspects they were involved in. I may be able 24 to assist you with aspects if you could tell us roughly 25 what time. There are at least two I think you mention, Page 28

1 although the timings of when they held the roles are 2 unclear. 3 A. Yes, and I don't hold the timings in my head so if 4 I need to, I can provide that information to the 5 Inquiry. 6 Q. That would be helpful. 7 A. So Andrew Russell was medical director. And was 8 replaced by Professor Peter Stonebridge who was medical 9 director, I believe, from just prior to Covid, so 10 I would say 2009, 2020, to the appointment of 11 Dr Pamela Johnston, who I think must have been in post 12 in 2022 for a period of about two years. 13 Q. And she was your predecessor? 14 A. Correct. 15 Q. So Dr Johnston, I think, was the medical director who 16 was responsible around the time when the due diligence 17 review was ordered? 18 A. It was her review, yes. 19 Q. And I think, would she have been -- when did you say she 20 came into post? 21 A. I think around 2022, but I would need to clarify the 22 specific dates. 23 Q. And she would then also have been in post, I think, at 24 the time when the Scottish Government review into 25 unresolved concerns related to Mr Eljamel was reported, Page 29	1 health. So my assumption from that is he was in post 2 during the period of the review. 3 Q. Yes, but this is really what I'm interested in, was 4 there somebody else performing the role at that time? 5 A. It would have been Professor Peter Stonebridge. 6 Q. Right, so it was in a kind of acting role? 7 A. Yes, an interim/acting/covering role. 8 Q. Understood. That was precisely the matter I was 9 interested in elucidating. Thank you very much. And as 10 far as the responsibilities of the medical director are 11 concerned, is it correct to say that the clinicians who 12 work within NHS Tayside are effectively responsible to 13 you? 14 A. So I have responsibility for -- I suppose responsibility 15 lies in different areas. So obviously every single 16 doctor has a professional responsibility to the 17 regulator and that is a personal responsibility. As 18 medical director, I'm responsible for ensuring that the 19 systems and processes that oversee their fitness to 20 practise, revalidation and appraisal are in place. 21 Ultimately, an organisation has a chief executive who, 22 as the accountable officer, is accountable for the 23 delivery of every element of everything. 24 So, yes, they have a responsibility but not a line 25 management responsibility and I professionally oversee Page 31
1 at least, I think? 2 A. Yes, I think so. 3 Q. And we know, if one looks at page 39 of the document 4 which is as far as the tables take us, that Dr Russell 5 was still in post in March 2015. Was there someone else 6 between him and Professor -- was it Stonebridge? 7 A. Stonebridge, no. 8 Q. No? 9 A. No. 10 Q. So do you think Dr Russell then was in post until 11 shortly before Covid? 12 A. Yes, I think -- that's my recollection. I believe 13 Dr Russell -- Professor Russell, had a period of ill 14 health and Professor Stonebridge acted as the deputy for 15 that period of time. 16 Q. Yes, and another aspect, which you cover in your 17 sections if you like in the statement, was the ordering 18 of the report from Tracey Gillies who was the executive 19 medical director of NHS Lothian. That took place in 20 late 2018 and reported I think in 2019. Do you know who 21 was in post at that point? It might have been between 22 the two, roughly? 23 A. I think there was probably an overlap but I recognise 24 I think that Ms Gillies wanted to speak to Dr Russell as 25 the medical director and was unavailable due to his ill Page 30	1 them. So I suppose it's that difference between I don't 2 operationally manage individual doctors but they have 3 a professional line through to me and I have 4 a professional line through to the chief medical 5 officer. 6 Q. Thank you. I'm interested in this aspect of the way 7 that things work in terms of where the responsibilities 8 lie. In particular, you pointed out a distinction 9 between your role as medical director and your role as 10 responsible officer earlier. What you were just 11 describing there, I think, was the responsibilities of 12 the responsible officer, is that right? 13 A. Correct. 14 Q. But I think as far as other clinical governance 15 responsibilities are concerned, what is your role in 16 that and what is the role of the chief executive? 17 A. So I think I have already said, the chief executive is 18 accountable for everything. Clinical governance is -- 19 responsibility lies between myself and the nursing 20 director, to ensure that we have appropriate -- we have 21 oversight over the clinical governance arrangements and 22 for medical staff and some other staff, professional 23 governance responsibilities for other staff. So 24 doctors, dentists, et cetera, all lie within my 25 responsibility, healthcare scientists, psychologists, Page 32

1 et cetera. But the clinical governance responsibilities 2 are shared between myself and the nurse director. And 3 that's to ensure that we have appropriate systems and 4 processes in place and that we, as medical and nurse 5 director, have oversight over those processes and be 6 able to seek assurance from them and then provide 7 assurance through to the clinical governance committee, 8 which really is the committee -- the sub-committee of 9 the board that provides scrutiny over our clinical 10 governance arrangements. 11 Q. So just, if we put the responsible officer side to one 12 side, the revalidation aspect and talk about the rest of 13 the clinical governance, you are responsible, along with 14 the nurse director, I think is Mr Dunn, is that right? 15 A. Correct. 16 Q. And your job is to oversee clinical governance 17 systems and ultimately, to be accountable to the board 18 for those systems? 19 A. Yes. 20 Q. Where does the chief executive fit into that? 21 A. So the chief executive is a member of the clinical 22 governance committee so has oversight there. So I can 23 tell you how it works today. 24 Q. Yes. 25 A. So the nurse director and I have oversight and we have Page 33	1 from complaints through claims, through -- so there's 2 different routes that information needs to be put 3 together that helps build the bigger picture. And we've 4 adopted the sharing intelligence framework that HIS 5 produced, which is a really simple framework that 6 helps -- what it's done is it's taken all of the 7 significant inquiries across the United Kingdom over 8 a period of time, including the Francis Review and 9 looked at where there's common themes. 10 And in using that -- so that framework has warning 11 signals of things that you might be hearing in other 12 parts of the system that would help you understand where 13 there's a trigger or a place to triangulate information. 14 So at every single clinical governance meeting that the 15 nurse director and I chair, we have a pause and 16 reflection at the end and use that framework to say: is 17 there anything that anybody is hearing that is a worry 18 or a trigger in the system that would lead us -- not 19 come to a judgment, but to seek further lines of 20 enquiry. 21 Q. Is whistleblowing part of that? 22 A. So whistleblowing will be confidential. The nurse 23 director is the executive lead for whistleblowing. 24 Q. So is whistleblowing information not taken into account 25 in that system? Page 35
1 a clinical governance meeting structure where we have 2 all of the senior clinicians from across the breadth of 3 NHS Tayside where they report on their clinical 4 governance arrangements around safe, effective and 5 person-centred care. We also have a risk management 6 structure that we oversee weekly, all category 1 events, 7 the most serious adverse events within the organisation, 8 complaints, and we also commission all serious adverse 9 event reviews. 10 Q. Yes. We discussed that -- 11 A. That's our oversight of the current arrangements. 12 Q. What about other aspects of the system that could be 13 related to clinical governance, like complaints for 14 example, where does that sit? 15 A. So we bring that through our risk management in terms of 16 our oversight of that and we also will scrutinise 17 complaints through our clinical governance meeting. 18 What Mr Dunn and I introduced when we both took up post, 19 which was around a similar time, there was a few months 20 between us, was we recognised one of the real challenges 21 in a healthcare system and -- is how do we triangulate 22 information. So information around whether care is 23 safe, whether it's effective, will come from multiple 24 different sources. So educational governance, we'll 25 hear from trainees, we'll hear from different parts -- Page 34	1 A. So it won't be able to be taken into account due to the 2 confidential nature of that but the nurse director, in 3 discharging her executive role of whistleblowing lead, 4 will hear that information and be party to and aware of 5 that information so can be able to triangulate that. 6 Q. Yes, so it could be fed into the system, albeit 7 anonymously -- 8 A. (Overspeaking) it can, yes. 9 Q. Just let me finish the question. It will be fed into 10 the system, albeit anonymously, is that right? 11 A. Yes. 12 Q. As another source of information? 13 A. An awareness of the information will be in the system to 14 prompt a question, yes. 15 Q. Thank you. I'm just interested also, are there any 16 other parts of the system? We've covered quite a few 17 there, can you think of any others that are part of the 18 information-gathering process? 19 A. So all different domains of governance. I have talked 20 about educational governance which I think is really 21 important. Clinical governance. Professional 22 governance. You know, are there any concerns around 23 a doctor not being appraised on time or any concerns 24 through that. And I'm happy to talk a bit more about 25 that if that's something that you'd want to know about. Page 36

1 Yeah, I think we've probably covered quite a lot of 2 that. 3 Q. Thank you. And you mentioned when you and Mr Dunn 4 started, starting quite close together and no doubt 5 pooling your views on these things, you effectively 6 tried to develop a better system for triangulating the 7 information, is that right? 8 A. It's really notoriously difficult in healthcare systems 9 to triangulate information -- 10 Q. I just wanted to know whether that's what happened? 11 A. Yes, we recognised we just needed to build and 12 strengthen on and evolve what's been there before. And 13 I think, yeah, so we wanted to improve it. I guess 14 that's the nature of healthcare, we always want to 15 improve where we have. I have no doubt that whenever 16 I leave this role, the person taking it on from me will 17 strengthen what I have put in place as well. 18 Q. That was based, I think, on a Healthcare Improvement 19 Scotland paper or initiative you mentioned; what was the 20 name of that? 21 A. Yes, "Sharing intelligence framework". 22 Q. When did that report, or when did that gives its views? 23 A. I can't remember. 24 Q. Was it shortly before that or around that time? 25 A. No, it was probably a year or so before that I think. Page 37	1 to the Eljamel affair over a long period of time, in 2 particular in relation to the triangulation of 3 information, is that right? 4 A. That's a finding in that report, yes. 5 Q. Thank you. And is that a finding that's accepted by the 6 board now? 7 A. Yes. The board -- 8 Q. And that's presumably why you and Mr Dunn tried to do 9 something to improve it, is that right? 10 A. It's one reason, not the only reason. It's part of 11 being a doctor, a clinician. You always want to be 12 able to do better than you've done before. So that 13 is -- there's no doubt that's a significant factor, of 14 course it is. 15 Q. Thank you. It would, of course, have been incumbent 16 upon those who held the same role as you and Mr Dunn, 17 being responsible for clinical governance before, to try 18 to do that as well? 19 A. Of course. 20 MR DAWSON: Sir, that would be a convenient moment. 21 THE CHAIR: Yes, surely. 22 Dr Cotton, we're going to take a short break now, 23 about 15 minutes and we'll aim to start at 11.25. Just 24 before you leave the room, I'm going to mention 25 something I mention to any witness in your situation. Page 39
1 I can provide the date, I just don't have it in memory. 2 Q. That's okay. And you were suggesting that that paper 3 had tried to almost triangulate itself, information that 4 had come up from national inquiries, including for 5 example, the Francis Inquiry, is that right? 6 A. Yes. 7 Q. And the Francis Inquiry was quite historic by that 8 point, wasn't it? 9 A. Yes. 10 Q. So would it not have been expected that the systems that 11 you were trying to improve had already been in place by 12 then? 13 A. I think there had been attempts to do that across the 14 breadth of the healthcare system to do that. So the 15 shared intelligence framework wasn't just about the 16 Francis Inquiry, it looked at all major inquiries over 17 quite significant periods in time. 18 Q. But would it be fair to say the need to triangulate 19 information, as the word you've used, was -- well, 20 frankly, it's quite a common sense principle really that 21 arises from clinical governance, doesn't it? 22 A. Yes. 23 Q. And I think it was the case that the due diligence 24 report, which, as we'll come back to was done in 2023, 25 had identified that there had been failings in relation Page 38	1 To keep matter regular we do ask, now you've started 2 giving evidence, that you don't discuss that evidence in 3 the break and we'll see you back here in quarter of 4 an hour. Thank you. 5 A. Thank you. 6 (11.11 am) 7 (A short break) 8 (11.26 am) 9 THE CHAIR: Thank you, Dr Cotton. Have a seat, we're ready 10 to resume. 11 MR DAWSON: Thank you, sir. 12 Dr Cotton, I think you have some notes with you, is 13 that right? 14 A. I do. 15 Q. And have you been using those notes in the evidence that 16 you have given so far? 17 A. No. 18 Q. Okay, and could you tell me, please, whether the notes 19 were compiled by you? 20 A. Yes, they were. 21 Q. And can you tell me why you thought it was a good idea 22 to bring notes with you? 23 A. I have spent the last few weeks reviewing the documents 24 that you asked me to review, so -- I recognise there are 25 quite a lot of them, so I just thought it was Page 40

1 appropriate that I just try to be as well prepared as 2 I could. 3 Q. Understood. We were talking a little bit about aspects 4 of accountability and responsibility, particularly 5 within your role, by extension to an extent by the 6 predecessors in the role, and I have asked you some 7 questions about the chief executive's responsibility. 8 You've told me that the chief executive is the 9 accountable officer, is that right? 10 A. Correct. 11 Q. I think what you said was that that means that she's 12 accountable for everything, is that right? 13 A. Correct. 14 Q. Is it an essential aspect of accountability that someone 15 take responsibility for the things for which they are 16 accountable? 17 A. So yes, but I guess the accountable officer does that by 18 having the appropriate professionals around them to 19 discharge that accountability. And so, I guess the 20 accountability is held by the person but the 21 responsibility can be devolved. So obviously clinical 22 matters will be devolved down to myself and the nurse 23 director, as the clinical experts, the finance director, 24 the public health director. So I suppose that's how 25 I understand it set out through the blueprint of the Page 41	1 be much better placed to be able to answer the question. 2 It's just I don't have the evidence available -- 3 Q. Those people are people who no longer work for the 4 health board, is that right? 5 A. Correct. 6 Q. Is it a part of your role to be accountable for what the 7 predecessors in the role did? 8 A. NHS Tayside as the corporate body, yes. I guess we'll 9 have different responsibilities or accountabilities 10 professionally. So I'm professional lead, accountable 11 through to the regulator for my own actions, as is every 12 doctor. 13 Q. So, Dr Cotton, sorry, is that a "yes" or a "no"? 14 A. I'm not following the tenor of your question. 15 Q. It's quite a simple question. I said: are you 16 accountable for the actions of the predecessors? 17 A. I'm not accountable for the actions of other doctors as 18 an individual person, no. 19 Q. Are you accountable for their actions in your capacity 20 as the medical director? 21 A. So as a member of the board and as being a member of 22 NHS Tayside, yes. From a corporate perspective, yes, we 23 are all collectively accountable today for the actions 24 of others in the past, of course we are. 25 Q. Because if the situation were otherwise -- you mentioned Page 43
1 governance in how that accountability is discharged. 2 Q. Do you think "accountability" means a situation in which 3 someone is responsible for things that happen and can 4 give a satisfactory reason for them? 5 A. Yes. 6 Q. And does that mean, ultimately, although assistance is 7 provided certainly in clinical matters by yourself and 8 the nursing director, that the accountable officer 9 should be able to take responsibility and give 10 a satisfactory reason for everything that happens within 11 the health board? 12 A. I believe that's the role of the accountable officer, 13 yes. 14 Q. Thank you. I'm interested in understanding a little bit 15 about the way in which that responsibility and 16 accountability works with regard to the acts of 17 predecessors in your role because, as I said right at 18 the beginning, a feature of the evidence that you've 19 provided to the Inquiry is to direct us towards others, 20 some of whom we've discussed, who are more directly 21 involved in things that you've answered questions about, 22 is that right? 23 A. That's correct. That's because I have not had the 24 evidence available to be able to answer the question and 25 therefore the person who was involved at the time will Page 42	1 a moment ago that you're accountable to patients and 2 indeed not just the patients in your area but the public 3 in general, is that right? 4 A. Correct, yes. 5 Q. If it were the case, for example, that a patient wanted 6 to know what had happened in their prior treatment, that 7 would be something the patient would be entitled to 8 know, isn't that right? 9 A. Correct, yes. 10 Q. And if the patient were keen to know that, the medical 11 director might be one of the people that they could 12 contact to try and find that out, isn't that right? 13 A. Correct. 14 Q. And if the response to that patient were: "I can't tell 15 you, you'll have to go and ask somebody who doesn't work 16 here anymore", that wouldn't work, would it? 17 A. No, and that wouldn't be acceptable either, would it. 18 Q. Yes. So why is it acceptable to do that with regard to 19 this Inquiry? 20 A. I don't think I have said that, have I? 21 Q. Well, you've directed us to people, in the same as I've 22 suggested that you accepted you wouldn't do for 23 a patient, to go and speak to people who don't work for 24 NHS Tayside anymore? 25 A. So I think where that's answered in the Rule 8 is around Page 44

1 very specific questions where, as currently the board 2 does not have an ability to answer the question. So 3 you're right, there are specific questions where we hold 4 no corporate information, emails, I believe there were 5 questions around: why was it commissioned and when was 6 it commissioned? That sort of question. I have been 7 unable to answer that question because I do not have the 8 knowledge to be able to answer that question. 9 Q. Part of allowing your successors to be accountable for 10 what you do is leaving records to enable them to do 11 that, isn't it? 12 A. Yes. 13 Q. And that, in your case, has not happened, is that right? 14 You don't have the records to be able to answer the 15 questions, is that fair? 16 A. I would have answered the question otherwise. 17 Q. Yes, but the position is that you haven't? 18 A. I have not. 19 Q. And you have directed us to other people and places, is 20 that right? 21 A. Yes, in order to try and assist the Inquiry with gaining 22 the answer that you'd asked. So that was the intent for 23 directing the Inquiry to others who might be best placed 24 to answer the questions that you were seeking answers 25 to. Page 45	1 Q. Indeed, we've been looking at the various components of 2 doctors' ethical responsibilities in lots of difference 3 areas, but in fact doctors wouldn't be able to deliver 4 that if they don't have the systems around them to 5 enable them to do that, is that right? 6 A. Correct. 7 Q. And therefore, is it important that when a health board 8 is offering a service, so for example we're interested 9 in neurosurgical service, it would be important the 10 health board puts in place facilities and staff to 11 enable that service to be delivered, is that right? 12 A. Correct. 13 Q. Is that sort of matter, a matter for the medical 14 director to be involved in, in broad terms? 15 A. Where it's about the safe delivery of care, yes. 16 Q. Because one of the things that one of our expert groups 17 told us, the neurosurgical group, I asked them: if you 18 needed more staff and more equipment, where would you 19 go? And the answer was: the medical director. Is that 20 right? 21 A. Yeah, you'd absolutely go through two routes, I think. 22 You'd go through the professional line and you'd also go 23 through the managerial line about the resource 24 allocation piece, but also what's the professional risk 25 being held here. Page 47
1 Q. Because if the system were to work in a different way, 2 and there were no records and you changed the person in 3 the role, that would be a way of avoiding 4 responsibility, wouldn't it? 5 A. It wouldn't be acceptable really, would it, to be able 6 to not answer the question. I think that's the 7 difficulty that we have. So you can't discharge your 8 responsibility if you've not got the information 9 available. 10 Q. And you think it's not acceptable that you can't answer 11 the questions? 12 A. Well, I don't have -- no, I don't think it is acceptable 13 I can't answer the question. 14 Q. It's important, is it not, that the health board in 15 general put in place systems to enable high standards of 16 patient care to be delivered, is that broadly correct? 17 A. Yes. 18 Q. And one aspect that we've been looking at, which we're 19 particularly interested in asking you about because 20 you're the medical director, is the extent to which it's 21 important that systems put in place -- the systems that 22 are put in place enable doctors to be able to deliver 23 their ethical responsibilities; is that correct? 24 A. Yes, the whole breadth of their professional 25 responsibilities, including ethical, yes. Page 46	1 Q. So there would be, just on the staffing side, you would, 2 in a particular department, have an escalation route 3 professionally to be able to get assistance with that 4 sort of situation? 5 A. Yes. 6 Q. And you'd also have -- I don't mean to be disparaging, 7 but administrative staff, effectively managers who would 8 be responsible for practical aspects of it, buying 9 equipment and hiring more staff and that sort of thing; 10 is that how it works? 11 A. Yes. Yes. 12 Q. I'm interested in the extent to which, in that regard, 13 you as the medical director, consider that it's not just 14 about the delivery of systems which enable doctors to 15 fulfil their ethical obligations, but whether you 16 consider there to be ethical obligations incumbent upon 17 the organisation itself? 18 A. Gosh, I don't know if I have considered that. So the 19 responsibility of the organisation is to deliver 20 healthcare that is safe and effective. Whether that 21 feels to me that could be an ethical matter, yes. 22 Q. So this is an interesting area I think because you, of 23 course understand as a long-standing consultant, that 24 you have certain ethical responsibilities as a doctor, 25 yes? Page 48

12 (Pages 45 to 48)

1 A. Ethical and professional. I think they're broader than 2 just ethical alone, but, yes, I agree. 3 Q. But I'm interested in when you discharge your 4 responsibilities, along with your colleagues, whether 5 there being ethical responsibilities on the board itself 6 is something that features in your decision-making? 7 A. So I think when the executive and the board make 8 decisions they take the breadth of professional advice 9 in coming into a decision-making and ethics would be 10 part of any decision-making, as would be, you know, all 11 other aspects. I don't think they're -- yes. 12 Q. You think there are ethical considerations in providing 13 the service of the health board? Is that what the "yes" 14 is to? 15 A. Yes. 16 Q. Amongst other things? 17 A. Yes -- 18 Q. Financial, et cetera? 19 A. Yes. I don't think you can look at any one thing in 20 isolation, but absolutely that needs to be considered as 21 part of the bigger picture, of course it does. 22 Q. Thank you. Could we have a look, please, at NHST-04719. 23 We looked at some documentation last week with your 24 colleague Mrs Watson relating to difficulties which, at 25 least were being set out at a later stage than this Page 49	1 sections that you answered, I think. 11 August 1998, 2 this is a letter from Mr Eljamel. If we just scroll 3 down a bit, please, we can see that's who it is from. 4 It says: 5 "Annual Leave. 6 "My annual leave year runs from October to October. 7 To date I have only managed to take 10 days annual leave 8 this year. As you know, Mr Varma ..." 9 Who we've discussed with others was the clinical 10 lead consultant when Mr Eljamel joined the service: 11 "... leaves at the end of the month and it will 12 therefore be impossible for me to use up any more leave. 13 "Would it be possible for me to carry this forward?" 14 Now, we look at some more documentation with 15 Mrs Watson about this, but this letter it quite a 16 helpful microcosm of what appeared to be going on at the 17 time, which was effectively that Mr Eljamel was in 18 a situation where he had been one of the neurosurgical 19 consultants for three years, just under three years by 20 this point. And by this point, one of the consultants 21 had left and the other lead consultant, Mr Varma, was 22 about to leave. 23 I'd be interested to know how it is, in 24 circumstances like that where someone can't take their 25 annual leave and there doesn't appear to be much Page 51
1 letter, which is dated 1998, relating to the provision 2 of the neurosurgical service within Tayside. And if we 3 could just have a look at this, please. This is 4 a letter from Mr Eljamel. It's very short. To 5 a Mr Maclean, the director of medical services. Now, 6 what role is that? 7 A. So I think that would be -- again, this is a confusing 8 landscape of titles and organisations. I believe that 9 Dr Derek Maclean would have been what would be the acute 10 medical director, the medical director for hospital 11 services rather than a board director at that time. 12 Q. Yes. 13 A. But I'd need to go back and look through those tables 14 again that you showed me earlier, but that's what 15 I believe -- 16 Q. That's fine. I'm not quizzing you on the particular 17 roles historically, but I'm interested to know -- based 18 on what you said, this is a letter about annual leave, 19 but it's effectively an escalation of an issue through 20 the professional route as we discussed a moment ago, is 21 that right? 22 A. I can't see where that is. 23 Q. We'll scroll down a little further. 24 A. I have read this before, but -- 25 Q. Yes, it's one of the documents that was produced in Page 50	1 prospect of them taking the annual leave when the only 2 other consultant is about to leave the service, how it 3 is that a system could claim to be supporting the 4 surgeon in the delivery of his ethical responsibilities? 5 A. So I think you're right to be asking that question. So 6 the purpose of annual leave is to ensure that the 7 doctors are well-rested and fit to do their role and the 8 question that this letter prompts for me, or the 9 response should be I actually don't think it's okay that 10 somebody gets a limited amount of annual leave. That 11 would worry me as a medical director. And the question 12 that would prompt me, rather than purely just to prove 13 that, was: what needs to be done to ensure that you are 14 safe and rested? What is it that we need to put in 15 place to be able to take the leave that you're required 16 to take? Rather than allow that leave to carry forward 17 because I would have suspected that the entitlement to 18 annual leave at around that time would have been 19 between 28 and 30 days, roughly. So that's 20 a significant proportion of annual leave that's not been 21 taken; two-thirds of it. Which would worry me. 22 The options would be: do we bring a locum in? Do we 23 speak to another health board to take responsibility for 24 the service for a period of time in order to allow the 25 clinician to be rested? Recognising, I believe at this Page 52

1 time, that -- I'm just trying to recall the staffing 2 levels within the department from what I have read at 3 this time. I believe that there were locums being put 4 in place around this time. So I think this letter 5 prompts, rather than just to prove a series of questions 6 for me. 7 Q. Yes, would the questions -- could you equate that to 8 concerns? 9 A. Yes. 10 Q. Yes, because it looks -- this is not your responsibility 11 today, you weren't involved at this time, but it does 12 look like we're looking at a service where someone can't 13 take their annual leave, such that they're under too 14 great an amount of pressure, is that right? 15 A. The letter doesn't say that they're under pressure but 16 I would be worried that they're not taking their annual 17 leave -- if they're not under pressure they will become 18 under pressure. 19 Q. That's precisely what I was interested in your take, 20 Dr Cotton, because this sort of letter might come to you 21 nowadays and if you were to receive such a letter, that 22 would be the way you would interpret it, you would be 23 concerned this person is perhaps not able to operate, 24 literally, to their maximum potential? 25 A. There's a "why" question and "is it safe" question. Page 53	1 the question of taking on too many responsibilities, you 2 know, so there's a job planning element to that which 3 probably doesn't sit fully within the clinical 4 governance but within the professional governance. 5 I know, in healthcare we like to silo things up into 6 different elements of governance. However, they are 7 fundamentally and intrinsically linked and I think that 8 comes back to my earlier point around that 9 triangulation, that sharing of intelligence. It's all 10 elements of governance you need to consider because you 11 can't just look at one in isolation. 12 Q. So would a letter like this then, based on what you've 13 just told us, should it prompt further investigation to 14 try and find out what's going on here, because perhaps 15 there may be more information to be gleaned? 16 A. Yes, and I don't know -- I can't read, from this letter, 17 what conversations have occurred to get to the approved 18 comment at the bottom right. Although I recognise 19 there's three days between the letter being written and 20 the approval given in the bottom right-hand side. So 21 I don't know what assurances were sought in those 22 three days, but me reading that letter, as I've already 23 said to you, prompts questions. 24 Q. And bringing things up to the modern day, one aspect of 25 the systems that exist now that you're involved in, Page 55
1 Those are the two questions, reading this letter, that 2 come to my mind. 3 Q. And is it an important feature of the clinical 4 governance systems that we've been discussing, that this 5 sort of issue be kept under review and control? 6 A. This would have flagged an issue for me around the 7 sustainability of the service, I think. That's the 8 question I think would prompt in my mind. If we've had 9 a doctor saying they've only been able to take ten days' 10 annual leave. 11 Q. And does it follow logically, because this is another 12 area connected to this that the Inquiry is interested 13 in, that the systems of clinical governance should take 14 account not just of annual leave but also, in order to 15 try to make sure that the doctor is able to work to the 16 best of their ability, also other pressures which may 17 exist within the workplace, such as how many things 18 they're taking on at any given time? 19 A. All of those need to be considered. 20 Q. And that's the responsibility of the clinical governance 21 system, is that right? 22 A. Not purely just the clinical governance system, I think 23 there's a managerial element to this as well. I think 24 there's a professional governance element to this as 25 well. You know, there's a job planning -- you raised Page 54	1 I think Ms Connor told us, is something called the 2 "Responsible Officer Advisory Group", is that right? 3 A. That's correct, yes. 4 Q. Could you tell us about that because she was keen that 5 you should do so? 6 A. Okay. Yes, very happy to do so. So that was a direct 7 output from my predecessor, Dr Pamela Johnston's 8 assessment of the materials and the due diligence 9 report. And what she recognised was that -- two or 10 three things -- and it links back to a point you made 11 earlier, Mr Dawson, which was around how do you record 12 something as well? How do you record your 13 decision-making, et cetera, that corporate memory? 14 So, what she recognised was that the decisions of 15 the responsible officer ultimately are the decisions of 16 one person, how do we have a governance structure that 17 allows -- that allows a structured ability to discuss, 18 to record, to risk assess? And I think that's 19 an important point around risk assessment of 20 professional concerns; how does the responsible officer 21 have sight of those professional concerns as early as 22 possible? 23 So she put a governance structure -- and I believe 24 you have the Terms of Reference for that as part of the 25 evidence and a copy of the very first minute. That is Page 56

1 a structured meeting that has the responsible officer, 2 the deputy responsible officers, and the senior medical 3 leaders. So I have already described the structure that 4 I have in place, so medical director of acute services, 5 medical director of the three health and social care 6 partnerships, mental health, primary care, et cetera, 7 all attend that meeting and any doctor has an escalation 8 process that can escalate a doctor to that group, where 9 we can then go through a checklist, a mini triangulation 10 or a triangulation exercise that will record that and 11 then allow a risk assessment. And that's done in 12 a structured way to help advise the responsible officer 13 on what the professional concerns are of the 14 professional body, around whether it's the practice, 15 whether it's been -- any factor that might impact on 16 that professional delivering their duty. 17 We've further strengthened that, over the last 18 two years, by -- and I think you've probably heard this 19 evidence from Professor Emma Watson who is the medical 20 director PSD, previously NES, who was the responsible 21 doctor for doctors in training. So either 22 Professor Watson or one of her deputies, when we are 23 discussing any doctors in training, will attend the 24 Responsible Officers Advisory Group, so we can share 25 information across two different responsible officers. Page 57	1 Q. But one of the sources which you are using to 2 triangulate matters arises through the responsible 3 officer route where you, as you say, are almost 4 reporting information to yourself. You are a source of 5 information, reporting it to yourself and Mr Dunn; is 6 that correct? 7 A. Yes -- yes. 8 Q. And this, as you've said, came out of the due diligence 9 review, as I understand it, is that right? 10 A. Yeah and I think -- so, Dr Johnston at the time also 11 went to a responsible officers training group in England 12 and recognised there's a slightly different maturity of 13 systems in England than there are in Scotland. And 14 I know subsequent to -- subsequent to NHS Tayside 15 establishing that governance structure, the other health 16 boards in Scotland have done that and indeed, I spoke 17 and presented our experience at the responsible officers 18 network at the GMC buildings earlier this year on our 19 experience and what we've learnt from putting that 20 process in place. 21 I think, coming back to the one of the questions you 22 asked me earlier, was that structure allows a clear, 23 documented, risk-assessed, auditable trail of how 24 decisions get made and why they get made and why they 25 get made on the information that you have at that time, Page 59
1 That structure has a structured set of meetings that 2 occur approximately every eight weeks and we review any 3 doctors that we have any concerns around on that list 4 and get updates from them. But we also have the ability 5 to step up an urgent meeting if there is an immediate 6 concern that cannot wait and that can occur within 12, 7 24 hours. 8 Q. So just to understand this in the context what we were 9 discussing about you having different roles. This is 10 a means by which you are triangulating information 11 around doctors and concerns about doctors in your 12 responsible officer role, is that right? 13 A. Yes and the confusing part of that is I might need to 14 advise myself, as responsible officer. Or as 15 responsible officer, I might need to advise the medical 16 director, who is myself, because I hold two roles there. 17 Q. Yes, let's just get this clear because I think this is 18 important how the system works, because you mentioned 19 earlier -- I think we were talking about you wearing the 20 other hat, if you like, the clinical governance side of 21 things, where you're interacting with your colleague, 22 Mr Dunn and you're trying to triangulate a wider range 23 of sources of information which might give rise to 24 concerns. 25 A. Yes. Page 58	1 which wasn't in place till 2023. 2 Q. Okay, so there are two components of it, I think. One 3 is recognising the need, within the responsible officer 4 context, properly triangulated information about 5 concerns that might relate to a doctor, is that right? 6 A. Yes. 7 Q. And then beyond that, there was another aspect which is 8 to do with making sure that that process, and presumably 9 how it feeds into the wider clinical governance scene, 10 is properly documented and could be audited, is that 11 right? 12 A. Yes and also that is visible -- not the detail of the 13 individual clinicians that we discuss, but I provide 14 oversight to our staff governance committee on the work 15 of that group. So that the board have visibility of 16 that we have the right structures and processes in place 17 to allow to us discharge those responsibilities as well. 18 Q. And the reason why that group came about and why these 19 two components were focused upon in the aftermath of the 20 due diligence report, was that report found and accepted 21 that the systems prior had been lacking in this regard, 22 is that right? 23 A. Yes, that's what the report found. 24 Q. So it found that there was inadequate triangulation of 25 different sources of potential concern? Page 60

1 A. Yes. 2 Q. And it found that there was inadequate documentation of 3 that sort of information? 4 A. Yes, and hence my difficulty in being able to answer in 5 the Rule 8 the questions that you posed. 6 Q. I understand, indeed, but one of the things that you're 7 trying to do to address that, as I understand it, is to 8 try -- on that second component, is to try to make 9 sure -- you have used the phrase "corporate memory". 10 I don't think it's a phrase you've used a lot, but quite 11 a few of your colleagues, in responding to questions, 12 used the phrase "organisational memory". 13 A. Yes. 14 Q. And they have all identified, in different places and 15 you have too -- although I don't think you used the 16 phrase particularly -- that it is difficult to find out 17 what went on historically in this record because there 18 is simply not the documentation to enable you to do so, 19 is that right? 20 A. Yes. Yes. 21 Q. And that's something, to be fair, that you're trying to 22 work on, is that right? 23 A. Yeah, absolutely. 24 Q. Okay. None of those systems work, do they, if there are 25 inadequate triggers or flags within the system to enable Page 61	1 Mr Eljamel's case at all, was it? 2 A. Yes, we can't identify why that case was 3 included in that report. 4 Q. But actually, if one looks at the report, the case, 5 albeit not one of Mr Eljamel's, does actually flag up 6 some deficiencies in the system, doesn't it? 7 A. Yes. 8 Q. Which would tend to suggest that deficiencies in the 9 system applied in the cases of other consultants as 10 well? That's natural, because they're systemic; is that 11 fair? 12 A. So I think it's fair there were themes within that case, 13 as I think you've highlighted, that have exactly the 14 same themes, yes. 15 Q. Because one of the features of those cases is that 16 there's a considerable amount of time between the 17 surgery where something went wrong and the system 18 kicking in to do something about it, isn't that right? 19 A. For the adverse event being reported and recognised, 20 yes. 21 Q. Yes, indeed. But the systems are designed, I think, to 22 try to make sure that they kick in early in order to try 23 to maximise learning and repairing the damage, isn't 24 that right? 25 A. Correct. Page 63
1 anyone to raise the concern, be it within the ROAG or 2 anywhere else, isn't that right? 3 A. So yes, the signal needs to be heard. 4 Q. So for example, I know that you've looked in some detail 5 and tried to help us as best you can, within the 6 limitations about what the due diligence report was 7 looking at. One of the things that that did -- we can 8 look at it if it's helpful, doctor, I'm not trying to 9 catch you out in any way, but there are a number of 10 cases that are looked at in that, aren't there? There 11 are a selection of cases that were looked at? 12 A. Within the due diligence report? 13 Q. Due diligence report, yes, which of course is the basis 14 for the changes that you've told me about just a moment 15 ago? 16 A. The cases specifically, or the report? 17 Q. No, I mean the conclusions. 18 A. The conclusions, yes. 19 Q. The conclusions, in part, relied upon looking at aspects 20 of the system and in places, looking at a selection of 21 six cases to try to work out whether those cases gave us 22 any clues about what had gone wrong, is that right? 23 A. So, yes, there were six cases that were looked at as 24 part of that due diligence report, yes. 25 Q. We learned that, in fact with Mr Dunn, that one of them wasn't Page 62	1 Q. And so if, for example, if we put it in the ROAG 2 context, if the individuals who were on that don't know 3 that something has happened, something has gone wrong, 4 they couldn't report that to you, could they? 5 A. No, you have to have knowledge of the event, of course 6 you do. 7 Q. Absolutely. So it's important, not just that there is 8 this triangulation of information, and indeed escalation 9 into the clinical governance system, but also that the 10 systems exist and function properly to be able to make 11 sure that information about things going wrong comes to 12 light in the right places in the first place, is that 13 right? 14 A. Yeah and part of that is do individual people within the 15 system -- and it's quite a blunt word to use really 16 about the delivery of healthcare, but we've used it 17 a lot -- know their roles and responsibilities and 18 understand those clearly. And that allows those signals 19 to be heard as early as possible. 20 Q. Because where things go wrong, there are a number of 21 theoretical obligations to try to raise that to a level 22 with someone who can do something with that information, 23 isn't that right? 24 A. I'm not sure -- I think they're obligations, not 25 necessarily theoretical obligations. Page 64

1 Q. Yes, so when something goes wrong, people have 2 an obligation to tell people about it, isn't that right? 3 A. Of course they do. 4 Q. Why was the focus, as you understand it, as you've 5 studied it, in the due diligence report on the 6 triangulation of the information, rather than on the 7 question of whether the information had been properly 8 brought to light in the first place? 9 A. I suppose both those things need to happen, don't they. 10 Q. Absolutely, but why was the focus on the triangulation 11 aspect? 12 A. I suppose triangulation is important, isn't it, because 13 that helps describe what a bigger picture is and whether 14 there is a cause for concern. I didn't author that 15 report so I can't tell you the detail of the thinking 16 behind it, but I think the point you made is a hugely 17 valid point, is both those things -- both those 18 conditions need to be true at the same time. 19 Q. Because you understand that, I think within the ROAG 20 context, that you'd need both of those things to be 21 working properly, for the information to come to you and 22 then you, as you put it, to advise yourself in your 23 other capacity that this is something we need to look 24 at? 25 A. Yes, they need to come to light within clinicians within Page 65	1 healthcare has been hierarchical since its inception. 2 What I think -- and I think you've heard the phrase 3 "just culture" with Mr Dunn. 4 Q. Yes. 5 A. And part of that language came, I think, out of the 6 Francis Report, around how do we, as a healthcare 7 system, have the ability to listen to voices of -- and 8 it's not just doctors, it's not just nurses, it's all 9 staff because all staff will have a -- if they have 10 a concern, have a route to be able to raise that and 11 have an important voice there as well. So I think that 12 that's the bit that allows the system to work. 13 Q. These systems existed back to 2002 -- 14 A. Correct. 15 Q. -- but I think what the due diligence report tells us, 16 although it's not its focus, is that they didn't work, 17 isn't that right? 18 A. They certainly weren't effective, no. 19 Q. When you say the combination of system and culture is 20 "the magic", perhaps is not the right word, I might 21 suggest to you, because in fact these are the 22 fundamental building blocks of an effective healthcare 23 system, are they not? 24 A. I agree, maybe that language is poorly chosen. 25 Q. Yes, totally understood but in essence, there is Page 67
1 the system and to be able to escalate them where they 2 need to be escalated. So it's -- I think it comes back 3 to that -- from a medical perspective, the duties of 4 a doctor and that fundamental, you know, where you think 5 something's not right, you have a responsibility to 6 speak up about it. 7 Q. And we looked, with Mr Dunn, at some of the policies 8 that have been around, for example, you mentioned it in 9 your own assessments I think, that there was an adverse 10 incident management policy in existence within 11 NHS Tayside since at least 2002, is that right? 12 A. Yes. 13 Q. And the policy contained a number of components 14 requiring, based on the severity of the incident which 15 had taken place, various different escalation mechanisms 16 to bring the occurrence of the incident and what had 17 happened to various people's attention within the 18 system, is that right? 19 A. Yes, and so I think -- I think you heard from Mrs Watson 20 earlier -- no, last week. So there's two elements to 21 that, isn't there, it's the systems and processes and 22 then there's the culture that allows that to work. And 23 that's the magic in a system is the cultural piece, and 24 I think you heard from Ms Watson how challenging that 25 can sometimes be in what is a hierarchical system and Page 66	1 a recipe which needs to be -- a balance that needs to be 2 struck and there need to be systems in place, but if 3 there is not an attempt to try to make sure that these 4 components of the systems are working, then what you can 5 end up with, especially in a field like neurosurgery, 6 which is highly risky, is people with very significant 7 consequences? 8 A. Yes. 9 Q. Can I ask you some questions about -- we're going to 10 hear from one of your colleagues later this week, 11 Sandra MacLeod, who I think speaks to aspects of the 12 document system, but you have provided some information, 13 I think more in the clinical context about some of the 14 documents that were available to you. I'd like to ask 15 you some questions about that. 16 Can we have a look, please, at the statement at 17 paragraph 113.7. This is a passage in which you provide 18 some information about what you've been able to glean 19 about the nature and extent of Mr Eljamel's practice, in 20 particular in the context of available documentation. 21 A. I don't have it yet. 22 Q. Don't worry. You say -- you mention there, if we can 23 just go a little bit further up, actually. You mention 24 there -- we'll just go from 113.1, it's easier. You 25 tell us that: Page 68

1 "The broad categories of documents relating to the 2 professional activities of Mr Eljamel that exist are 3 detailed in paragraphs 100.2 and 100.3, in addition to 4 the information included below. 5 "Information relating to Mr Eljamel's practice is 6 also held in patients' method records. This will 7 include information such as clinical correspondence, 8 operation notes, contemporaneous records and any results 9 of tests or scans carried out, and nursing records. 10 "Information related to Mr Eljamel's work would also 11 be captured in the minutes of the NHS Tayside 12 Neurosurgery MDT meetings which were held as 13 sub-specialties. 14 "The sub-specialties Neuro-oncology MDT records are 15 held by NHS Tayside Cancer Team. 16 "Neurosurgery Radiology MDT records are held 17 informally and any notes necessary were documented by 18 the clinician in the patient's medical record." 19 And: 20 "Spinal MDT records are held nationally by 21 NHS Grampian." 22 So the reason why I think you have answered this 23 question is there's a particular clinical component to 24 understanding where all the different activities that 25 one might be performing in a neurosurgical area and Page 69	1 record around an individual. 2 Q. Understood. So when one requires to find records 3 relating to an individual or indeed records that might 4 be relevant to this Inquiry, one would need to go to 5 multiple different places, is that right? 6 A. Correct. 7 Q. So even now, even post-digitisation, if there were 8 records that existed in this category they would be held 9 in different places, would they? 10 A. So we'd have -- acute records would be held all in one 11 place in terms of correspondence, about contemporaneous 12 records of in-patient stays, of operation notes, of 13 diagnostic tests. They would all be held in a system 14 that we would call clinical portal, which actually 15 amalgamates systems together but presents it as a single 16 record, but we would still have -- 17 Q. Just to understand, is that basically the equivalent of 18 an old school file of your medical records -- 19 A. Yes. 20 Q. -- in clinical portal, is that? 21 A. We still have those as well. 22 Q. Understood, but then what you've identified here for us 23 is that there are other places where records potentially 24 relevant to a patient's care could be held? 25 A. Yes. Page 71
1 therefore where the records would be generated and kept, 2 is that right? 3 A. Yes. 4 Q. And so you're telling us here that there would be 5 various different places where records would be kept, 6 including in places which are not the patient's medical 7 records, is that right? 8 A. Yes, and records would be held -- the individual health 9 or medical record will contain about an individual 10 patient but where, for example, a multi-disciplinary 11 team meeting would be held, there might be a meeting 12 of -- a record of that. But any outcome that relates to 13 the individual patient would then also be put in the 14 medical record or the health record. That language 15 sometimes is used interchangeably. 16 Q. Understood. 17 A. So certainly during the relevant period, I think records 18 will be potentially quite fragmented depending on 19 whether it's a wider discussion or whether it's around 20 an individual patient. That is less so nowadays because 21 we have much more mature digital systems, we have better 22 digital systems for capturing patient records, and 23 multi-disciplinary team meetings, for example, in this 24 case. But within health, still we have multiple digital 25 systems that capture information. So there is no single Page 70	1 Q. And you've identified one as in various different 2 multi-disciplinary team environments that neurosurgery 3 would be engaged with, is that right? 4 A. Yes. 5 Q. Have people looked for whether these records still 6 exist? 7 A. My understanding is yes, they have. 8 Q. And what's the answer as to whether they do? 9 A. I don't believe that there's comprehensive records that 10 have been found. I'd need to go back through the detail 11 of all the information. 12 Q. Because what you've produced to us, as I understand it, 13 is four, effectively internal to neurosurgery meetings, 14 which relate to the very end of Mr Eljamel's practising 15 career with Tayside. Beyond that, I'm just interested 16 in understanding whether any further searches for this 17 sort of medical -- because you've helpfully laid out for 18 us the sorts of things we might look for but I'm not 19 sure whether we've been told whether these documents 20 have actually been searched for? 21 A. So my understanding is they've been searched for and not 22 been found. And I recognise that this is some 23 significant time ago that, you know, from 1995 to 2014. 24 Whether those records still exist -- or should they have 25 existed still or should they have been destroyed within Page 72

1 appropriate retention schedules? So I don't know the 2 answer to that question. But I know that an attempt -- 3 they've been through all the records that have been held 4 within neurosurgery and not identified any additional 5 records. 6 Q. Yes, but what you're telling us here is certain records 7 wouldn't be held within neurosurgery, they would be -- 8 A. (Overspeaking) If they were neurosurgical MDT records, 9 they would be, yes. 10 Q. Yes, but what about neuro-oncology, which is held in 11 NHS Tayside cancer team, for example? 12 A. So, we've been out to all parts of our system to look 13 for information where we believe it might be held. And 14 what we've identified is what we've provided, what we 15 haven't got is any other records that have been 16 identified. 17 Q. I see, and another category of records which is not 18 talked about here but is talked about in other places 19 would be something called mortality and morbidity 20 meetings. I think you tell us that the practice was 21 such meetings would have taken place in neurosurgery 22 from 2000, is that your recollection? 23 A. Yeah, I believe so, yes. 24 Q. Yes, and again, that sort of meeting, would that be held 25 within neurosurgery? Page 73	1 relation to patient care, is that right? And that's 2 exactly why they might be escalated through the clinical 3 governance system because if the meeting discovered 4 something's gone wrong here, there would be 5 an obligation to escalate it, isn't that right? 6 A. Yes. 7 Q. And there would therefore not only be -- there should 8 not only be records of the meetings themselves but also 9 records of escalations, in appropriate cases? 10 A. Yes. 11 Q. And where would the escalation information be held, in 12 theory? 13 A. So through the clinical governance reporting structure, 14 through the minutes of each relevant clinical governance 15 meeting. So you would have locally, within a service, 16 for example, neurosurgery, so you'd have -- so 17 neurosurgery, or in my practice gastroenterology, we 18 would have clinical governance meetings, we'd have -- as 19 parts of that, because morbidity and mortality meetings 20 are an element of clinical governance not all of 21 clinical governance and that will be held within 22 an individual service, that will be escalated to 23 a grouping. So you've said specialist services which 24 would be appropriate for neurosurgery. Surgery, acute 25 services, and then acute services would report on the Page 75
1 A. So they would be held within neurosurgery and then would 2 have been reported through the clinical governance 3 processes. 4 Q. If they gave rise to matters that require to be reported 5 through those -- 6 A. (Overspeaking) Yes, not everything discussed, as I think 7 you're probably alluding to, you know, the system needs 8 to stratify before it gets reported at each level so, 9 yes. 10 Q. So in theory, if we put document retention aside, there 11 would be records of those meetings, yes? 12 A. A record of those meetings should have been kept, yes. 13 Q. They would have within the time, yes? 14 A. Yes. 15 Q. Or should have been at the time, is that right? 16 A. I don't know because we haven't got them, but yes. 17 Q. But there should have been records kept of that nature 18 at the time? 19 A. Absolutely, and we keep records of mortality and 20 morbidity meetings today, of course we would. 21 Q. Yes, but they should have been kept at the time? 22 A. Yes. 23 Q. Because those meetings are discussing important -- 24 A. (Overspeaking) Clinical governance -- 25 Q. -- and sometimes complex issues that have arisen in Page 74	1 clinical governance activity of the entirety of all the 2 hospital-based care through to the meeting that I chair. 3 Q. Understood. 4 A. Alongside the nurse director. 5 Q. If there had been escalations, there should be records 6 of all of those escalations, is that right? 7 A. If there have been escalations, there should be records 8 of them, yes. 9 Q. And is it possible -- I don't know whether you know the 10 precise details, but what you've told us, I think -- and 11 I think the position is that there aren't any records of 12 that, is that right? 13 A. We haven't identified any records, no. 14 Q. Other than -- I'm not sure whether they are technically 15 mortality and morbidity meetings, but there are the four 16 meetings that you've given us information for? 17 A. Yes, I can't remember the detail of the meetings but 18 I recall seeing them, yes. 19 Q. Yes, and there's something else that we've seen, another 20 concept, if you like, which may fall into this area, 21 something called "clinical audit". Is that a concept or 22 is that a separate type of meeting? 23 A. So there's different elements of clinical governance. 24 So clinical audit will be part of clinical governance. 25 Morbidity/mortality reviews will be. Adverse events, Page 76

1 complaints. All these make up elements of clinical 2 governance. So clinical audit will be auditing of 3 practice against a set standard. And then allows you to 4 benchmark and identify if there's any either 5 deficiencies or whether there's areas that we excel in 6 or areas that we need to improve on and then you'd have 7 an action plan. And the purpose of audit, it's not 8 a single event, it's a cycle of activity. So you'd 9 audit the practice against the standard, you put 10 an improvement process in place, you'd revisit and 11 re-audit that -- again, in an appropriate period of 12 time. That might be six months, it might be a year. 13 That's the process of audit. 14 Q. And was that taking place in this space, in the 15 neurosurgical space over the period that we're 16 interested in? 17 A. So I don't know because I haven't seen the records. 18 Q. If it was, would there be records of it? 19 A. There should be. Whether we've still retained them is 20 a different question. 21 Q. But I mean at the time, there should have been records 22 if this was going on, yes? 23 A. Yes. 24 Q. And because you have told us helpfully where all the 25 different records would be kept, who would be carrying Page 77	1 meeting might be around complaints, it might be around 2 adverse events. So you'd pick all these different 3 elements of clinical governance and what would be looked 4 at in the totality is clinical governance. So clinical 5 audit is a component of clinical governance and that's 6 the structure that that all feeds through. 7 Q. Understood, but I think the difference with that is you 8 say that the consultant would be doing it themselves, is 9 that right? 10 A. The audit? 11 Q. Yes. 12 A. No they would have oversight of it. It's likely that 13 that would be done -- you'd ask a member of the team to 14 do that. 15 Q. But it's done within the team, rather than by 16 an external body, is that right? 17 A. Correct, yes. 18 Q. Understood. 19 A. Unless it's part of a national audit programme. 20 Q. In which case it might be done by an external body? 21 A. It would be reported -- so, I'm just thinking of some of 22 the audits. So we have a national audit programme in 23 place and the name has totally escaped me now. So, for 24 example, the Scottish hip fracture audit is a national 25 audit that has oversight by Public Health Scotland and Page 79
1 out that activity and where would the clinical audit 2 outcomes be held? 3 A. So audit is activity that would almost certainly be 4 directed through the consultant body because you'd 5 identify areas or topics that felt that you should be 6 auditing. So for example, say a new -- so at the time, 7 new NICE guidance, or new SIGN guidance, or new college 8 guidance or something came out, you'd audit your 9 practice against that. Who would undertake that would 10 not necessarily be the consultant who would actually do 11 the detail of the audit. It would be -- for example, it 12 might be a doctor in training, it might be a medical 13 student supervised by a doctor in training, it might be 14 by -- if there was an overlap between nursing practice, 15 it might be -- you know, so you would identify people to 16 do the work, but the oversight would be around the 17 consultant and the reporting would come back to 18 a clinical governance structure. 19 Q. And how would that find itself into the clinical 20 governance? Would it be via some sort of appraisal 21 system, or be separate? 22 A. No, it would be part of -- so clinical governance has 23 all these different bits in it, so you might have 24 a focused clinical governance meeting that is looking at 25 your clinical audit. The next clinical governance Page 78	1 then we feed our data into that, and then it would get 2 benchmarked and then it comes back with certain 3 outcomes. So some audit is undertaken nationally and 4 some is undertaken locally. 5 Q. Okay, and appraisal is another aspect of that system, 6 another component of the clinical governance system, is 7 that right? 8 A. So I think I would call appraisal as part of 9 professional governance, about the activities and 10 professional practice of a doctor. 11 Q. So it's you wearing your responsible officer hat rather 12 than wearing the clinical governance hat; is that 13 correct? 14 A. Yes, but appraisal is individual responsibility as 15 a doctor. So I have my own responsibility as 16 a registered medical practitioner to make sure that 17 I fulfil my professional obligations in terms of having 18 regular appraisal, et cetera. So there's an oversight 19 of it, responsible officer, and then there's 20 a professional obligation to do that. 21 Q. And then, in the case of a consultant neurosurgeon, 22 where would the records relating to any appraisal be 23 held? 24 A. So the records for appraisal during the relevant 25 period -- I think you've heard already in evidence, Page 80

20 (Pages 77 to 80)

1 there's been change of that process and obviously 2 appraisal came in during that relevant period. 3 Appraisal would have been held as a paper record 4 initially, and the summation of the appraisal, each 5 individual appraisal is held within what's called 6 a form 4 which is the appraiser's summary of the 7 discussion of that appraisal. That currently is now 8 held electronically, as is the audit appraisal practice. 9 Q. And are there any records that you were able to find, or 10 your colleagues were able to find, relating to any 11 appraisal having taken place with Mr Eljamel? 12 A. Yes, I believe there's a document -- and I need to go 13 back through in detail about a form 4. And I can't 14 remember who was the appraiser at the time, but there is 15 a form 4. 16 Q. And again, you mentioned the appraisal coming in. Are 17 you talking about at the time when the responsible 18 officer regulations kicked in, in December 2012? 19 A. No, appraisal came in before that. 20 Q. Yes, and when did it come in? 21 A. I think 2004. 22 Q. 2004. So if what you've been able to produce, as you 23 recall, is a single appraisal for Mr Eljamel, is that 24 right? 25 A. Yes. Page 81	1 correspondence around that, even particularly with 2 Scottish Government and the BMA at the time, around 3 bringing the appraisal process. So, yes, I think it 4 was -- it meandered through, rather than very 5 systemically came in, is what I can read from that. 6 Q. But as you have said, I think that was a particular time 7 of mandatory appraisal system that started then. But 8 you have evidence there was an appraisal system being 9 operated before that, is that right, from 2004? 10 A. From 2004, yes. 11 Q. And again, just in terms of where the information 12 pertaining to appraisal would be held within the system 13 at that point, where would that be held? Would that be 14 held within a particular department, or...? 15 A. So at that point -- so I know we had an appraisal office 16 for some considerable length of time. I can't tell you 17 when that office started and when that person was in 18 post. I believe it would have been around that time but 19 I can certainly come back with the details and the dates 20 if that would be of use. 21 Q. But there would be some sort of office away from the 22 neurosurgery department, that would compile all the 23 appraisal-related documentation, whatever that might 24 have been called? 25 A. Yes. Yes, yes. Page 83
1 Q. Yes, but there was a system for appraisal -- 2 A. Yes, there was. 3 Q. -- which went on from 2004? 4 A. And in the records you've shown me earlier, there are 5 names of people who were appraisal leads. So I believe 6 the medical director put Professor Rowley in initially 7 as the appraisal lead and then Mr Musheer Hussain, 8 et cetera. So there would be people who have had 9 responsibility for that since it came in. 10 Q. Because there's quite a bit of correspondence that 11 you've shown us which you've managed to find relating to 12 that later period, when the responsible officer 13 regulations came in. I think before that, there was 14 quite a lot of discussion going on. Professor Rowley 15 was definitely someone who was involved in that, as well 16 as the medical director at the time. 17 There's quite a bit of correspondence with 18 consultants generally, I think, and indeed other medical 19 practitioners, basically saying: there's a system coming 20 in, we don't quite know what it's going to look like yet 21 and it seems to take quite a lot of time and go down 22 a number of different turns; is that broadly what 23 happened at that point? 24 A. Yes, I would agree, that's my -- 100% my interpretation 25 of that. And also I think there was a lot of national Page 82	1 Q. Understood. 2 A. And that still exists today. 3 Q. Yes, and as far as the clinical audit was concerned, 4 again, I think you told us that the information compiled 5 within the neurosurgical department. That would then be 6 fed into the clinical governance system, is that right? 7 A. Yeah, if like, as you've discussed with other 8 escalations, there was something to report. And 9 clinical governance isn't just reporting about things 10 that need to be improved, but also where we do things 11 very well and others can learn from that. 12 Q. Thank you. Could we look again, please, at the 13 statement just where we were, 113.7. You say there: 14 "NHS Tayside does not know the total number of 15 patients under Mr Eljamel's care during the period of 16 his employment with NHS Tayside. NHS Tayside does not 17 hold a comprehensive list of all patients who Mr Eljamel 18 treated from 1995 until his suspension in December 2013. 19 "NHS Tayside holds approximately 4,000 operation 20 notes for patients who were operated on, or on behalf 21 of, Mr Eljamel. These relate to approximately 22 3,800 individual patients as some patients were operated 23 on more than once. NHS Tayside can take steps to 24 identify the medical records that still exist for these 25 3,800 patients, however this would take a further Page 84

1 two months to carry out this work. Should the Inquiry 2 require this piece of work to be undertaken, please 3 inform NHS Tayside. 4 "In January 2026 NHS Tayside advised the Eljamel 5 Inquiry that NHS Tayside still retains 721 deceased 6 patients' medical records from the 1,638 deceased 7 patients." 8 So, I'm interested just to understand how it is 9 you've been able to compile all of this information, in 10 particular you mention there being 4,000 operation notes 11 which relate to 3,800 individuals, as I understand it 12 because some people have had more than one operation; is 13 that correct? 14 A. That's correct yes. 15 Q. Why do you still hold those operation notes and not 16 other records? 17 A. So my understanding is since they were held locally 18 within the neurosurgical department. 19 Q. So they somehow have survived the cull of other records, 20 is that right? 21 A. I think what would have happened is that a copy of the 22 operation note would have been held within the 23 department and I guess what -- and again, this is 24 supposition, so I can't tell you for certain, but it's 25 likely that a department will want to hold a record of Page 85	1 the records retention policies ... which must be 2 followed for data protection purposes. This includes 3 both corporate, administrative records, and patients' 4 medical records. 5 "To find out if there is any information relating to 6 the professional practice of Mr Eljamel missing from the 7 patient medical record, NHS Tayside would be required to 8 carry out a full note review of all known patients of 9 Mr Eljamel. 10 "Some information is no longer available due to the 11 decommissioning of old data management systems and 12 technologies. There is limited organisational and 13 professional knowledge from the current operational, 14 medical and corporate leadership teams, who were not in 15 post in NHS Tayside at the relevant time. 16 "The key documents and/or key information relating 17 to the professional practice of Mr Eljamel in his work 18 with NHS Tayside that NHS Tayside is aware have been 19 lost or destroyed are detailed below. The reason for 20 destruction where known is also included." 21 So there's a couple of aspects that I would like to 22 follow up. As we discussed earlier, 114.2, are you 23 assuming that records have been disposed of in line with 24 records retention policies or do you know that? 25 A. I think that's a conclusion that was made rather than Page 87
1 activity because then you'd be able to go back and audit 2 against it. The original operation note will be held 3 within the individual patient record. 4 Q. So why would it be that those operation notes would 5 continue to be held even although others would be 6 destroyed, I think as you've assumed, in accordance with 7 document retention systems? 8 A. I don't know. 9 Q. Is it perhaps because, as you've just said, they still 10 had a function, ie to do with clinical audit? 11 A. I think that's possible. 12 Q. Could we look at 114.1, please. Again, these were 13 questions about document management that you answered 14 together -- I mean you answered them, but you answered 15 several questions together, not that you answered them 16 with others: 17 "NHS Tayside has combined the response to 18 Questions 114-117 listed above, to avoid duplication in 19 its response. NHS Tayside has numbered the response 20 paragraphs below under Question 114. 21 "Due to the time that has elapsed since Mr Eljamel 22 last worked for NHS Tayside (over ten years) and the 23 preceding 18 years period in which he was employed as 24 a surgeon in NHS Tayside, some records no longer exist. 25 These records will have been disposed of in line with Page 86	1 a fact of a record being destroyed, but I would need to 2 go back to look at -- and Sandra might be able to help 3 with this when you speak to her later this week, 4 around -- my understanding is we're meant to keep 5 a record of what was destroyed and therefore whether 6 that has been the basis of that statement or not. But 7 I'd need to go back and look at the detail of that. 8 Q. Yes, two components of that. When records are destroyed 9 I think that's right, you're meant to keep a record of 10 what was destroyed, is that right? 11 A. That's my understanding of the policy, yes. 12 Q. So say, for example, patient records reach a certain 13 retention policy and someone decides: we should destroy 14 these records according to the policy; you should keep 15 a record of the fact you've done that, is that right? 16 A. Yes. 17 Q. And also in connection with this, my understanding of 18 the policies -- I think we've touched on this already -- 19 is what they impose are minimum periods for which 20 records must be kept, is that right? 21 A. Yes. 22 Q. So to assume that they have been destroyed in accordance 23 with the policy you would, in fact, need to know what 24 the decision-making process was that accompanied that 25 destruction because you can't say that something was Page 88

1 automatically required to be destroyed after a certain 2 number of years, is that right? 3 A. I think that's a reasonable assumption to make. 4 Q. Because what the systems require -- and you have 5 provided us with some of the documents that show this, 6 I think -- is that effectively, a decision is made at 7 that stage as to whether or not, when that particular 8 time period is reached, the documents hold any utility 9 or not, is that right? 10 A. So is "utility" the right word? Yeah, I suppose any 11 use, yes. 12 Q. Yes, so it wouldn't be correct, I think, to assume that 13 records have simply been destroyed in accordance with 14 a policy without knowing why the decision was made to 15 destroy them at that time? 16 A. Yes, to come back to the earlier point I made. 17 Q. Yes, thank you. And you mention there the word 18 "decommissioning" of old data management systems and 19 technologies. This was something that we touched on to 20 a certain extent with Mr Dunn although it wasn't quite 21 clear, certainly to me, whether this was something you 22 could perhaps or others could help us with. 23 A. Okay. 24 Q. The reason why this came up in particular was that you 25 were the one who did the analysis of the due diligence Page 89	1 complaints and adverse events, yes. 2 Q. So Datix came in and replaced certain previously 3 existing systems. We know from some of the 4 documentation. 5 A. That's correct, yes. 6 Q. When did that happen? 7 A. I would need to refer to my timeline. I can't recall 8 the date. I think it was around 2014, I think, but 9 I need to go back to the source document. 10 Q. So at that time, as I understand it from the 11 documentation, in particular the due diligence review, 12 there is suggestion that the decommissioning of those 13 systems was the reason why, for example, there are no 14 pre -- or very few pre-2012 complaints records. Do you 15 remember that from the due diligence review? 16 A. Yeah, I do recall that and I do recall that is 17 an inability to search back in time. 18 Q. Yes, because the due diligence review and indeed your 19 own review of the review, if I can put it that way, have 20 been disadvantaged by the fact that you didn't have 21 access to complaints that existed before 2012, and the 22 reason that's given for it is the fact that this old 23 system was decommissioned, is that right? 24 A. Yes and complaints prior to any electronic system would 25 have all been paper based, from the beginning of his Page 91
1 review and the due diligence review explained that there 2 had been certain historic records which had been lost 3 because of the fact that old systems had been, in some 4 way, replaced. I think it was to do with the 5 replacement of two previous systems, one of which was 6 an adverse incident management system and one of which 7 was a complaints-based system and that they were 8 replaced by Datix, is that right? 9 A. That's correct, yes. I think this paragraph might also 10 refer to decommissioning of old patient administration 11 systems as well. So we currently use a system called 12 TrakCare, so that manages a patient within the 13 healthcare environment. So any appointments they might 14 have, any planned procedures, any waiting lists, 15 et cetera. So I think this might also refer to other 16 systems, not just the adverse event management systems. 17 Q. Right, so when was it that the Datix -- am I correct in 18 my understanding -- Mr Dunn did help us with this -- 19 that Datix effectively is a computer system, is that 20 right? 21 A. Yes. 22 Q. It's a system which, perhaps amongst other things, is 23 a place nowadays where one would record adverse 24 incidents and would record complaints, is that right? 25 A. Datix is. Yes, it's a risk management system, Page 90	1 practice. 2 Q. Why is it the case -- so did you say it happened in 3 2014, you thought? 4 A. I think so -- 5 Q. (Overspeaking) Around about then. 6 A. -- I'd need to go back and check the document. 7 Q. So the key thing really is it happened very shortly 8 after the events in connection with which complaints 9 might have been made. Why was it the case that records 10 which still fell within the retention period were not 11 retained within the Datix system? 12 A. I don't know. I can't answer that question. I wasn't 13 involved in the decommissioning or the provision of the 14 new system, so I don't know the answer to that. 15 Q. Can we just look at this as a matter of logic. So it is 16 the position, as I understand it from the due diligence 17 report, that pre-2012 complaints information disappeared 18 because the old system was decommissioned, is that 19 right? 20 A. That's my understanding too, yes. 21 Q. And the old system, as I understand it, it's quite 22 simple. It's a move from a paper-based system to 23 a computerised system, is that right? 24 A. No. So I think there was an adverse event system that 25 was electronic, that went into a new electronic system Page 92

1 prior to the AIM system that was a paper system. 2 Q. Okay, and so why is it that that system did not 3 incorporate records from the last however many years 4 fell within the retention period? 5 A. I don't know. 6 Q. So is it your understanding, from your study of the 7 report, that in around 2014, effectively all of the 8 pre-2012 records of complaints were destroyed? 9 A. That's my understanding from that report, yes. 10 Q. Okay. Even though although some of those would have 11 been relatively recent at that time? 12 A. Potentially, yes. 13 Q. Because if, for example, the 2010 ones were destroyed 14 that was only four years before that point, is that 15 right? 16 A. That would be correct, yes. 17 Q. Right. Is this something that somebody else might be 18 able to help as well -- I don't want to stretch your 19 knowledge too far, Dr Cotton. 20 A. So, I don't know. I don't know who would be best 21 placed to provide that information to you. 22 Q. The reason why I'm asking you, to be clear, is because 23 you're the person who has undertaken an analysis, to the 24 extent you're able, of the due diligence review and what 25 it says and what its limitations were. And this Page 93	1 to find. 2 Q. And what sorts of documents were put in it, as you 3 understood it? 4 A. So I think there were documents around adverse events. 5 There were documents around correspondence between 6 people, much of which I believe has already been disclosed to 7 the Inquiry. In fact, I believe all of it has. So, 8 yes, that's my understanding of the type of information 9 that was sought. 10 Q. Thank you. So there was an attempt, I think, when one 11 reads the report, to try to compile what was broadly 12 considered to be relevant information into one place, as 13 that had not been done before, is that right? 14 A. So I agree. I think that was what Dr Johnston concluded 15 when she authored the report was, it was the first 16 attempt for the board to try and actually pull as much 17 information together to try and understand what had 18 happened, recognising that she was doing that piece of 19 work at least a decade afterwards. 20 Q. And when you say "afterwards", you mean after what? 21 A. After Mr Eljamel no longer was employed within 22 NHS Tayside but also recognising that trying to look 23 back through the practice of that was a decade, but 24 going back then another 20 years prior to that. 25 Q. Indeed. Page 95
1 appears, certainly on our reading, to be a clear 2 limitation of it. That one is looking to try to find 3 out what happened with regard to Mr Eljamel, and there's 4 a significant disability in doing that because of the 5 fact that records which appear possibly could have 6 contained, for example, information about complaints or 7 adverse incidents that should, if they existed, have 8 been reported through the systems that we've discussed 9 do not appear to exist, even although they don't 10 pre-date the 2014 introduction of new electronic systems 11 by that much. Can you help us with that or have you 12 told us everything you can say about it? 13 A. I don't have any more answers to give you, Mr Dawson. 14 Q. Okay. One of the other things that we learned from the 15 due diligence report is that something called 16 an "information log" was created at around that time, is 17 that right? 18 A. Sorry, could you ask that question again? 19 Q. Yes. One of the other things that one can learn, if you 20 read the due diligence report, as I know you have, is 21 that something called an "information log" was created 22 at that time, is that right? 23 A. So I think it was compiling all known information that 24 was held through PLRT, as it was established, or 25 a corporate record of all documents that they were able Page 94	1 A. So it was trying to attempt to try and understand what 2 had happened over a very significant timeframe. 3 Q. That is something that would have been easier to do had 4 one been ten years before that, wasn't that right? 5 A. I would agree. 6 Q. So there was a disadvantage. Although Dr Johnston was 7 trying to pull together the information, there would be 8 limitations on the amount of information because of the 9 passage of time, yes? 10 A. It's a limitation that we're facing today. 11 Q. Indeed. 12 A. And, your Lord, you are also facing. 13 Q. Well, I'm interested in that aspect because one of the 14 things that has become apparent in the way in which 15 documentation has been produced by you and your team to 16 the Inquiry is that it contains information which 17 doesn't come from the information log, is that right? 18 A. Yes, because I think the due diligence report was 19 focused and obviously the questions that you've -- you 20 asked us to respond to were broader than was considered 21 in Dr Johnston's report. 22 Q. Well, all of them are connected with Mr Eljamel and the 23 systems around -- 24 A. (Overspeaking) I recognise that. 25 Q. -- have to be. So where are the additional places that Page 96

1 you've accessed information, other than the information 2 log? 3 A. So corporate records, and records held within different 4 teams. 5 Q. So just to give an example of one of the things that 6 you've helpfully produced and we've looked at with 7 Mrs Watson is a 460-page HR file related to Mr Eljamel. 8 A. Correct. 9 Q. Did that come from the information log? 10 A. I believe that was looked at through the due diligence 11 report, yes. 12 Q. So that was available to the people that compiled the 13 due diligence report as part of the log? 14 A. I believe the HR file was available to the authors of 15 the due diligence report. However, you may wish to 16 confirm that with the authors of the due diligence 17 report because I didn't author it, so I can't -- there's 18 not a catalogue at the back of the due diligence report 19 to say what information they held and looked at. 20 Q. But there is a catalogue of the information in the 21 information log, isn't there? 22 A. Correct. 23 Q. And the information log is what they used to compile the 24 due diligence report -- 25 A. That's my understanding. Page 97	1 relevant to what we're looking at, isn't that right? 2 A. Yes. 3 Q. One of the things that existed at one point, for 4 example, was a theatre logbook relating to surgeries 5 that had been undertaken by Mr Eljamel, is that right? 6 A. There was a theatre logbook of surgeries that occurred 7 within the neurosurgical theatre of which Mr Eljamel's 8 practice was part of, yes. 9 Q. Yes, and there were several of those, isn't that right? 10 A. Yes. 11 Q. Some of them, as we've discussed with Ms Connor, were 12 destroyed, isn't that right? 13 A. I understand, yes. 14 Q. And the others you have been able to produce to us, is 15 that right? 16 A. Yes. 17 Q. So were those documents, that's the ones you have 18 produced and the ones that were destroyed, were they in 19 the information log? 20 A. I'd need to go back and look. I can't tell you that off 21 the top of my head. 22 Q. But my understanding was that they were recovered from 23 the office next to the theatre where Mr Eljamel did his 24 work, is that right? 25 A. I believe so, yes. Page 99
1 Q. So that means there is a catalogue of what they used to 2 compile -- 3 A. (Overspeaking) So I didn't author the due diligence 4 report, Mr Dawson. 5 Q. Well, I understand that, but as a matter of logic, is it 6 not the case that if there's a list telling us what's in 7 the information log and the information log is what they 8 used, then we have a list of what they took into account 9 to compile the due diligence report? 10 A. I follow that logic, yes. 11 Q. Is that right? 12 A. That's my understanding, yes. 13 Q. Thank you, and you were mentioning there the other 14 sources from which you've been able to get information, 15 corporate records, I think you said. What does that 16 mean, broadly? 17 A. So board reports, minutes of meetings, et cetera. 18 Q. And are there any other places where you've managed to 19 find information in addition to what was contained 20 within the information log? 21 A. I'd need to go back and look in detail at where all 22 of the information was sourced from. So I would need 23 some time to do that. 24 Q. Okay, but you accept -- and that's helpful. You have 25 looked at other places and you've found things that are Page 98	1 Q. Does that mean that they were not in the information 2 log? 3 A. I can't tell you this. I'd need to go back and look. 4 I'm very happy to go and do that. 5 Q. Was there any indication in the paperwork that you 6 looked at relating to Dr Johnston's decision around the 7 creation of the information log as to why one had not 8 been created relating to the Eljamel saga earlier? 9 A. No. 10 Q. Would that be, again, something we would have to ask 11 her? 12 A. Yes. 13 Q. Could we have a look, please, at the report at page 70. 14 Are you familiar with the concept of something called 15 a "fauxpology", Dr Cotton? 16 A. I beg your pardon? 17 Q. Are you familiar with the concept of something called a 18 "fauxpology"? 19 A. No. 20 Q. It is a concept which arises actually out of some 21 evidence that's been made available to the Inquiry which 22 we're going to look at later this week in a report that 23 we have. It's a situation where apologies are issued in 24 order to try to protect the reputational interest of 25 a body but they're not actually either clear or properly Page 100

1 intentioned. You understand the concept? 2 A. I understand the concept, yes. 3 Q. We asked you some questions here -- I'll read them out 4 in a second -- relating to a statement that was issued 5 by NHS Tayside in your name, which was issued around the 6 time of one of our Inquiry hearings, the preliminary 7 hearing last September. Do you recall issuing these? 8 A. Yes, I do. 9 Q. Yes. Now, we'll have a look at the particular details 10 of them in a moment, but these questions weren't 11 answered by you, were they? There's that one and we can 12 look at the one over the page, if you want to see that, 13 too. 14 A. No, I don't believe they were. 15 Q. They were answered by one of your colleagues who deals 16 with communications, is that right? 17 A. That's correct, yes. 18 Q. Why was the decision made for her to answer these 19 questions rather than you because you made the 20 apologies? 21 A. I don't recall why a decision was made around that. So 22 these are my words on behalf of NHS Tayside and I have 23 already said earlier in evidence that as an organisation 24 we had opportunity to intervene earlier and that is 25 particularly around -- and we've covered some of the Page 101	1 or, if there had been additional concerns raised, 2 I cannot understand why he was not removed from 3 operating if not other elements of his practice. And 4 I fundamentally can't understand that level of 5 supervision. 6 Q. But how do you know what the level of supervision was? 7 A. I believe it's all described in terms of the 8 correspondence, that his practice was supervision around 9 meeting him once a week to go over his inpatients. It 10 didn't fundamentally address his surgical practice. 11 Q. So you've been able to deduce that to -- 12 A. (Overspeaking) From the evidence that I have got, 13 I cannot understand why he was allowed to continue to 14 operate alone or was allowed to operate -- or operate at 15 all. I cannot understand that. 16 Q. So effectively -- I think we've discussed aspects of the 17 disciplinary procedure with Mrs Watson, but effectively 18 that means you think at the time when he was put under 19 clinical supervision in June 2013, he should have been 20 suspended, is that right? 21 A. I think a proper risk assessment should have taken place 22 and either he needed direct supervision of his surgical 23 practice, as in one-to-one supervision, or not operate 24 at all, or suspended. And that would require probably 25 some subject matter expertise at the time but I can say Page 103
1 areas in the due diligence report, but particularly 2 around the decision on the level of supervision. And 3 maybe it doesn't come out clear enough in this but 4 fundamentally, that decision was flawed and it was 5 inadequate and it was unacceptable. I think that could 6 have been much -- said much stronger in that, and 7 I guess, at two levels. 8 One as -- one as NHS Tayside but, two, as a doctor, 9 that is unacceptable and we should have done much better 10 then and people have come to harm and distress as 11 a consequence of that decision. 12 Q. Okay, so you're recognising there, I think as a doctor 13 but also as one of the executives of the board, that 14 something went wrong with the supervision requirements 15 of Mr Eljamel, is that right? 16 A. Fundamentally, yes. 17 Q. How do you know that? 18 A. So, many times I have put myself in the shoes of 19 thinking about the concerns raised around the surgical 20 practice of a surgeon. And I cannot understand, based 21 on two really simple principles of decision-making, is: 22 was it safe for patients and was it safe for staff, but 23 fundamentally was it safe for patients not to have, 24 either as a very bear minimum, supervised the surgical 25 practice of Mr Eljamel when there were concerns raised Page 102	1 to you, as medical director, that's the decision-making 2 process I would be starting to think about when I had 3 read those concerns. 4 Q. But I think you said a moment ago that he should not 5 have been allowed to operate, is that right? 6 A. Yes. I don't think he should have been. I think if 7 I was to make that decision today, I would not let him 8 operate. 9 Q. I see, and is that from the point of time that 10 identified when the clinical supervision started or at 11 some earlier point in time? 12 A. So I think certainly when clinical supervision was put 13 in place, the supervision did not address the risk. The 14 risk was about his practice in the operating theatre. 15 Q. Because there, of course, had been a sequence of events, 16 which I hope you picked up from the documentation, that 17 brought these risks to the fore at an earlier stage. In 18 fact, what we have learned was there was a complaint 19 made which led to a serious clinical incident review. 20 The complaint was made to the chief executive, I think, 21 in December 2012, is that right? 22 A. Yes, I have read that SCEA, yes. 23 Q. That was a complaint by the medical practitioner who was 24 the patient. 25 A. Yes. Page 104

1 Q. And it was an allegation of wrong-site surgery. 2 A. Yes. 3 Q. And wrong-site surgery at the time, we learned with 4 Mr Dunn, was described within the AIM policies as 5 a "never event", is that right? 6 A. Yes. 7 Q. Should he have been stopped from operating at that 8 point? 9 A. So what I cannot see is how an assessment of that, under 10 any form of risk assessment, led to a decision around 11 what was the appropriate level of oversight of that 12 doctor's practice. So that's what I can't see. I would 13 strongly have considered much greater scrutiny of 14 practice, if not stopping him operating or stopping him 15 doing a certain type of procedure. I would have 16 considered all of those things. 17 Q. And on the basis of the information available to you, 18 what would the view have been that you think you would 19 have reached in that important position in December of 20 2012? 21 A. I think I go back to the first principle that I said 22 earlier, which was: was it safe for patients? And 23 I don't think -- if the answer is "no" to that, then 24 whatever the action has to be, has to be proportionate 25 to turn that "no" into a "yes". It's very difficult to Page 105	1 be something that is reported by anyone that knows of it 2 within an hour, isn't that right? 3 A. Once the adverse event has been identified, yes. 4 Q. Yes. So within the period of there being an accident or 5 incident arising, whether it's a never event or not, 6 there requires to be a 1-hour or a 24-hour reporting 7 period, is that right? 8 A. That's what the policy says, yes. 9 Q. And so, of course if, as you've told us, the occurrence 10 of surgery or an event like that is so significant, is 11 it not the case that his practice should have been 12 stopped in 2007? 13 A. I think there was an opportunity to understand why that 14 happened and an intervention could have been put in 15 place then. 16 Q. Should it have been? 17 A. Again, with the caveat of limited information and not 18 being there at the time, I think that was 19 an opportunity. The "should" bit I think is really 20 difficult to answer but it was definitely 21 an opportunity. 22 Q. Dr Cotton, there are a lot of people for whom this is 23 an extremely important passage of evidence and you've 24 been good enough, in relation to this aspect at least, 25 to give your professional opinion. You're very well Page 107
1 put myself in somebody's shoes historically, with now 2 all of the context, so I would fall back on those 3 principles. And if it was stopping somebody operating 4 for a period of time until you established all of the 5 facts, that would be the right thing to do. 6 Q. So presumably, as I understand it -- you will know more 7 about it than me -- the wrong-site surgery being 8 a never event is a particularly persuasive thing. And 9 although it is fair to say that there may have been 10 other information that you're not privy to, I think what 11 you're telling me -- please correct me if I'm wrong -- 12 is that that in itself and in particular, the status 13 that that's given within the policies that existed at 14 the time, would really need quite a lot of evidence to 15 weigh against it to stop the intervention being to take 16 him off surgery completely? 17 A. Yes. It's a very, very, very big red flag. 18 Q. Yes. We know from the due diligence report that there 19 was a wrong-site surgery which took place in 2007, isn't 20 that right? 21 A. Yes, that's correct. 22 Q. And of course, the adverse incident management policies 23 tell us that if there is a never event that takes place 24 like that -- and that was in place at that time because 25 it had been in since 2002, we know -- then that should Page 106	1 placed to be able to give to. And within the 2 parameters of understanding that you don't have all of 3 the information that would have been available at that 4 time, can I ask you again, should he have been stopped 5 from operating in 2007? 6 A. I don't know. I genuinely don't know the answer because 7 it was a fundamental opportunity to do that and I think 8 that could have been an opportunity missed. 9 Q. Would an adequate system of clinical governance have had 10 that result? 11 A. It would have resulted in him being stopped to operate? 12 Q. Yes. 13 A. So a system of clinical governance would have identified 14 that and would have reported it and would have had 15 oversight of senior clinicians, such as the medical 16 director, in to make those decisions. 17 Q. Of course, because that would be the escalation route at 18 that time? 19 A. Yes. 20 Q. Similar to the way it would be now? 21 A. Correct. 22 Q. And if the medical director were applying the same 23 criteria as you to the significance, in the assessment 24 of a never event, does it not follow that the decision 25 should have been that he should have been taken off Page 108

1 operating at that point? 2 A. I can follow that logic completely, 100 per cent. 3 Q. So the answer to the question is "yes"? 4 A. I think you're asking me to give a certainty of 5 a decision I would make at the time. I find that very 6 difficult to put myself in those shoes. I think I have 7 been really clear that I think there was an absolutely 8 missed opportunity there. So I can't tell you for 9 certainty what decision I would make at that time, but 10 I do fundamentally think there's a missed opportunity. 11 Q. I don't think that complying with the proposition that 12 that should have been the result requires any degree of 13 certainty. I'm asking you whether it should have 14 happened, not whether it certainly would have happened? 15 A. It could and should have happened, yes. 16 Q. Thank you. 17 MR DAWSON: That would be a convenient moment, sir. 18 THE CHAIR: Thank you. Right, we're going to break now, Dr, 19 for lunch and we resume again in an hour's time. 20 A friendly reminder not to discuss your evidence over 21 the lunch break. Ms Miller will take you back to the 22 witness room. Thank you. 23 Thank you. 1.50, everybody. 24 (12.53 pm) 25 (The short adjournment) Page 109	1 where failings have been identified." 2 And we asked you: 3 "Please explain what failings [NHS Tayside] have 4 been identified relating to the systems surrounding the 5 professional practice of Mr Eljamel to which the 2023 6 review related and what improvements have been made as 7 a result." 8 So I think, as we identified, these questions 9 weren't answered by you but the apology that I have just 10 referred to was issued by you, is that right? 11 A. It was, yes. 12 Q. I think you may have touched on this already, but the 13 apology that's there relates -- well, first of all, it 14 identifies that many people have experienced 15 considerable distress as patients of Mr Eljamel; is that 16 correct? 17 A. Yes. 18 Q. And I think what you're trying to indicate is that 19 certain things that the board have done fell short 20 subsequent to that, is that right? 21 A. Yes. 22 Q. And that you focused in, in particular, on the handling 23 of ongoing complaints and concerns, is that right? 24 A. That's correct. 25 Q. I think we've identified, in our discussion earlier, Page 111
1 (1.52 pm) 2 THE CHAIR: Good afternoon, Dr Cotton. We're ready to 3 resume. Mr Dawson. 4 MR DAWSON: Thank you. Dr Cotton, we were looking at 5 page 70, can we have that up, please, of the statement. 6 These were the questions that we identified earlier 7 relating to certain comments and an apology that were 8 issued by you on 10 December 2025. It says: 9 "... the BBC reported that: 10 "Dr James Cotton, executive medical director of NHS 11 Tayside stated that... 'We know that many people have 12 experienced considerable distress as patients of 13 Mr Eljamel and we understand that in many cases we have 14 added to that trauma in the way that we have handled 15 ongoing complaints and concerns. We are sincerely sorry 16 for this.' 17 "Please explain what NHST was apologising to 18 patients for, in particular what trauma they accept they 19 caused, when and how?" 20 And if we look over the page to page 71, we also 21 asked you: 22 "It was also reported that: 23 "Dr Cotton added that since the publication of 24 NHS Tayside's 2023 Due Diligence Review into Eljamel, 25 the board had 'fully committed to making improvements Page 110	1 that there were some other aspects, I think, that you 2 think fell short. 3 A. Yes. 4 Q. They weren't mentioned here, were they? 5 A. No. 6 Q. Just focusing on the complaints and concerns aspect, 7 because I know this is an aspect that you've looked at 8 in the context of evidence that you've provided in the 9 due diligence review. What was it particularly about 10 the complaints and concerns process that you felt had 11 compounded, if I could put it that way, the distress 12 that patients had experienced? 13 A. I think it's several factors actually, I don't think 14 there was one. I think -- and we've covered a lot of 15 this already this morning I think already, in terms of 16 adverse events that were not thoroughly and fully 17 investigated, complaints that were not responded to in 18 a timely enough or probably in a robust enough fashion 19 and -- sorry, I have lost my thread. 20 Q. You were explaining to us the aspects of the complaints 21 system, so there were aspects that were -- the adverse 22 incident review system hadn't worked robustly enough, 23 I think -- 24 A. (Overspeaking) Yes, and we had spent some time 25 discussing that this morning. Page 112

1 Q. Yes, we had, but just on the complaints and concerns 2 aspect, you have told us that some of them were not, 3 I think, responded to in a timely and robust enough 4 fashion, is that right? 5 A. Correct. 6 Q. Can you say anything more about that? What in 7 particular -- the times we can see which were outwith 8 the times that were sort of prescribed, if you like, 9 you've provided some evidence about that in the written 10 form. As far as -- I think, the due diligence report 11 tells us something about the fact that some complaints 12 and concerns were not dealt with through the formal 13 complaints process. Is that correct? 14 A. Correct. 15 Q. And were you able to identify how many people that 16 related to, what the scale of the problem was? 17 A. No, I can't. 18 Q. No, would that be another one that we can maybe address 19 to other people who were more involved in doing that at 20 the time? 21 A. Yes, I'd need to probably go back and look at that in 22 the evidence. 23 Q. Thank you. Although the question wasn't answered by 24 you, it relates to the apology you've given. At 25 paragraph 12.2, your colleague, I think it's Page 113	1 earlier because there's a lack of trust and that is 2 within of the reasons that you'd consider removing 3 a doctor from the workplace, if you can't trust them. 4 Q. Yes, well, we may discuss that just now because it's 5 a helpful point to do. Obviously, when we were 6 discussing earlier, earlier points than start of the 7 clinical supervision in June 2013 at which suspension or 8 some other measure might have been put in place, what 9 we're doing now is we're going the other way and 10 identifying a point after that before the suspension was 11 actually imposed in December 2013 at which a suspension 12 might have been imposed. Is it your interpretation, in 13 light of the information that was communicated in the 14 interim report, that a suspension should have been put 15 in place at that time? 16 A. If I couldn't trust the doctor, I would consider 17 suspension and, yes. 18 Q. Yes and that's what you mean by the "probity aspect", 19 that gives rise to considerations of trust? 20 A. Of trust. 21 Q. Because you are were obviously -- if we're imagining 22 that you were the person there at the time because you 23 would be the person there now, you're trying to work out 24 whether the patient can trust the doctor and if you 25 can't trust the doctor then why should the patient; Page 115
1 Miss Duncan, answered this question, and she set out: 2 "The failings identified in the Due Diligence Review 3 2023 included: 4 "Inadequate clinical supervision when Mr Eljamel 5 was placed under indirect supervision when he should 6 have been directly supervised in theatre." 7 I think in our conversation earlier you've accepted 8 that still is the position, isn't it? 9 A. 100 per cent. 10 Q. Thank you: 11 "Inadequate senior input to the supervision 12 arrangements resulting in inadequate assessment of risk 13 and consideration of patient safety." 14 I think, again, you've accepted that? 15 A. 100 per cent. 16 Q. "No action taken when the [Royal College of Surgeons] 17 sent an interim report ... to NHS Tayside 18 in October 2013 raising concerns of probity, poor 19 communications and poor behaviours by Mr Eljamel." 20 Again, that's a report you helpfully looked at for 21 us. Is that still a position that's accepted by 22 NHS Tayside? 23 A. Yes, particularly because of the probity element to that 24 and I think that is, for me, a -- that is one of the 25 questions around why suspension couldn't have been done Page 114	1 would that be fair? 2 A. I think that's a fair assessment and I would probably 3 just go back to the principles that I have outlined 4 before in decision-making. So when you're medical 5 director, you're never -- and a concern is raised, it's 6 never physically formed at the time. You don't know all 7 of the facts but what you do have to do is make sure 8 that you understand what risk you're holding and how you 9 mitigate against that risk. And if you've got concerns 10 raised by an external body around whether somebody is 11 truthful -- that's what probity is, it's whether that 12 person's truthful -- you can't trust them then. 13 Q. Because we've looked at this with other witnesses and 14 I know you've looked at this as well, the October 15 report -- and indeed, the ultimate report which was 16 produced in December, or sent in December -- that 17 identified issues of truthfulness both with patients and 18 with other colleagues, isn't that right? 19 A. Correct. 20 Q. So there's a sort of double-barrelled issue with that, 21 isn't there? 22 A. Yes. 23 Q. And it goes on to say that another aspect that was 24 included in the 2023 review was that: 25 "The conclusion that patients were placed at Page 116

1 potential risk of harm due to the inadequacy of the 2 supervision arrangements ..." 3 So that's back to the aspect we were discussing 4 before, do you agree with that? 5 A. Yes. 6 Q. And then one other aspect that we haven't touched on 7 yet, that: 8 "The ceasing of an internal investigation into 9 Mr Eljamel by NHS Tayside after he intimated his 10 retirement in early 2014." 11 Again, I know that's something that you've 12 considered in broad terms, but that related to the fact 13 that after the full report came through in December, we 14 know that Mr Eljamel was suspended, and that we 15 discussed this with Mrs Watson last week, that there 16 were some initial moves towards there being what she 17 called a preliminary investigation into Mr Eljamel and 18 that someone called Dr Johnston, I think, was contacted. 19 Are you aware broadly of that correspondence? 20 A. Yes, I am. 21 Q. And a decision was made in early 2014 not to go ahead 22 with that investigation, as I understand it because 23 Mr Eljamel had intimated an intention to retire. Now do 24 you accept that that was something that should not have 25 happened? Page 117	1 apology which was issued in December 2025? 2 A. Yeah, I accept the apology could have been fuller and 3 better worded. 4 Q. Because we discussed this to an extent with Ms Connor 5 and I think apologies, in these sorts of circumstances, 6 are extremely important, aren't they? 7 A. Yeah. 8 Q. It's important that they should be clear, is that right? 9 A. They should be clear, they should identify what went 10 wrong and what we've done about it. 11 Q. Yes, and they should be comprehensive, covering all of 12 the things that we've mentioned, is that right? 13 A. I agree and I think that apology fell short. 14 Q. And I think another aspect that we discussed this 15 morning was the fact that there was, recognised within 16 the due diligence report, a lack of triangulation, the 17 word that you used earlier of the various different 18 governance systems, is that right? 19 A. Yes. 20 Q. And I think you've already told us that's something that 21 you accept? 22 A. Yes. 23 Q. And you have also told us this morning, that there 24 appears to have been an apparent failure within that 25 system to have recognised the wrong-site surgery that Page 119
1 A. Correct, it should have happened , we should have 2 continued with the investigation. 3 Q. Why would that have been important? 4 A. Because we hadn't fully concluded or understood the 5 issues. The Royal College of Surgeons only identified 6 some aspects of it. I just -- and yeah, I just don't 7 understand the logic behind that. Sorry, I just don't 8 understand the logic of that decision-making. 9 Q. Yes, because there would have been an advantage to the 10 systems and the service to continuing an investigation 11 because it could have given rise to considerable 12 learning? 13 A. 100 per cent. 14 Q. Yes, okay. I think there are other aspects that we've 15 probably touched on already actually of the due 16 diligence report that are identified as failings. In 17 particular, around lack of documentation, that was 18 something I think we touched on earlier, which I think 19 you've already accepted that that was a justifiable 20 conclusion? 21 A. Yes. 22 Q. And in that context I'm interested to understand why 23 these aspects, which your colleague has helpfully set 24 out for us there and indeed more that you've helpfully 25 identified as you're accepting, didn't feature in the Page 118	1 occurred in 2007, is that right? 2 A. Yes, we've talked about that, yes. 3 Q. So because of the fact that -- this is very important, 4 Dr Cotton, because of the fact you hold a very important 5 position, you were the person selected to issue this 6 apology, do you think it now appropriate to 7 issue an apology for all these things having occurred? 8 A. Yes, I do. 9 Q. And so could we take that to mean that you apologise on 10 behalf of NHS Tayside -- 11 A. I do, yes. 12 Q. Thank you. I wonder whether we could have a look at 13 a document, please. This is one you helpfully gave to 14 us but I think it was a little bit of a mystery as to 15 what it was, but it might be relevant to some aspects 16 we're looking at. It's NHST-01654. I think, in 17 advance, this may be one of the documents that's quite 18 hard to read, it's in very small print, but we'll try 19 our best and try and zoom in. Now, this is a document 20 which I think is undated, is that right? 21 A. I haven't seen the date. In fact, I looked at this over 22 the weekend. 23 Q. Can you tell us what you understand this to be? 24 A. So I think, what I have read from this, this is 25 a document that was compiled by Dr Hilton-Christie, who Page 120

1 was the associate medical director for clinical 2 governance. And I think this would have been around the 3 time of the due diligence report, is what I think this 4 is from. But recognise there is no date, so I can't be 5 certain on that. 6 Q. Do you know when Dr Hilton-Christie held that position, 7 perhaps? 8 A. So she left, I would think about two years ago and held 9 that position until that point and is currently the 10 medical director for NSS. 11 Q. Right, so it would be a reasonable assumption, based on 12 that information and what this is related to, is that 13 this may have been an exercise that Dr Hilton-Christie 14 was asked to carry out in connection with the due 15 diligence review, is that fair? 16 A. I think so. That's what I -- and I viewed this over the 17 weekend and that's my conclusion from that. But again, 18 I'm not speaking from a place of authority but 19 a judgment reading it. 20 Q. Understood, because this is an assessment of some 21 medical records to try to work out what the position, 22 with consent and informed consent, might have been, 23 isn't that right? 24 A. That's how I have taken that document as well. 25 Q. The interesting thing about that is, that isn't Page 121	1 A. Yes. 2 Q. And in this document what happened, I think, underlying 3 it is that Dr Hilton-Christie was asked to look at 4 a sample, which I think comes from a number of different 5 years over Mr Eljamel's practice of medical notes to try 6 and work out the position with consent, is that right? 7 A. Yes, that's what I take from this document. 8 Q. We heard, when we heard evidence from our ethics group, 9 that there is something that exists in medical practice 10 called a "consent form"; is that correct? 11 A. Yes, that's correct. 12 Q. And we heard that a lot of the ethical guidance pointed 13 out that the consent form should be used as evidence of 14 consent but shouldn't dominate or take over the consent 15 process. Is that an ethical principle you recognise? 16 A. So that's a principle of consent. It's a process -- the 17 signing of the form is not the consent. 18 Q. Indeed, but the form might be used as evidence of some 19 sort of consent process having taken place? 20 A. Yes, and certainly contemporary process would be 21 documenting what that discussion was with a patient, 22 what the risks, the benefits, and how that would be 23 weighed up, and what the alternatives would be. And 24 that would be contemporary consent and certainly for the 25 type of procedures undertaken and the risk associated Page 123
1 something that the due diligence review looked at 2 directly, is that right? 3 A. No, it didn't. 4 Q. So it may be that there was an investigation of that, 5 which looks like a helpful investigation, but somehow it 6 didn't make its way into the due diligence report, is 7 that right? 8 A. No, I agree, it didn't. 9 Q. Because, as you will probably know, questions around 10 consent and informed consent are significant issues for 11 some of the Eljamel patients, you're aware of that? 12 A. I am and actually reading this document, there are 13 concerns, aren't there, reading that. 14 Q. Yes, because we've heard some evidence from our ethics 15 group in quite a lot of detail about the importance of 16 consent and informed consent, particularly in an ethical 17 context. That will be something that you recognise, 18 I'm sure? 19 A. I do recognise that, yes. 20 Q. And we talked about the fact that it had been something 21 which had featured as an important component of ethical 22 medical practice for a number of years in various 23 different ethics-related publications. 24 A. Yes. 25 Q. Is that your recollection? Page 122	1 with those procedures, my expectation that would have 2 been by the operating surgeon. 3 Q. Yes, and the way that those forms work, I think, is that 4 there's a bit where, obviously subject to what you've 5 said about the need to document the conversation 6 somewhere else, the medical records or wherever, there's 7 a bit in the form that's signed by the patient and a bit 8 that's signed by the operating surgeon, is that right? 9 A. Yes. 10 Q. And so what this says is: 11 "This spreadsheet contains information on an audit 12 that was carried out by Dr Sharon Hilton-Christie, 13 [associate medical director] for Clinical Governance and 14 PLRT." 15 What's "PLRT"? 16 A. That is the Patient Liaison Response Team, I think, 17 that's referred to in the due diligence report as 18 a structure that was put in place. 19 Q. Yes, we heard about that from Ms Connor when she was 20 here, thank you: 21 "The audit was to take a random sample of 22 Professor Eljamel's patients and look at their notes to 23 find out if there was evidence of consent, and if the 24 patient had signed to consent to the procedure. It was 25 also to document who had carried out the consenting of Page 124

1 the patient, if it was Professor Eljamel or someone else 2 on his behalf. 3 "It was found that of the 14 notes available, all 4 had evidence of a signed consent form except one. 5 However, it should be noted that this patient's notes 6 were not in good condition. 7 "It was also found that out of the 13 consent forms 8 found, none of them were signed by Professor Eljamel 9 himself." 10 A. Yeah. 11 Q. What does that indicate? 12 A. I think I have already probably expressed my opinion on 13 that. I don't think that demonstrates adequate consent 14 in terms -- 15 Q. (Overspeaking) Does that mean he didn't take the 16 consent? 17 A. He certainly wasn't there -- well, what I would read 18 from that is if he has not signed them, he has not been 19 sitting face-to-face with that patient; that's what 20 I read from that. 21 Q. Understood. 22 A. My clinical practice involves taking consent and that's 23 not my practice, nor others. 24 Q. Understood, and one of the issues that's alluded to 25 there, I think you've told us that one would expect to Page 125	1 a case notes review? 2 A. That's what I'm reading from this. This is we've taken 3 a sample and then we've looked at case records. 4 Q. And as I said, my understanding is that this doesn't 5 become part of the due diligence process, although 6 Dr Hilton-Christie has carried out this potentially 7 helpful exercise? 8 A. Yes, and I think, maybe just reflecting on an earlier 9 set of questions regarding the investigation, I think 10 if -- so recognising that Dr Hilton-Christie and 11 Dr Johnston were attempting this exercise some 12 significant time afterwards, if consent had been 13 a factor that had been identified certainly in 2013, 14 2014, continuing that investigation would have allowed 15 this to be examined in a bit more detail. 16 Q. Yes, indeed. 17 A. With a bit more information available at the time. 18 Q. Yes, as you said earlier, the earlier the 19 investigations, the better the information that would be 20 likely to be available, is that right? 21 A. Yes. Yes. 22 Q. Thank you. One aspect of the apology that I'd be keen 23 to follow up with you a little bit is understanding -- 24 it's an area we haven't touched on with many other 25 witnesses yet and it's something that you've covered, Page 127
1 find notes elsewhere of the consent process, is that 2 right? 3 A. And the process would be -- you know, the process would 4 be maybe an initial clinical consultation with the 5 patient in a clinic to discuss, you know, symptoms and 6 signs and what a proposed course of treatment would be. 7 That would be followed up probably by another detailed 8 discussion around the planning of surgery on the day of 9 the procedure. So it would be visible, it would be time 10 and space with patient provided with adequate 11 information to come to a person-centred choice for them 12 about what the benefits and risks are. 13 What that wouldn't be, unless it was an emergency 14 situation, a short process. That should be over 15 a period of time with spaces between them to allow 16 appropriate reflection. 17 THE CHAIR: All should be recorded in the notes in some 18 form. So both the initial discussion in the clinic and 19 also the more detailed follow-up discussion when you're 20 perhaps getting closer to a decision on surgery? 21 A. It should, yes. 22 THE CHAIR: Thank you. 23 MR DAWSON: Thank you. And the review, as we've said here, 24 it doesn't indicate that patients were actually involved 25 in Dr Hilton-Christie's analysis, does it; it's Page 126	1 albeit slightly indirectly in your report is to do with 2 complaints. Now, the complaints system, or the 3 components of complaints that one can see coming up, 4 certainly from our Terms of Reference but also in 5 documentation, is that there are various different types 6 or levels of complaint that one sees. So, for example, 7 one sees reference to issues, concerns being raised, 8 feedback being provided, and then something of a more 9 formal complaints process. 10 Is it important that a complaints system, for it to 11 work well, recognising that there will be a place for 12 various different levels of issue that a patient might 13 have which might appropriately be dealt with in 14 different ways? 15 A. Yes. 16 Q. And so, whereas something might be able to be dealt with 17 in relatively short order with a conversation with 18 a nurse or with a consultant, something else perhaps 19 more serious would require a more formal system and 20 a more robust investigation, is that fair? 21 A. Yes. 22 Q. And is that, as far as something you know about, I think 23 the current complaint system, which you have told us 24 already will be a component of the clinical governance 25 mechanisms, does NHS Tayside now try to recognise that Page 128

1 an effective system requires to have these various 2 different stages or levels of complaint or issue or 3 feedback being raised? 4 A. So you may well have seen in the complaints process, we 5 have stage one and stage two complaints, so that allows 6 early resolution and then followed by a more formal 7 investigation. There may be, as you've rightly said, 8 you know, something happens in a ward that requires 9 a conversation between two individuals to work out what 10 the problem is and how it's resolved. And that's -- 11 where there's a concern or a complaint, the earlier it's 12 resolved the better it is, but I would agree that, you 13 know, we do recognise that within our current systems 14 and processes, so stage one early resolution, stage two 15 formal investigation and reporting. 16 Q. And the systems which exist at the more -- well, who is 17 able to make a complaint within the systems? 18 A. In terms of? 19 Q. Who might a complainer be, who can make a complaint? 20 A. In terms of a -- so a patient, or a relative on behalf 21 of a patient, yes. 22 Q. Indeed and does the complaint system then relate to 23 issues emanating from or on behalf of patients, whereas 24 other systems, for reporting of issues or feedback or 25 concerns, such as the whistleblowing system, that Page 129	1 are sort of dealt with locally within the department to 2 which they relate; is that correct? 3 A. So they'll be managed through a central complaints team 4 in terms of monitoring that complaint and in each 5 complaints team, there's a -- it will go back to the 6 service to provide the investigation and the response to 7 that complaint. There'll be oversight from that though, 8 in terms of the clinical director and the lead nurse and 9 the care group manager. So they will have oversight 10 over the response to the complaint, the nature of the 11 complaint, and oversight over the timeliness of that as 12 well. 13 So what doesn't happen is that the complaint just 14 goes back to the service for the service to answer and 15 then go away again. There's oversight from the 16 structure above it. 17 Q. So when you say from the "structure above it", is that 18 a complaints department or something like that? 19 A. So a function of the complaints team who manage the 20 process and then from the care group level -- so 21 remember I talked to you earlier a little bit about 22 there's the clinical service and then sitting above 23 that, there's the clinical director, clinical care group 24 manager, that manage several different services in 25 a grouping. That group have the operational oversight Page 131
1 operates separately, is that right? 2 A. Yes, because they're hearing from different 3 perspectives, different issues. So yes, there's 4 processes, there's grievance processes, there's informal 5 raising concerns. Trainees have an opportunity, for 6 example, if they are concerned about anything, can 7 report indirectly to the director of medical education. 8 We have whistleblowing processes, we have patient 9 complaints. We have care opinion as well, which is 10 another way of seeking feedback from patients. So we 11 have different mechanisms for listening. 12 Q. Yeah. And that's all part, or a sub-part, if you like, 13 of the information gathering process, the intelligence 14 gathering process, that goes into the triangulation 15 system that you talked about earlier? 16 A. Yes, and we report differently. We report together and 17 in different elements of that through our clinical 18 governance reporting to board. So we report on our 19 complaints performance but we also report on the 20 learning from that. We report on our duty of candour 21 which is a statutory report that goes through to board. 22 So there's lots of different elements of that, that 23 report through. 24 Q. One of the, sort of, features of the system, as 25 I understand it from the statement, is that complaints Page 130	1 of the response of that complaint. So they will see the 2 nature of the complaint around the level beneath them. 3 So it's not -- I suppose the concern, or the question, 4 I think -- I'm not sure if I'm hearing correctly is, 5 it's not -- they're not marking their own homework, no. 6 Q. So that's not particularly what I was saying, but that's 7 an interesting component of it. I was just trying to 8 understand how the system works. So what you are 9 telling me, I think, is that there are probably two 10 components of the system which are recognised: one is 11 that the service that is being complained about, if you 12 like, needs to be involved because they are best placed 13 to be able to provide the answers, is that right? 14 A. Correct, of course they are. 15 Q. But then also, in order to try to prevent the 16 possibility that might be thought to be them deciding 17 whether the complaint against them is correct or not, 18 then there's an independent aspect to the service, where 19 someone is overseeing it, is that right? 20 A. Yes. Yes, that's put much better than I did. 21 Q. Thank you. And what we were talking about there, that 22 would be when something reaches the stage of a formal 23 complaint, is that right? 24 A. Yes. They'll also see the stage one complaints. 25 Q. Right, so the stage one complaints would be -- Page 132

1 A. (Overspeaking) And early resolution. 2 Q. Early resolution. So that would be the sort of thing 3 that someone was trying to resolve more locally by 4 conversation, rather than going through a formal 5 complaints mechanism, is that broadly correct? 6 A. Yes, so they'll have an awareness of the nature of it, 7 yes. 8 Q. I see. So the separate body oversees all of those, is 9 that right? 10 A. Yes. 11 Q. Okay. One thing that you've helpfully sent to us and 12 we've had a number of these come through over the last 13 year or so, is the complaint files. When is a complaint 14 file generated? 15 A. Oh, gosh. I think when a complaint will be lodged with 16 the complaints and feedback team, that would be the 17 start of it. 18 Q. So that could apply to any type of complaint even if it 19 was quite low level and even if it was resolved locally, 20 as long as it went through the complaint team, is that 21 right? 22 A. If it went through the complaint team, they'd keep 23 a record of that, yes. And that would be on the Datix 24 system. 25 Q. Understood, but if, for example, there was an attempt to Page 133	1 Q. And it would be necessary to be able to do that for -- 2 if someone were to come along now and ask whether all of 3 the complaints had been handled properly, it would be 4 necessary to have all of the complaints of whatever 5 level, documented within the system so that we would 6 know when the complaints were made, how they were 7 handled and whether they were properly resolved, is that 8 right? 9 A. Yeah, if a complaint occurs in a clinical environment, 10 a patient has a concern or something and raises it with 11 a nurse, consultant, it should be contemporaneously 12 recorded as part of that healthcare episode. Where it 13 goes into a formal process, obviously that's recorded 14 elsewhere. 15 Q. And at what point would it be incumbent upon the 16 consultant or the nurse who had this complaint raised to 17 them in the informal sense to say: this is something 18 that really needs to go through the formal process? 19 A. If it couldn't be resolved. 20 Q. Right, okay. So are the complaints files then -- the 21 complaints files you've sent us, we have asked for the 22 complaints files and you've sent us quite a few files 23 and those files are ones that effectively live within 24 the complaints department that you've talked about. Is 25 that right? Page 135
1 try to solve something more locally without involving 2 the complaint team, would that be a possibility? One 3 could raise it with a consultant or a nurse or 4 something? 5 A. Yes, absolutely. 6 Q. Yes, and would that then be documented separately, ie 7 would it be documented in the patient's notes? 8 A. Yes, very likelihood, it would be recorded somewhere. 9 It could well be recorded, if it was on the ward, you 10 know, "patient complaint" or "was asking about" and then 11 there would be a narrative around a ward round entry or 12 an entry in the health record, that's very possible. 13 THE CHAIR: Would that not have to go into the Datix system? 14 A. No, it wouldn't record everything, no. 15 THE CHAIR: Right. 16 MR DAWSON: But it would be important that that be recorded 17 somewhere? 18 A. Yes. 19 Q. Because even though the system might recognise that 20 there are different levels at which different complaints 21 should appropriately be handled, it's important that 22 what is complained about and what was done and the 23 resolution should all be documented somewhere within the 24 broad system; is that correct? 25 A. Yes, it should be captured somewhere, of course. Page 134	1 A. Yes. 2 Q. So there may also be other complaints or feedback that 3 were dealt with, without getting to that, that should be 4 contained within the notes, is that right? 5 A. Within individual health records, yes, whichever bits of 6 them that are -- you know, whether it's the nursing 7 record, the medical record, the AHP record, yes. 8 Q. Dependent on the person that was recording -- 9 A. (Overspeaking) -- and the situation and the context, 10 yes. 11 Q. Okay, because I'm trying to work out, in the context of 12 what we discussed earlier about the systems being shut 13 down and information about complaints being lost from 14 before 2012, whether there still should be complaints 15 information from before that period that appear but just 16 not in complaint files, in other places. There should 17 be, theoretically? 18 A. In patient records, that would be a place that you could 19 look, yes. 20 Q. So we should be able to find -- if complaints were made, 21 we should find them there? 22 A. Yes, it would require reading the entire record to 23 identify them. 24 Q. Of course. Because we've heard some evidence already 25 from the Patient Safety Commissioner for Scotland about Page 136

1 the fact that sometimes formal complaints systems can be 2 difficult to access for certain people. In fact, she 3 pointed out that sometimes the people who need the 4 complaints system the most, because of various issues 5 that they have, may find it hardest to access. Is that 6 a phenomenon that you recognise? 7 A. I can see how that could happen, absolutely. 8 Q. Also I discussed with her the fact that it might be 9 deemed quite British not to want to complain about 10 things in a formal sense anyway and perhaps therefore be 11 more comfortable to raise it through an informal 12 channel. Whether you subscribe to that theory or not, 13 that's at least a possibility, isn't it? 14 A. I don't know if I can comment on whether it's British or 15 not. Is "British" the word you said? 16 Q. Yes, I did. 17 A. Yeah, I'm not sure I can comment on whether that's -- 18 THE CHAIR: Whether British or not, I think the point that's 19 being suggested is that some people may be reticent 20 about coming forward out of a sense that they don't want 21 to cause trouble or some such reason. 22 A. Yes. 23 THE CHAIR: You recognise that? 24 A. Of course, I absolutely recognise that. 25 MR DAWSON: So as a result of these various different Page 137	1 et cetera. So it comes back -- a robust clinical 2 governance system should have an ability to see 3 intelligence from the breadth of the system not in its 4 isolation and narrowness. 5 Q. And in this context it is a little bit, I think, like 6 through the responsible officer group trying to make the 7 people who are contributing intelligence to that better? 8 A. Yes. 9 Q. Which is trying to improve the overall system? 10 A. Yes. 11 Q. Within the separate box, the complaints box, one would 12 need to be looking at a wider variety of material than 13 just formal complaints to understand the full breadth, 14 as you said, of the complaints-related information 15 that's available, would that be right? 16 A. Yes, I think that's a fair assessment. 17 Q. Thank you. Could we look, please, at the due diligence 18 report, which is NHST-00075 at page 12. Page 13, in 19 fact. This is the due diligence report that you looked 20 at for us and one of the aspects that we know that it 21 looked at was, it says there "Complaints and feedback" 22 and it says: 23 "[A] summary of the complaints and routes to 24 resolution." 25 So at that time, there were, available to those who Page 139
1 factors, it would be wrong if one were to have 2 a clinical governance system that was only looking at 3 formal complaints as a means of working out whether 4 there was an alarm bell that should be ringing about 5 a doctor's practice; is that correct? 6 A. Sorry, say the question again for me, please? 7 Q. What I'm asking you is because of the context that we've 8 described and the possibility that complaints may be 9 raised in a system which is not the formal complaints 10 system but documented in other places, if one had 11 a clinical governance system which relied, in part on 12 complaints, to try to work out whether there should be 13 alarm bells ringing about a doctor's practice or 14 possible poor practice, it would be wrong for that 15 system only to be looking at formal complaints, it would 16 need to be look at a wider variety of information to get 17 a better picture, wouldn't it? 18 A. Yeah, and I think I probably outlined some of this in 19 our conversation already over this morning and this 20 afternoon, and it comes back to concerns around clinical 21 practice rarely fit -- there's rarely one complaint, in 22 terms of one theme or type of complaint. They're 23 usually across a broader one. I think some of the 24 examples you've shared with me around the college 25 report, around communication, probity, complaints, Page 138	1 were compiling the due diligence report, 98 complaints. 2 And we see that there were: 3 "Number logged on Datix system and closed, 93." 4 And: 5 "Number of complaints not on Datix (therefore we do 6 not have a date [they] were closed) [was] 5." 7 Is that right? 8 A. Yes, I read that as well. 9 Q. I think the position, Dr Cotton, is that you have, in 10 fact, been able to supply us with more complaints 11 information since this report. So in response to us, 12 the Inquiry, asking you, NHS Tayside: can you give us 13 all the complaints information? You have, in fact, 14 actually been able to give us more complaints-related 15 information and more complaints files than was included 16 within this report, is that right? 17 A. Yeah, that's my understanding. And my understanding for 18 that is because -- so the system, Datix, is not 19 a very -- is a very clumsy system, it's very hard to 20 extract information out of it and I think they've done 21 a much more forensic trawl of that system to be able to 22 pull more complaints off. 23 Q. Right, so my understanding is you've now told us about 24 111 complaints and because there's some duplicates, it 25 came from 107 patients. So you have more, but they all Page 140

1 still came from the Datix system, is that right? 2 A. I believe so, yes. 3 Q. Right, and that was because somebody looked more 4 carefully in it, is that right? 5 A. The search function is incredibly poor in that system. 6 That's why it's being upgraded to a better system 7 next year. 8 Q. Okay. So if we could just scroll down a little bit, 9 obviously some of the analysis here has to be viewed at 10 the context that we're only looking at a smaller subset 11 that is now available to us because you've been able to 12 provide us with 111 complaints files, effectively. Is 13 it correct to say that both the due diligence review and 14 what you've done for us is providing formal complaints 15 files, is that right? 16 A. In terms to you? 17 Q. Yes. So you've not done that trawl amongst the wider 18 amount of information? You've provided the complaints 19 files. To be fair, that's what we asked for. 20 A. I think that's correct, yes. I would need to go back 21 to -- 22 Q. (Overspeaking) So I'm just trying to contextualise the 23 discussion we're about to have about what we can learn 24 about the complaints from this because we are looking at 25 the complaints files which are the ones that went Page 141	1 an explanation to us but I wonder if you could, for our 2 purposes, help explain why it is that so many are under 3 "enquiry"? 4 A. Can you just refer, to me, the section within the -- 5 Q. Yes, I can. 6 A. -- within the Rule 8 to which that refers to? 7 Q. Yes. Yes, paragraph 224(d).2, or 224(d).1. If we can, 8 please, go to that in the statement, please. 224(d).1. 9 A. Thank you I have got it. 10 Q. Just bear with us a second we'll get it up on the 11 screen, Dr Cotton, thanks. So what you're setting out 12 here is: 13 "The outcome codes for complaints listed on the 14 spreadsheet ..." 15 Now, you've provided us with a separate spreadsheet 16 with I think 111 cases in it: 17 "... and the explanation of the outcome codes is 18 provided below ..." 19 You explain there what "upheld", "partially upheld", 20 "not upheld" and "transferred to another unit" means and 21 "consent not received", "complaint not on Datix". And 22 at the bottom, you say: 23 "Enquiry logged on to Datix as an enquiry not 24 a complaint which means there is no outcome code 25 assigned. These are investigated in the same way as Page 143
1 through the formal system, both in the due diligence 2 report and in the -- 3 A. (Overspeaking) And additional ones that we've 4 identified, yes. 5 Q. Excellent. So, as far as the analysis of the 98 was 6 concerned, one of the things that it tells us is that 7 the "mean days taken to close complaint" was 79. Now, 8 I understand that one of the conclusions of this report 9 was that that was too long, is that right? 10 A. Yes. 11 Q. We heard some evidence from one of the other executive 12 medical directors, NHS Lothian, Ms Gillies, who showed 13 us some documentation that suggested that 20 is the 14 target, is that right? 15 A. That is the required target, yes. 16 Q. So I think it was accepted, and do you accept now, that 17 that was too long to deal with these complaints? 18 A. Yes. Yes. 19 Q. And we have an analysis there of the ways in which the 20 material was analysed to try to work out what the 21 outcomes were. Now, one aspect that is -- slightly 22 makes this statistical information hard to follow is the 23 fact that about two-thirds of the complaints were deemed 24 to be an enquiry. Now, you've helpfully -- we asked you 25 about this in the statement and you've provided Page 142	1 a complaint ensuring a response. Often this is due to 2 the amount of time lapsed." 3 Now, if we could go over the page, you elaborate on 4 this. You tell us: 5 "Further to the above information regarding the 6 'enquiry' coding, NHS Tayside received complaints 7 relating to Mr Eljamel following his departure. These 8 were logged as 'enquiries' and coded as such. This was 9 because the normal complaints procedure would class 10 these as 'out of time' and NHS Tayside wanted to ensure 11 they would be investigated appropriately. 12 "These were fully investigated where possible to 13 ensure that a response could be provided to the 14 complainant. In many cases meetings with the 15 complainant/family/representative was offered and 16 carried out by the clinical teams supported by 17 a consultant. This was followed up with a letter and 18 an apology, if relevant depending on the circumstances 19 of the complaints. The cases where complaints were not 20 fully investigated was due to clinical records not being 21 available as they had been destroyed in accordance with 22 NHS Tayside Health Records Strategy and Policy. It 23 should be noted that these cases were prior to 24 NHS Tayside receiving the Do Not Destroy notice from the 25 Inquiry." Page 144

1 224(d).4: 2 "The table below provides an overview of the numbers 3 regarding the outcome coding." 4 And you tell us that "enquiry" was, in fact, now up 5 to 66. Then, over the page, we see the total of 111 6 "fully upheld", 12, "not upheld", 6, et cetera. 7 "Partially upheld", 12. 8 Now, the coding of something as an "enquiry", albeit 9 an administrative matter, as I understand it, 10 effectively creates a potentially misleading outcome 11 because the fact that something is coded as "enquiry" 12 doesn't necessarily mean that the outcome of the 13 investigation was that it wasn't fully or partially 14 upheld; is that correct? 15 A. Yeah, no, that's how I read that. I agree, yes. 16 Q. Yes. So, if one were to look at these statistics as 17 they appear there, it might seem to be the case that 18 only 12 were fully upheld. But I mean, for example, we 19 know that full apologies were issued even on the 98 that 20 were in the due diligence report in 24 cases, is that 21 right? 22 A. Yes, I read that as well. 23 Q. And indeed, some form of apology, if I recall, was 24 issued in a much larger number of cases than those, 25 which would tend to suggest, would it not, that, in Page 145	1 In fact, it's slightly mysterious because it says to us 2 that the system didn't include anything before 2012 but 3 I think in this figure 1 we see that there were, in 4 fact, some from 2011, is that right? 5 A. Yeah, I -- that's confused me as well. 6 Q. Yes, so the position was that the system before 2012 had 7 been switched off effectively but somehow a small number 8 from 2011 were also considered? 9 A. That's what I have taken from that data. 10 Q. But insofar as complaints were made at an earlier stage, 11 none were considered by the due diligence review. You 12 may not have this detail at your fingertips, but I think 13 it is the case that some of the additional ones that you 14 have now provided to us do come from before 2011? 15 A. I think that's the case but, yes, I don't have that 16 detail to my fingertips just now. 17 Q. It's okay. If we take it as read we're in agreement 18 that there are some from before 2012, 2011, how have 19 they appeared through the Datix system in your 20 subsequent searches? 21 A. I don't know. I'd have to go back and look at them in 22 detail. 23 Q. Okay, because, logically speaking, the 2011 ones 24 shouldn't have been in the due diligence review, isn't 25 that right? Page 147
1 fact, the outcome was that there was a basis upon which 2 an apology should be issued in a large number of cases? 3 A. Yeah, and I would agree. I don't think that coding of 4 enquiry is at all helpful. 5 Q. Thank you. Could we go back to the due diligence 6 report, please, NHST-00075. And again, with the caveat 7 at page 14, please -- sorry, if we go back to 13, in 8 relation to the statistics I was just giving you there: 9 "Full apology regarding their surgery/care, [in] 24 10 [cases] ... 11 "Acknowledgement and apology for their experience, 12 [in] 53." 13 So a total of 77 cases, in fact, in which some level 14 of apology was issued, is that right? 15 A. Yes. 16 Q. And of course, that's the smaller subset of 98 rather 17 than the full 111 that you've now provided to us? 18 A. Yes. 19 Q. If we could go over the page, please, one other aspect 20 of this which I think is worth pointing out. Now, 21 you'll remember that we discussed the computer systems, 22 the change of systems, the AIM system and the complaint 23 system that were changed earlier. This resulted, at the 24 time of the due diligence report I think, in the fact 25 that they were looking at only a certain time period. Page 146	1 A. Correct. 2 Q. Logically speaking, if only using Datix as a means of 3 gathering the information, you shouldn't have been able 4 to provide us anything before 2012, isn't that right? 5 A. So I found these graphs difficult to interpret because 6 what I don't know from them is -- this is complaints by 7 year received. 8 Q. That's right. 9 A. And I think there's a subsequent graph underneath this. 10 Q. We'll get to that in a second, yes. 11 A. That, again, I find misleading as well, and I find it 12 confusing actually because what I don't know is when -- 13 for this one in particular, I don't know when in this 14 year those 2011 ones were in. So I found it really 15 difficult to interpret. 16 Q. But insofar as, in addition to this, you've been able to 17 provide complaints which were logged before 2011, you 18 can't currently explain to me how they could've come 19 through Datix, is that right? 20 A. Not without looking at them, no. 21 Q. Understood. I mean, even just as a matter of logic 22 because what this report tells us is that Datix only 23 includes ones from after 2012. So you shouldn't have 24 been able to find any on Datix. 25 A. Well, I don't know if an open complaint that hadn't been Page 148

1 closed would have been pulled over from the old system 2 or not. That's my only thought process that is going 3 on, but I'd need to get underneath that and that may 4 explain why there's a lag between 2011 and 2012. That's 5 the only logical explanation I can really think of. 6 Q. Just in terms of -- I'm sure when you were compiling 7 your response you didn't go and gather all the documents 8 yourself, you had somebody helping you to do that? 9 A. Lots of people. 10 Q. Who does that? In terms of the physical searching -- 11 you know, there might be people who can tell us better 12 answers to this. 13 A. It was our clinical governance team and the complaints 14 and feedback team will have pulled the information that 15 sits behind -- 16 Q. (Overspeaking) So they may be more expert in these 17 systems, if I can put it that way? 18 A. Yes. 19 Q. Yes. And it is the case I think, just to clarify, that 20 both now, in the 111 complaints and at the time of the 21 due diligence review, we were only looking at complaints 22 on Datix, is that right? 23 A. That's my understanding. 24 Q. And these were complaints that were lodged through the 25 formal system, as we've discussed earlier? Page 149	1 Is that what it says? 2 A. Yes, I read that as well. 3 Q. And then later, I think against 2018, a further spike in 4 complaints is noted, where it says: 5 "Documentary airs on BBC. 6 "Cabinet Secretary request for assurance to Health 7 Boards." 8 And: 9 "NHS Lothian Medical Director review." 10 So these are trying to correlate spikes in the 11 number of complaints with certain publicised events, is 12 that right? 13 A. Yes, that's -- 14 Q. (Overspeaking) You've obviously undertaken, to some 15 extent, a review of this. Do you understand what the 16 significance or relevance of that graph is? 17 A. Not particularly, no. 18 Q. No conclusions appear to be drawn from it. 19 A. As with -- I don't know what that adds. 20 Q. I mean, one might suggest that what it's seeking to 21 propose is that people didn't make complaints at the 22 time, if you like, of their earlier surgeries but only 23 made complaints at a time when there was publicity 24 around the Eljamel saga; is that what appears to be 25 trying to do? Page 151
1 A. Yes. 2 Q. Thank you. Could we just have a look, for a moment 3 please, at figure 2. So this is another graph which was 4 produced relating to the complaints information and it's 5 said that: 6 "The review then looked at the pattern of when 7 complaints were received to correlate the spikes in the 8 number of complaints being received with related events, 9 including publication of external reports and media 10 coverage, principally in 2014, 2015 and 2018." (As read) 11 And I think we can see there, that there is a red 12 dot above 2014 which indicates that that was the time at 13 which an "internal review of 150 patients after RCS 14 report", "media interest growing", "GMC restrictions on 15 practice", and "Professor Eljamel retires" were events 16 that were noted as taking place, is that right? 17 A. Yes, that's what I read. 18 Q. And then there's a higher spike, if you like, in 2015, 19 where what is narrated is: 20 "[Patient] A features in media. 21 "[Patient] B mounts legal claim. 22 "Complaints in media." 23 And: 24 "Public requests to publish internal 25 investigations." Page 150	1 A. It maybe links back to the question that you asked 2 earlier and Lord Weir clarified for me, around people 3 being hesitant to complain because they don't want to 4 make a fuss, and a wider awareness sometimes provokes 5 that deeper thinking by people and rightly so. 6 Q. But that might be a legitimate conclusion to draw from 7 this, but (a) it's a conclusion that's not drawn, is 8 that right? 9 A. No, I don't believe it is drawn in the way I have 10 described it. 11 Q. And equally, it would be a slightly artificial way of 12 doing things because the report couldn't consider any 13 complaints that were made before 2011, isn't that right? 14 A. Yes. 15 Q. So in effect, what might have been happening is people 16 were complaining later on who had made complaints 17 before, but wanted their complaints re-aired because 18 there was a renewed attention on the Eljamel saga. It's 19 possible? 20 A. Yeah, I find it difficult to interpret this. 21 Q. Okay. And if we look at figure 3, over the page, 22 please. This is the one, I think, that you were 23 referring to earlier. What this tells us, I think, 24 is -- when one correlates it with the information in 25 figure 1, which indicates post-2011, how many complaints Page 152

1 were made every year -- this clarifies for us that those 2 complaints relate to surgeries which go back 3 historically quite far, don't they? 4 A. Yes. 5 Q. For example, there are a number of -- there are three 6 complaints related to surgeries in 1997, is that right? 7 A. I think that's 1996. 8 Q. Sorry, 1996, apologies. Is that right? 9 A. Yes, that's how I interpret that as well. I agree. 10 Q. There is one complaint related to 1997, 1998 and 1999? 11 A. Yes. 12 Q. Two in 2000, and 2001? 13 A. Yes. 14 Q. Five in 2002? 15 A. Yes. 16 Q. And then one can see every year other than 2003, there 17 were some complaints related to surgeries undertaken at 18 that time, is that right? 19 A. Yes. 20 Q. And in figure 4 what we see here is the same statistics 21 but broken down in other ways, using colours to try to 22 illustrate what the nature of the complaint was. And is 23 it fair to say the vast majority of the complaints 24 related either to clinical care or communication? 25 A. Yes. Page 153	1 Q. And you are unable -- NHS Tayside is unable to tell us 2 what actions were taken as a result of any of these 3 complaints, is that right? 4 A. Yes, we have been unable to. 5 Q. And is that a feature of the problem that you described 6 earlier, that there is a lack of documentation 7 indicating corporate memory, if I could put it that way? 8 A. To the lack of available evidence, yes. 9 Q. Yes. So you couldn't tell me -- because this is an area 10 that the Inquiry specifically needs to look at. 11 NHS Tayside cannot tell us whether action was taken as 12 a result of these complaints or what action was taken? 13 A. So, we can't tell you the story of what's happened here, 14 no. 15 Q. Yes. 224(e).3, you say: 16 "The current practice in NHS Tayside is that 17 learning is the responsibility of each local governance 18 group. An example from practice is included in each 19 quarterly paper we provide to the Clinical Governance 20 Committee, as part of the regular reporting of 21 complaints data which includes updates on all Key 22 Performance Indicators (KPIs) for Complaints Handling, 23 a quarterly report from Care Opinion, and a patient 24 story or narrative from a clinical service to illustrate 25 how feedback is being used to drive and sustain Page 155
1 Q. In fact, one might say the vast majority related to 2 clinical care? 3 A. Yes. 4 Q. Thank you. Could we have a look, please, back at the 5 statement, paragraph 224(e).1. So this is just after 6 where we were, if we just go back to the previous page. 7 This is where the table was of your 111 and the 8 breakdown of those and then, at 224(e).1, you were asked 9 to give us information about: 10 "Any steps taken by NHS Tayside as a result of the 11 outcome of the complaint[s] [or] claim[s] ..." 12 And you say: 13 "NHS Tayside is unable to provide specific outcomes, 14 action plans, or documentation, in relation to 15 complaints, beyond what is listed in the spreadsheet for 16 complaints identified above ... 17 "It has always been, and continues to be, the 18 responsibility of the clinical team involved in the 19 complaint to ensure that any learning arising from 20 complaints is shared with the relevant areas and that 21 all necessary actions are implemented." 22 As we've found out already -- you've told us 23 already, Dr Cotton, complaints are an important part of 24 the clinical governance system, isn't that right? 25 A. Yes. Page 154	1 improvements. In quarter two this year (July 2025 2 to September 2025), NHS Tayside started to include 3 feedback from patients about their experience accessing 4 the feedback team, which is a KPI. This has been mostly 5 positive with minor areas for development around 6 communication. The Patient Experience Team is currently 7 working to improve the sharing of information around 8 closing the loop on learning using the Datix system, and 9 a test is currently being carried out in two areas 10 within NHS Tayside." 11 And then you say: 12 "NHS Tayside has no evidence regarding any steps 13 that were taken following the outcome of the legal 14 claims shown in the spreadsheet for legal claims ..." 15 Above. So in relation to the patient team 16 experience and closing the loop, I wondered if you could 17 help us with that, as it was a little difficult to 18 follow what it meant? 19 A. So this paragraph is talking about two different things, 20 I think. So the patient experience team is coming to 21 work to improve the sharing of information and closing 22 the loop and the feedback from the patient experience 23 team, so this is part -- an assessment of feedback 24 around the process but also, the earlier part of the 25 paragraph talks about the performance indicators for Page 156

1 complaints handling, reporting through the governance 2 routes. So I think this paragraph actually is trying to 3 say two different things about two different issues. 4 Q. Right, and on the closing the loop aspect, could you 5 just help us with that? 6 A. In terms of? 7 Q. What does it mean? 8 A. Oh, a feedback loop. So a bit like I described with 9 audit, an intervention is done, we seek feedback on 10 that, we assess that and then we do that. So closing 11 the loop is testing something and then seeking the 12 feedback from it as part of that continuous learning and 13 improvement. 14 Q. So this relates to the complaints system and what we're 15 trying to do is to derive full learning from the process 16 and close the loop off, is that what we're doing? 17 A. This is kind of normal business in terms of teams will 18 be working, they will be looking at improvements, tests 19 of change, assessing the process, and then re-testing it 20 again and again and again. So that's what that 21 paragraph is describing -- or that sentence is 22 describing. 23 Q. It's normal business now? 24 A. Yes. 25 Q. But it doesn't appear to have been normal business in Page 157	1 the opening statement to the Inquiry that was given, not 2 on behalf of those previous directors or executives but 3 on behalf of the current board, as I understand it; is 4 that a correct interpretation? 5 A. Yes. 6 Q. So what it said there is, in the opening statement it 7 was stated that the 2023 due diligence review was 8 conducted because it was recognised that previous 9 investigation reports into Mr Eljamel's practice did not 10 sufficiently address the full range of issues. 11 What was it about the previous investigations that 12 was insufficient? 13 A. So there was a series of investigations. So I believe 14 you've heard from Ms Gillies and what couldn't be seen, 15 I think, from that report is what actions were taken 16 upon the findings of that. So that was inadequate and 17 not closed the loop. The Royal College report had 18 a look back at 150 patients in the report. What I can 19 see is that that was a clinical case note review but 20 what that wasn't is a comprehensive assessment of those 21 150 patients. So I believe that's what was referring to 22 in that paragraph. 23 Q. And the 2023 due diligence report was an attempt to try 24 to fill the gaps, is that fair? 25 A. That's my understanding of why that was commissioned, Page 159
1 relation to the complaints that we were looking at? 2 A. No, I would agree with that. 3 Q. And indeed, it doesn't appear to have been something 4 even that was normal business relating to the legal 5 claims which you've also provided information about? 6 A. No. 7 Q. Because we don't know what the outcome of those was 8 either? 9 A. Of the legal claims? 10 Q. Yes. 11 A. We wouldn't know the outcome of the legal claims. 12 Q. But you don't know what steps were taken internally as 13 a result of the legal claims? 14 A. No, I don't. 15 Q. So the loop hasn't been closed, effectively? 16 A. In those, no, from that perspective. 17 Q. Thank you. We've looked at some of the details of the 18 due diligence report, this is an area that you helped us 19 with in your responses. And I'd just like to ask a few 20 more general questions about that report and what your 21 understanding was of it, recognising that you've already 22 told us that certain aspects may need to be deferred to 23 your predecessor who may be better placed to answer 24 them. 25 In doing this, I'm deriving some information from Page 158	1 yes. 2 Q. It also says that -- the opening statement, that is -- 3 it goes on to say that there was previously a lack of 4 oversight around the timing and nature of reviews and 5 actions taken to address review findings. So what was 6 deficient about the way in which the findings had been 7 responded to or implemented in the previous reviews? 8 A. I think I have probably referenced some of that in what 9 I have recently said, Mr Dawson, in terms of that 10 certainly what I can't be clear is that, for example, 11 the NHS Lothian report, any action was taken at all from 12 that report. So that's what I think is meant by that. 13 Q. Yes. So there was an inadequacy that you recognised, to 14 be fair in the opening statement, on behalf of the 15 current board, both in the nature and extent of the 16 investigations but also in being able to say: well, this 17 is the outcome and this is what we did as a result. 18 There were failings in both areas, is that fair? 19 A. Yes. 20 Q. One aspect of the investigations which is of interest is 21 you've mentioned, I think, in your evidence already, if 22 I recall, the agency called "Healthcare Improvement 23 Scotland"? 24 A. Yes. 25 Q. And you will be aware, as the medical director, that Page 160

1 that is a body which can become involved in 2 investigations of the nature of the investigations that 3 you've looked at for us from 2013 to 2023? 4 A. Yes. 5 Q. First of all, could you help us with what the process 6 would be if NHS Tayside wanted to undertake 7 an investigation which had Healthcare Improvement 8 Scotland provide their services and assistance with it? 9 A. In terms of today? 10 Q. Yes, how would you go about doing that? 11 A. So, I have done this. I have contacted the medical 12 director for Healthcare Improvement Scotland to discuss 13 a case in what's called a "responding to concerns 14 process", that there will be a formal oversight and 15 governance from HIS that will want specific details. 16 And I think it would be better, in terms of the actual 17 detail of what HIS do and the mechanics of how they do 18 it, to obviously defer that to them. 19 But my experience has been -- so the practical bit, 20 from my perspective, is I would have a direct 21 conversation with the medical director in HIS and raise 22 a concern. They would take it to their responding 23 concerns group and they'll have an assessment of what it 24 is, the concern that's being raised and then 25 an appropriate reaction, whatever that would be, whether Page 161	1 A. Identified. 2 THE CHAIR: You've identified. 3 A. Yes. 4 THE CHAIR: That's helpful, thank you. 5 MR DAWSON: That was Mr Pearson from Healthcare Improvement 6 Scotland who gave us some evidence about this. One 7 aspect of Mr Pearson's evidence was that he, as someone 8 who has been involved in that organisation for some 9 time, said I think it came about in 2011, considered 10 that although it sits within the NHS Scotland system, 11 Healthcare Improvement Scotland has a degree of 12 independence about it because it sits separately from 13 the territorial health boards, is that right? 14 A. Correct. 15 Q. And also its focus is on healthcare improvement whereas, 16 of course, territorial health boards have a multiplicity 17 of different things to worry about, is that right? 18 A. Yes, territorial health boards are about operation and 19 delivery of services, not the scrutiny part or assurance 20 or evidence. 21 Q. Indeed. Your predecessors, as executives in 22 NHS Tayside, could have involved Healthcare Improvement 23 Scotland in their investigations, couldn't they? 24 A. Yes. 25 Q. Did your investigations indicate that any thought had Page 163
1 that be additional external scrutiny, whether that be 2 evidence of what actions the board are taking, 3 et cetera, will be varied and proportionate depending on 4 what the issue has been raised. So that's my personal 5 experience of working with HIS. 6 THE CHAIR: Sorry, can I just clarify the context that you 7 envisage in that situation because I think I have heard 8 evidence from the relevant officer of HIS to the effect 9 that there may be an investigation as a product of 10 a concern having come to them as a result of an audit 11 that they happened to be doing, but also -- and I think 12 this is what you're talking about -- a situation where, 13 absent any such concern having arisen in that way, you 14 have directly contacted them -- 15 A. I have, yes. 16 THE CHAIR: -- because of an issue that has come to your 17 attention. 18 A. Yes. 19 THE CHAIR: I just want to be clear that we're talking about 20 the latter situation, not the former when you're giving 21 this evidence? 22 A. The -- my raising concern? 23 THE CHAIR: Yes. So your concern that you have raised is 24 not a product of an ongoing issue, it's something that 25 you have -- Page 162	1 been given to that in the paperwork that you discovered? 2 A. I have not seen any evidence either to or for the 3 contrary of that. 4 Q. Thank you. I spoke a moment ago about the comments made 5 in the opening statement about the due diligence review. 6 It was an attempt to try to remedy some of the defects 7 in the previous reviews, as we've discussed; is that 8 right? 9 A. Yes, it was the first attempt to try and, as I've said 10 earlier today, pull it altogether. 11 Q. Did it, as far as you were able to discover, involve any 12 consultation with any of the Eljamel patients about what 13 it was that they felt required to be investigated? 14 A. I have not seen any evidence to say that patients were 15 involved in that discussion. 16 Q. And we've heard some evidence from other sources that 17 there had been a campaign ongoing since at least 2015 18 for a public inquiry in relation to Eljamel. So if 19 that's correct, it would be fair to assume that it was 20 known within NHS Tayside that patients had an opinion as 21 to what should be investigated in this regard, yes? 22 A. Yes. 23 Q. The 2023 due diligence review did not look at outcomes 24 for patients in terms of harm they had suffered, is that 25 right? Page 164

1 A. No. 2 Q. It didn't look at the question of adverse outcomes for 3 patients due to Mr Eljamel having spent time on other 4 professional commitments beyond his clinical 5 commitments, did it? 6 A. No. 7 Q. So, for example, his private practice, it didn't look at 8 that? 9 A. No. 10 Q. It didn't look at his teaching or research commitments? 11 A. No. 12 Q. It didn't look at his probity? 13 A. No. 14 Q. Which was an issue that you recognised earlier had been 15 flagged up in the 2013 review. 16 A. Yeah. 17 Q. Is that right? 18 A. Yes. 19 Q. It didn't look at the question of surgeries being 20 allocated, potentially inappropriately, to junior staff? 21 A. No, they didn't. 22 Q. It didn't look at the way in which Mr Eljamel interacted 23 with and treated his junior staff? 24 A. No. 25 Q. It didn't look at his research? Page 165	1 regulation. 2 Q. Yes, what I'm focusing on is whether there was 3 an examination, within the context of the 2023 due 4 diligence review, as to whether the obligations either 5 of Mr Eljamel or of the board had been complied with in 6 those regards? 7 A. No, I accept that point. 8 Q. It didn't look at those? 9 A. No, I accept -- 10 Q. You are right, of course, other agencies could have been 11 involved. 12 A. Yes. 13 Q. It didn't look at the question, which had been raised in 14 the context of the 2013 RCS review, about professional 15 governance matters, in particular his candour with other 16 professionals? 17 A. No. 18 Q. It did mention, in one place, the practice of attending 19 mortality and morbidity meetings, it did do that? 20 A. It did, yes. 21 Q. It didn't look at the question of whether information 22 could have been made available from the private sphere 23 as to the quality of the surgery he was carrying out? 24 A. No, it didn't look at that. 25 Q. It didn't look at the question of his resignation and Page 167
1 A. No. 2 Q. It didn't look at the involvement or non-involvement of 3 any other bodies that might have had a role to play in 4 managing aspects of Mr Eljamel's clinical practice? 5 A. No. 6 Q. It didn't, as we've already discussed, look at the 7 issue of informed consent? 8 A. No. 9 Q. Although there had been some investigation into that 10 done in the background, is that right? 11 A. That's correct, yes. 12 Q. It didn't look at the question of Mr Eljamel's candour 13 with his patients, his employer NHS Tayside, or the GMC? 14 A. No. 15 Q. It didn't look at any possible failings by NHS Tayside 16 in its obligations of candour with patients or other 17 agencies? 18 A. No. 19 Q. It didn't look at questions of possible criminality? 20 A. The report did not, no. 21 Q. It didn't look at questions about whether there had been 22 breaches of the regulatory system by Mr Eljamel? 23 A. No. I suppose, just in the regulatory bit and the 24 criminality bit, obviously there are the bodies that 25 have responsibility for looking at criminality and Page 166	1 the effect of that on the possibility of the GMC being 2 involved? 3 A. No. 4 Q. It did look at the question of his clinical supervision 5 though, which we've discussed earlier? 6 A. Yes. 7 Q. It didn't look into the question of NHS Tayside's role, 8 if any, in Mr Eljamel's name being removed voluntarily 9 from the GMC medical register? 10 A. No. 11 Q. And it didn't look at the question of whether previous 12 reviews had been adequate or not, although it did look 13 at what they had decided? 14 A. It looked at the reviews. It didn't assess the adequacy 15 of previous reviews. 16 Q. The due diligence review was completely inadequate, was 17 it not? 18 A. The due diligence review purpose was to assess what 19 information we held. I recognise what you've said is 20 there's other points that absolutely need further and 21 deeper investigation and I am really thoughtful that 22 an investigation -- and recognise some of those time 23 points are different. If an investigation had been 24 continued by NHS Tayside in 2014, some of those 25 questions may well have been resolved. And failing to Page 168

1 do that is a failing. 2 Q. It did look at the question of aspects of Mr Eljamel's 3 appointments? 4 A. It did. 5 Q. It looked at quite a specific issue, in fact, which was 6 to do with the question of whether consideration had 7 been given, in giving Mr Eljamel the consultant post in 8 the first place, to the possibility that he might have 9 held a clinical fellowship at an academic institute in 10 Connecticut; do you remember that? 11 A. I do remember that. 12 Q. It didn't, however, look at the fact that there was 13 a handwritten note in the HR file which indicated that 14 somebody had written on it that he held such a position? 15 A. Yes, I've seen that note and I understand you asked 16 Mrs Watson about that, yes. 17 Q. I did, but the due diligence review appears not to have 18 considered that handwritten note? 19 A. No. 20 Q. It also appears not to have elicited evidence from -- 21 I think it would be have been Mrs Watson at the time, if 22 I recall -- that she could identify who had made the 23 note, who had written the note; it didn't deduce that 24 evidence? 25 A. No, I don't think so. Page 169	1 which I'd be interested in your views on as well was, we 2 heard evidence from effectively private practice but 3 also from the university relating to what one might 4 describe as the lateness of the intimation to those 5 bodies of the concerns, as we put it, as they emerged 6 and arose in relation to Mr Eljamel. 7 Would sharing of information with bodies like that 8 be something that would fall within your broad remit 9 nowadays? 10 A. Yes. 11 Q. And why is it important that those bodies have 12 information shared with them about the sorts of concerns 13 from 2011, 2012, 2013 we've been discussing with 14 Mr Eljamel? 15 A. So I suppose it comes back to the breadth of clinical 16 practice of a doctor, because we're not talking of a doctor 17 but of a clinician, when it encompasses more than one 18 organisation, there may be concerns there or there may 19 be opportunity to prevent harm elsewhere in the system. 20 And that's the importance of information sharing. The 21 ROAG regulations have strengthened over time that make 22 that easier for me to do and it's something that now 23 I would say is commonplace and easy to do. 24 What I find particularly helpful is the relationship 25 I have with my employee liaison advisor for the General Page 171
1 Q. Were you able to ascertain from any of the materials 2 that you looked at -- although we may be able to get 3 views from other people about this -- what the Scottish 4 Government's position was in its discussions with 5 NHS Tayside around the time that the due diligence 6 report was completed? 7 A. I don't know, I can't comment on that. 8 MR DAWSON: Sir, I think that will be a convenient moment. 9 THE CHAIR: Right. Dr Cotton, we'll break now for another 10 15 minutes and aim to start again just after 3.15. 11 Thank you. 12 (3.04 pm) 13 (A short break) 14 (3.21 pm) 15 THE CHAIR: Thank you, Dr Cotton. I think we're ready to 16 resume. 17 MR DAWSON: Thank you, sir. Dr Cotton, we discussed earlier 18 in your evidence some of your reflections on aspects of 19 the period in 2013 to 2014 and your reflections, from 20 your perspective now, on things that might have been 21 done differently. One other aspect of the evidence that 22 we've heard -- we've touched on the possibility of 23 informing the regulatory authorities. One other aspect 24 of the evidence that we've heard which I think would be 25 something nowadays that might fall within your remit Page 170	1 Medical Council who is somebody I would be able to have 2 a rapid dialogue to seek advice from the regulator but 3 also to point me of any other connected bodies or 4 relevant bodies that, as a responsible officer, I would 5 be having a responsible officer to responsible officer 6 conversation with. And in my tenure that is something 7 that I have done frequently and made easier through the 8 change in the regulations which, I think if we look back 9 to 2012, 2013, 2014, that role of the responsible 10 officer and the importance on information sharing 11 probably wasn't as clear, although the need for it was, 12 or the importance of it was. But maybe the 13 accessibility and the ease of doing it at that time. 14 Q. Because, for example, my understanding from some of the 15 evidence we've heard, is that that bringing together of 16 the roles would mean if you, as responsible officer now, 17 had a doctor principally working within, let's say 18 Ninewells, who also worked in private practice, you 19 would effectively deal with looking at aspects of their 20 whole practice now, is that right? 21 A. Yes, that is correct, yes. 22 Q. And that's to deal with the very issue that you've 23 raised, it's important -- in the same way as you said in 24 other areas, to be able to gather as broad amount of 25 information as possible -- that you are looking at Page 172

1 someone's whole practice on the basis that issues may 2 arise there that could give you the clues that you need 3 to be able to make responsible decisions; is that fair? 4 A. Yes. 5 Q. And in the same way, presumably, logically, it also 6 flows from what you've already told us, that in the same 7 way as you would need all of the information that could 8 reasonably be gathered to try to make good decisions as 9 a responsible officer, and indeed in your clinical 10 governance role, the same would presumably apply to 11 people who had similar responsibilities in other 12 organisations. So, for example, someone who might be in 13 charge of the likes of Mr Eljamel working in the 14 university, for example? 15 A. Yes. Yes. 16 Q. So in the same way as you would want to have all of the 17 information you could reasonably collect to make good 18 judgments about their, for example, ongoing involvement 19 in clinical care, they might want to have all the 20 information that could be made available to them about 21 the question as to whether the individual should 22 continue to be involved in teaching, for example? 23 A. Yeah. 24 Q. Or research, for example? 25 A. Yeah. Page 173	1 A. Yes. 2 Q. Could we have a look, please, again, just at one aspect 3 of the due diligence review. It's NHST-00075 at 4 page 20. This was an aspect that we discussed earlier, 5 but there's just a particular bit that I wanted to ask 6 you about. Scrolling down a bit, please. This is the 7 section which is entitled "The effectiveness of 8 NHS Tayside in recognising, reacting to internal signals 9 of concern", and the question is "Why are we looking at 10 this?" We've touched on this already, Dr Cotton, in 11 some context. It says: 12 "As identified in the previous section, there were 13 a number of signals emerging in NHS Tayside in 2013 to 14 suggest there may be issues with Professor Eljamel and 15 his communications and practice. These were emanating 16 from the complaints and clinical governance processes 17 and were the reason that the Royal College of Surgeons 18 review was commissioned in June 2013." 19 Now, if we just pause there, is that accurate? 20 A. So I think what we've heard is there were signals 21 earlier than 2013, Mr Dawson. 22 Q. Yes. 23 A. Why -- 24 Q. That is the aspect that I was wanting to focus on, 25 Dr Cotton. It suggests that the signals were emerging Page 175
1 Q. Or in particularly extreme circumstances, there might be 2 issues about them spending time around other members of 3 the university staff, for example, in theory? 4 A. Yes, and without going into detail, I have lived 5 experience of that. 6 Q. Right, and so again, based on the reflections that 7 you've been able to give us about various aspects of 8 this, would you have considered it important that 9 Mr Eljamel's private practice and the university should 10 have been made aware of concerns about his practice at 11 an early stage? 12 A. They should have been made aware of concerns as soon as 13 possible, yes. 14 Q. And in the context of what we were discussing earlier, 15 we realise that could be at various different points. 16 A. Yes. 17 Q. But in effect, the same sorts of concerns that you said 18 should be ringing alarm bells within the hospital 19 system, should also be what trigger these -- what we 20 might call "partner organisations", or other 21 organisations to be told about it? 22 A. Yes. 23 Q. And if it were the other way round, you'd presumably 24 expect the same to be done to you, to be shared with 25 you? Page 174	1 in 2013 and that that's why the Royal College of 2 Surgeons' review was commissioned but we know that not 3 to be correct because the Royal College of Surgeons' 4 review was based on complaints arising, three in 2011, 5 four in 2012 and an increasing number of eight in the 6 early part of 2013. So in fact, even on the face of the 7 due diligence review, it's clear that information 8 emerged earlier than 2013 because of its analysis of 9 earlier cases that we've already discussed; isn't that 10 right? 11 A. Yes, and I have always been very thoughtful of there was 12 an opportunity to do an internal investigation before 13 commissioning the college to do a review. Although the 14 college review is a robust process with the governance 15 arrangements around it and an independence which is 16 what, as a medical director, you sometimes need, is 17 somebody external to give you that information. Whether 18 there was an opportunity to gather more information 19 internally. 20 Q. Yes, would it be fair to say a feature of the Royal 21 College review that would be a positive would be its 22 independence? 23 A. Yes. 24 Q. And indeed, the expertise of people who are in the Royal 25 College carrying it out who are very experienced Page 176

1 surgeons? 2 A. And that's one of the reasons you would seek someone 3 like the college, who don't regulate, don't -- but set 4 standards, to have that review. 5 Q. But I think as you identified, one of its major 6 disadvantages was time? 7 A. Yes. 8 Q. Because it was going to take time to report, time which, 9 I think you've already told us, really shouldn't have 10 been spent with Mr Eljamel continuing to operate on 11 people? 12 A. Yes. College reviews are lengthy processes and even the 13 gap between the interim report and the final report was 14 some time. 15 Q. Indeed. The passage goes on to say: 16 "The due diligence review can demonstrate there were 17 monitoring systems in place but we need to look at how 18 these were linked up to ensure there could be 19 a triangulation of signals and actions taken to respond 20 to emerging concerns from the multiple available 21 sources. The previous section describes the volume of 22 signals within the system and the period before 23 Professor Eljamel was suspended. In this section we 24 consider the reaction to these signals." 25 You reflect on this in the statement at Page 177	1 report, yes. 2 Q. Furthermore, there is a focus, even in the stated 3 passage that we looked at, on the issue being about the 4 triangulation of the concerns, which is of course 5 an important factor, isn't it? 6 A. Yes, and we spent some time discussing that this 7 morning. I agree, 100 per cent. 8 Q. Indeed. However, the triangulation of the concerns is 9 merely part of the process, as we've discussed. The 10 accessing of the relevant information to triangulate is 11 another important aspect? 12 A. Yes, yes. 13 Q. And would it be fair to say that the due diligence 14 report focused on the former but not the latter? 15 A. I think greater weight was placed on the former than the 16 latter. 17 Q. Thank you. Just bear with me a second. One aspect of 18 the material that you helped us with, which was of 19 clinical components so I thought I would try and address 20 it with you -- we touched on this already -- relates to 21 mortality and morbidity meetings and their significance 22 in the system. Now, we've heard about these from 23 various different sources but because of your clinical 24 background it may be that you can add more than others 25 were able. And I think it was an area where others may Page 179
1 paragraph 215.1, where you tell us that: 2 "A stated aim of the Due Diligence Review report 3 dated 23 August 2023 ... was to present facts to assist 4 the Medical Director in their assessment of the adequacy 5 of procedures to detect signals of concerning practice 6 relating to Mr Eljamel. In particular, the report 7 focused on the period leading up to the point where 8 Mr Eljamel was placed under supervision on 21 June 2013 9 to his suspension on 10 December 2013. The review 10 focused on this period as a key remit of the review was 11 to assess the adequacy of procedures to detect signals 12 of concerning practice relating to Mr Eljamel, and this 13 was the time period in which those signals occurred." 14 Would it be fair, based on what you've now told us, 15 to reflect on that last sentence, to say that that was 16 part of the period in which those signals emerge? 17 A. Yes, I think that's a better way of putting it. 18 Q. Yes, because it does appear to be the case, does it not, 19 when one looks at the due diligence review, that it, for 20 some reason, wishes to focus on that period? For 21 example, one of the areas we've already discussed that 22 it does cover is the clinical supervision and whether 23 that was adequate. The focus appears to be on that 24 period and not earlier; is that correct? 25 A. That is the prime focus of the period of time in that Page 178	1 have deferred to your better knowledge. Could we look, 2 please, at paragraph 10(a).18 of the report. You tell 3 us there, that: 4 "... data indicates that 79.7% of NHS Tayside's 5 returned cases were discussed at local M&M meetings. 6 The term 'returned cases' refers to the cases submitted 7 by NHS Tayside to SASM for inclusion in the national 8 audit." 9 Just to pause, "SASM"? 10 A. Scottish Audit on Surgical Mortality. Yes, apologies, 11 it's an acronym. 12 Q. That's fine: 13 "The SASM Report 2010 ... relates to national data 14 from 2009 and as part of this report demonstrates that 15 all data submitted to SASM evidenced that nationally 16 100% of neurosurgical cases were discussed at local M&M 17 meetings. The reason a figure for NHS Tayside 18 neurosurgery is not available, is that SASM reported 19 neurosurgical data only at a national level in the 2010 20 report and did not break these figures down into 21 individual health boards." 22 But you are able, I think, at the beginning of that, 23 to tell us that 79.7 per cent of NHS Tayside's return 24 cases were discussed at local M&M meetings; is that 25 right? Page 180

1 A. Yes, so the Scottish Audit of Surgical Mortality is 2 described as a national audit. It doesn't exist anymore 3 in that current guise. And that really focused on 4 mortality I think, not just on morbidity. But I'd need to 5 go into the report in detail. But, yes that's what it 6 indicates in that first sentence. 7 Q. Indeed, that was precisely the issue I wanted to raise 8 with you because it seems that the system at that time, 9 although you call these "M & M meetings", these 10 statistics are telling us, I think, about cases where 11 there are fatalities, is that right? 12 A. Mortality, yes. 13 Q. Mortality, yes. So the morbidity element of it, is that 14 something that you can help us with? The fact you're 15 calling them M & M meetings does tend to suggest that 16 they were used for that purpose as well, is that right? 17 A. They would have been used for morbidity but obviously 18 what's referred to in this paragraph is the data 19 reported to SASM which is a mortality review, not 20 a mortality and morbidity review. And therefore that's 21 why that's referenced in that way. 22 Q. Yes. So is there any sort of audit related to the 23 meetings held on the morbidity side? 24 A. So that would have been encompassed within the minutes 25 of the M&M meetings, capturing the discussion around the Page 181	1 us, the data that's been provided, or the information 2 provided, is insofar as these meetings might have been 3 used to discuss matters of morbidity rather than 4 mortality, that would be a matter for clinical judgment 5 to decide whether they should be used for that purpose 6 or not, is that right? 7 A. For what cases we discussed a morbidity perspective, 8 yes. 9 Q. Indeed, but what you've been able to provide us, for 10 mortality because of the audit, is that a high number of 11 cases were being looked at for mortality. 12 A. Yes. 13 Q. And indeed, the target I think, was that all mortality 14 cases should be discussed at this? 15 A. Yes. 16 Q. Could we have a look please, sorry to jump around, go 17 back to NHST-00075 where there's more information about 18 this. It says there: 19 "Mortality and morbidity (M & M) meetings for 20 clinical groups were introduced across NHS Tayside more 21 than 20 years ago ..." 22 So that's from 2023, when this is being written: 23 "... with the neurosurgery meeting established in 24 2000. These were the fora where attendees discussed 25 clinical cases, including complications following Page 183
1 morbidity element to it. 2 Q. Well, that would be at meetings which have been convened 3 for that purpose. What I'm trying to assess is whether 4 there is information about the extent to which these 5 meetings were actually routinely used to discuss 6 morbidity issues because I think -- we know from other 7 sources and I think also it's mentioned in the report -- 8 that the decision-making around whether a clinical 9 episode or a situation should be discussed at a meeting 10 like this, when it involved morbidity rather than 11 mortality, was left to a clinician's judgment; is that 12 right? 13 A. Yes, that would usually be the case, unless there were 14 specific areas on the morbidity that would be examined. 15 I'm struggling to think of an example from 16 a neurosurgical practice, not being a neurosurgeon, but 17 I'm just trying to think around, from my practice might 18 think about complication rates for a procedure or 19 re-bleeding rates from GI bleeding or something. So 20 that would be -- in my own practice, what we would do is 21 have regular looks at that sort of element. I don't 22 have the subject matter expertise to detail what 23 morbidity in a neurosurgical practice would be and how 24 that would be reviewed. 25 Q. Okay, just to understand the data that you provided to Page 182	1 surgery on a quarterly basis. M&M meeting were run on 2 the foundation that cases brought forward for discussion 3 were dependent on individual consultants highlighting 4 complications and being prepared to discuss their 5 practice openly with colleagues in line with the GMC's 6 Code of Conduct 'Duties of a Doctor'. 7 So the existence of the system is identified in the 8 due diligence report as being existed within 9 neurosurgery from quite an early period, at least 2000, 10 it says, I think? 11 A. Yeah, the existence of morbidity and mortality meetings, 12 and I think you've heard from others, is around the 13 emergence of clinical governance in (inaudible) in 1995 14 onwards. This was, in essence, that evolution and 15 building of the clinical governance structure. And so, 16 I was a young doctor at that point but I recall M&M 17 meetings coming into place around that time. 18 Q. I think we've also heard that they emerged particularly 19 as a feature of surgical practice, is that right? We've 20 heard from other witnesses that that might be -- 21 A. Yes, I have no doubt that they were there in surgical 22 practice. I can say from medical practice, they were 23 there as well. So I think there was a breadth of 24 practice around that time. 25 Q. Could we look at page 12 of this document, please. Page 184

1 Scroll down a bit, please. That's it, where it says: 2 "Mortality and morbidity (M&M) meetings. 3 "The review has not identified any documentation 4 from M & M meetings, nor any other internal documents 5 from internal monitoring meetings that raised concerns 6 about Professor Eljamel. There is also no evidence 7 identified in which he himself highlighted complications 8 in any of his own cases for discussion with colleagues 9 in line with the intended purpose of M & M meetings and 10 also as set out in the GMC's code of conduct 'Duties of 11 a Doctor'." 12 Now, that expands it out a little bit from M&M 13 meetings into other sorts of meetings that might discuss 14 these matters. As we discussed earlier, you've been 15 able to find four such meetings which take place very 16 much -- I think they're from late 2012 into late 2013, 17 at which my recollection is that Mr Eljamel was in 18 attendance at two and not in attendance at two, so it 19 looks like you have been able to get more information. 20 But what I'm interested in here, is it the case that 21 there was at this time and there is now no information 22 which would inform us as to whether the use of these 23 meetings, in particular the use of these meetings in 24 appropriate circumstances related to morbidity rather 25 than mortality, was being done appropriately by Page 185	1 is the process that was put in from 2013 formally, 2 although I think you've heard evidence previously around 3 different policies that recorded whistleblowing or 4 raising concerns, et cetera, that go back further than 5 that, but obviously this is around the formal 6 whistleblowing process. So if they felt that those 7 concerns were not being listened to, this would be 8 another avenue that they could pursue as well. 9 Q. Yes. So I think actually, when we looked at the ethical 10 rules around this with our expert group, that what the 11 rules encouraged was first of all, out of other 12 obligations towards one's professional colleagues, that 13 the best thing to do, if it were able to be done, was to 14 speak to the colleague about the concerns that one had. 15 Would that be the sort of process you would expect? 16 A. Yes, that would be -- if you had a concern you'd raise 17 it with the individual, if you felt that you weren't 18 being listened to, then you would raise that with your 19 professional line. And there are multiple different 20 individuals that you can raise those concerns with 21 within the organisation and still, should you feel not 22 listened to and have a concern, there is a formal 23 mechanism for doing that as well. 24 Q. Okay. You tell us about the 2013 policy at 10(a).34, 25 where you say: Page 187
1 Mr Eljamel? 2 A. Yeah, I have not seen any evidence. I recall seeing 3 those documents that you've referred to in terms of 4 attendance at those meetings. But, no, I agree with 5 your point. 6 Q. But the use of these meetings as a vehicle, if you like, 7 is described in both of these paragraphs as a feature of 8 a doctor's duty under Good Medical Practice, so 9 an ethical duty? 10 A. A professional governance duty, yes, I think 11 100 per cent. 12 Q. Thank you. You've helpfully provided us with some 13 information about aspects of the NHS Tayside 14 whistleblowing policies, another aspect of clinical 15 governance that we discussed. Can we go to 10(a).34, 16 please. Would it be logical, where there are issues 17 going wrong with surgeries, issues related to 18 communication with patients, that colleagues of 19 Mr Eljamel must have witnessed those at some point? 20 A. Yes. 21 Q. If they did so, would there be a professional ethical 22 obligation on them to have reported it through the 23 whistleblowing mechanisms? 24 A. So there would have been a professional obligation on 25 them raising it through normal process. Whistleblowing Page 186	1 "The NHS Tayside Whistleblowing Policy ... effective 2 from April 2013, was available to all employees, workers 3 and ex-employees of the organisation. This policy 4 supported staff to raise a concern under the Public 5 Interest Disclosure Act 1998 (PIDA) ... Examples of 6 public interest concerns described within the policy 7 included malpractice, fraud, abuse in care, omissions in 8 care, substantial poor performance or outcomes, danger 9 to public safety or damage to the environment. The 10 policy described how concerns could be raised and how 11 they would be handled. 12 "The NHS Tayside Voicing Concern Policy ([which 13 existed between] May 2010 [and] April 2013) ... was 14 available to all employees (including casual or 15 temporary staff) who had concerns relating to patient 16 safety, delivery of care, health and safety of employees 17 or visitors, or the impairment of the viability or 18 integrity of the organisation. Examples of concerns 19 described within the policy include malpractice, fraud, 20 abuse in care, omissions in care, substantial poor 21 performance or outcomes, danger to public safety or 22 damage to the environment. The policy described how 23 concerns could be raised and how they would be handled 24 and the policy took full account of the provisions in 25 the Public Interest Disclosure Act 1998 ..." Page 188

1 The 1998 Act that you helpfully identify there, was 2 the act whereby protections were given to doctors to try 3 to reinforce them reporting issues of concern; is that 4 correct? 5 A. I'm not an expert in that Act, but I believe so. 6 Q. I mean, you wrote these paragraphs that refer to that 7 Act, so presumably, broadly speaking, that -- 8 A. (Overspeaking) Broadly speaking. 9 Q. I think we've already heard, you mentioned yourself 10 I think, some previous inquiries which have given rise 11 to some changes to the way things are done within 12 hospitals. We've already heard this arose out of other 13 inquiries I think, where there were concerns about 14 people's ability to raise concerns in this way; is that 15 broadly your understanding? 16 A. Yes. 17 Q. And you tell us that the Act came in, in 1998, but 18 identified there being a policy, as far as you're aware, 19 which emerged only in May 2010; is that correct? 20 A. Yes, that's what we've been able to identify. 21 Q. Yes. So again, you're unable to tell us whether there 22 was such a policy before that? 23 A. I haven't seen any evidence of a policy before that. 24 Q. Okay, but as far as the policy "voicing concern" is 25 concerned, that lasted from May 2010 to April 2013, is Page 189	1 Sam Eljamel years before he was suspended." 2 It says there: 3 "NHS Tayside says it first became aware of 4 allegations the rogue doctor was harming patients 5 in June 2013 when he was put under supervision." 6 And it says there: 7 "However, three surgeons who worked alongside him 8 have now claimed to the BBC: 9 "NHS Tayside was told about concerns as early as 10 2009 ... 11 "Doctors who raised the alarm were shut down ... 12 "[Professor] Eljamel regularly left the operating 13 table to do private work ..." 14 If we could just scroll on to next page, please, it 15 says: 16 "The whistleblowers allege the surgeon regularly 17 allowed junior doctors to carry out surgeries 18 unsupervised when he should have been operating himself. 19 "They claim the disgraced [surgeon] was a bully who 20 was regarded as 'untouchable' since he brought money 21 into his department through 'questionable' research 22 projects." 23 It then says: 24 "'I was shut down' ..." 25 And it says: Page 191
1 that right? 2 A. Yes, that's the dates that were provided. 3 Q. Could you tell us, I mean, if you read those two 4 paragraphs one against the other, it rather looks like 5 the policy was designed to achieve precisely the same 6 thing in 2010 as it was in 2013. Are you able to tell 7 us what the innovations or differences were when the 8 2013 policy was introduced? 9 A. The whistleblowing policy? 10 Q. Hmm? 11 A. No, I'd need to go back and look at that in detail, 12 Mr Dawson. 13 Q. Okay, but from the narrative that you have said there, 14 all the sorts of things, the escalation, it looks like 15 basically it's the same sort of thing? 16 A. It's trying to achieve the same purpose. 17 Q. Yes. So there was a policy, there was a procedure in 18 2010 that could have been used? 19 A. Yes. 20 Q. Thank you. Could we have a look, please, at ELJ-00067. 21 And this is a newspaper article from June 16, 2023, 22 entitled "NHS Tayside accused of cover-up over disgraced 23 Dundee surgeon, Eljamel". It says: 24 "Whistleblowers claim NHS Tayside managers knew 25 about concerns over disgraced Dundee doctor Professor Page 190	1 "One doctor told the BBC: 'I did raise concerns at 2 the time but I was shut down. We were told we would 3 never get our traineeship. 4 "It went all the way up to the board. They all 5 knew about it'. 6 "An NHS Tayside spokesperson said: 'NHS Tayside were 7 not previously aware of these concerns by former 8 trainees relating to their experiences of 9 Professor Eljamel, who was suspended by NHS Tayside 10 in December 2013. 11 "We understandably take those concerns very 12 seriously and we would encourage anyone who has concerns 13 about Professor Eljamel to contact the Patient Liaison 14 Response Team." 15 Have searches been done to identify whether there 16 are any records of the board being aware of these sorts 17 of concerns being raised in 2009, or any other time? 18 A. So we've been through all the corporate records and 19 I don't think we've identified any knowledge of that. 20 I read this article and what's contained in it is deeply 21 alarming. 22 Q. Why do you say that, doctor? 23 A. I think it should be very evident, from what's described 24 in there, in terms of what's being reported is people 25 raising a concern and being shut down. And for somebody Page 192

1 using their position to from the word in the article 2 "bully" or intimidate, I think for any -- I actually 3 don't think you have to be a doctor or a professional to 4 not be alarmed by that article. 5 Q. And it would, I assume from what you say, be completely 6 unacceptable if a junior doctor were deterred from 7 raising these sorts of concerns, in particular with 8 regard to a threat, effectively, about their career 9 progression? 10 A. It's fundamentally unacceptable. Specifically, I know 11 my director of medical education has done a significant 12 amount of work around -- I think I touched on some of 13 this earlier, listening to feedback from training grade 14 doctors and other training grade staff is actually 15 a very important and early signal about the quality of 16 our services. So we've put a process in to seek 17 feedback, both through the formal process but also where 18 resident doctors can feel they can raise concerns in 19 an anonymous way as well. 20 Q. So you've put in place a system to try to achieve that? 21 A. It has been put in place, I think, two and a bit years 22 ago, three years ago. 23 Q. Right, because again, you mentioned Professor Watson. 24 She told us about this, and the way I think she put it 25 was the importance of educational governance as part of Page 193	1 something you're aware of, or at least conceptually 2 something that could happen? 3 A. So, I'm not aware of the detail of that. A patent 4 towards the department? Is that what was referred to -- 5 Q. Well, it is unclear from the documentation because it 6 simply lists various clinical trial projects in which he 7 was involved, which suggest that a patent was granted at 8 the end of it. 9 A. So that doesn't make much sense to me in terms of the 10 department or the individual would not hold a patent to 11 anything. We have a research and innovation governance 12 mechanism, TASC, that would oversee the governance of 13 any research product or innovation products, including 14 the appropriate legislation and the entitlement of any 15 patents that come out of intellectual property. That 16 wouldn't sit with an individual surgeon or an individual 17 department, that would sit within that research 18 governance process. 19 THE CHAIR: So the original proposition you put to the 20 witness, Mr Dawson, was that the patent was received by 21 the university not the department? 22 MR DAWSON: Well, could the patent be received by the 23 university or Tayside Health Board? 24 A. So again, it would have gone through that TASC 25 governance process, which is the university and the NHS Page 195
1 clinical governance. Is that what that system that's 2 been put in place is seeking to achieve? 3 A. That's part of it, yes. So you're right, educational 4 governance is important, fundamentally important, for 5 the reasons that you've outlined. 6 Q. So it would obviously be about trying to support the 7 resident doctors in training, but also would be about 8 trying to elicit further information for the 9 triangulation exercise that you told us about? 10 A. Yes. 11 Q. It suggests also here that Mr Eljamel may have been 12 involved in questionable research projects which may 13 have generated money for his department. How could 14 research projects have generated money for the hospital 15 or the department? Was that something that you're aware 16 of as a concept? 17 A. I don't understand what that's trying to say. And if 18 there's more detail, I'd be happy to look at it but 19 I don't understand that statement. 20 Q. Yes. There is some information available through 21 materials that have been provided to the Inquiry by some 22 of your colleagues, I think, that some of the clinical 23 research projects in which Mr Eljamel was involved 24 resulted in there being a patent being granted to the 25 university in relation to some equipment. Is that Page 194	1 coming together around clinical research, but that would 2 be through a highly regulated governance process. No 3 one individual would have benefited from that. And that 4 would have been -- a patent, potentially, I think, could 5 be held by either of those two bodies. I think it's 6 more likely the university, but -- 7 Q. I don't think what's being suggested here in the article 8 is, Dr Cotton, that Mr Eljamel benefited himself but 9 that, effectively, the hospital would have benefited 10 from his involvement in such activities or could have 11 benefited financially and that that may be a factor, 12 effectively, in this process that's described here of 13 complaints or issues with him being shut down? 14 A. Not that wouldn't have gone through TASC and that's been 15 in place, through different guises, over a long period 16 of time. 17 Q. Well, on that subject -- this was something that we 18 covered with Professor Rory McCrimmon from Dundee 19 University -- he told us about the TASC which was the 20 organisation that was brought into effect in 2010. It's 21 the Tayside Medical Services Centre, is that right, or 22 it's a research centre which exists within the 23 university, is that right? 24 A. Yes, it is. 25 Q. I understand it may have been under the control of Page 196

1 a Professor Jill Belch at one stage; is that a name 2 you've come across? 3 A. Yes, I believe -- there have been different directors of 4 research and development over a period of time. 5 Q. Yes, I think you've actually provided us with that, or 6 one of your colleagues has in the statement. And one of 7 the things that was said in the written opening 8 statement for NHS Tayside was that NHS Tayside would not 9 have access to information about Mr Eljamel's research 10 and that you hadn't undertaken any internal 11 investigations because research was undertaken as part 12 of a role which he held within the University of Dundee 13 which is a separate organisation. In fact, what we 14 heard from Professor McCrimmon was that that would be 15 the case post-2010 when the TASC body came into being, 16 which was an attempt to try to co-ordinate research 17 projects that were undertaken either in the hospital or 18 in the university, but before that, research projects 19 that Professor Eljamel -- or Mr Eljamel could have been 20 involved in would have been undertaken on the hospital 21 side, if you like; that's the way he put it. 22 So given that statement, it appears theoretically to 23 be the case that if documents existed about research 24 done before then, that they would be held within the 25 hospital, or would have been held within the hospital? Page 197	1 A. Absolutely, 100 per cent. 2 Q. Thank you. You also helped us with some questions 3 relating to the use of products and devices in 4 Mr Eljamel's surgeries. If we go back to the statement, 5 please, at paragraph 22.1. You say there: 6 "It is accepted practice to record implants, 7 products or devices used in the operation theatre record 8 and/or in patient notes." 9 The operation theatre record is the theatre logbook, 10 is that right? 11 A. Yes, the operation theatre record would be -- yes. 12 Q. We know this to be true because you've provided us with 13 some of the logbooks that still remain and they contain 14 information about products. 15 A. Yes. 16 Q. I think, quite often stickers or something that give 17 a serial number of a product, would that be the sort of 18 thing that one would expect to see there? 19 A. Yes. So when I -- so, I can speak for my own practice. 20 I can't speak to the detail of neurosurgical practice. 21 So in my professional practice when I use a device, it 22 usually comes with several stickers. Because I don't 23 act in an operating environment, we don't use that 24 record, but a copy of the sticker goes in the nursing 25 notes and then a separate copy of the sticker is kept Page 199
1 A. I think there is a possibility of that, although I think 2 there was a research and development director that 3 predated 2010 who would have been the point of 4 governance for that as well. So I think it was 5 Professor Belch, I think Professor Ellie Dow and then 6 previously -- I cannot remember who it was before that. 7 So that goes back quite a long way prior to 2010. So 8 there would've been a governance process about research 9 in place at the time. What records were retained from 10 that period, I think, are very limited. 11 Q. Well, I think the suggestion that was made in the 12 opening statement is that no search was done for those 13 records on the assumption that they would be held within 14 Dundee University. Now, the evidence that we've heard 15 is that, from a certain point, that that would be 16 an accurate assumption, but that before 2010, records 17 would be held on the hospital side, if I can put it that 18 way. Now, if that's right, that would mean that 19 a search could be done and that documents might be held? 20 A. So, I would need to come back to you on that, if that's 21 okay because I believe that still would have been under 22 the evolution of what then became TASC. So -- but 23 I'd need to come back to you on that. 24 Q. Yes, but in the event that searches could be done, you 25 would be prepared to make sure that they were done? Page 198	1 within the department around what we've used. 2 Q. You say there that the record is kept in the operation 3 theatre record "and/or the patient notes" meaning, 4 I think, that it might not be kept in the patient notes? 5 A. I think it would be accepted practice that it would be 6 on the operative note and that's what I've seen from 7 current evidence in the operating room -- 8 Q. (Overspeaking) Sorry, that it would be kept in ...? 9 A. Somewhere in the medical record. 10 Q. Right, it should be? 11 A. Yes, it should be. 12 Q. But the reason you say "and/or" is that it might not be, 13 isn't that right? 14 A. Yes. 15 Q. Okay. And so you then go on to tell us something about 16 the various products that might be used. You say: 17 "A summary of products and devices, which are 18 generally used within neurosurgical theatres, are as 19 follows ..." 20 And you give us a long list of the sorts of things 21 that might be used. And then you say, in 22.3: 22 "To identify all products or devices that Mr Eljamel 23 used in surgery on his NHS patients, NHS Tayside would 24 require to undertake a review of approximately 25 4,000 operation notes and collate these to identify what Page 200

1 products or devices were used. During this review, 2 NHS Tayside would also require to examine any available 3 patient's medical records for further information on 4 whether the product or device was unlicensed and/or 5 experimental at the time of use. It is estimated that 6 this work would take around six months to complete. 7 Should the Inquiry require NHS Tayside to undertake this 8 piece of work, please inform us." 9 Now, that's perhaps a slight catastrophisation of 10 the situation in that what might be able to be achieved 11 in shorter order would be such an investigation in cases 12 of patients who have claims that aspects of their care, 13 (a) involved products or devices and (b) who have 14 a basis for claiming that something has gone wrong in 15 that regard. That would be a much smaller subset, 16 wouldn't it? 17 A. Yes. 18 Q. Because not all patients would have products and devices 19 and not all patients would be suggesting something had 20 gone wrong? 21 A. Yes, that's true. 22 Q. Would that be a more achievable exercise, do you think? 23 A. That would be a more achievable exercise, yes. 24 Q. Thank you. One area -- I won't go through the long list 25 that you've helpfully provided to us, but one area -- Page 201	1 an expert to be able to compile this list. So 2 I certainly can go back and get more detail around 3 those, should that be of assistance. 4 Q. That would be helpful, thank you. If there are some 5 particular aspects that people would like to us follow 6 up, I'm sure we can communicate that to you. Thank you. 7 I wonder if we could have a look at a document, please, 8 NHST-01541. This relates to some of the 9 behind-the-scenes activity related to, I think, the 10 circumstances arising out of Mr Eljamel's suspension. 11 It's a document that you provided to us. And if we 12 could just read it, it says: 13 "The purpose of this SBAR briefing is to appraise 14 the Medical Director NHS Tayside, and the Chief 15 Executive of the ongoing actions following the 16 requirement to suspend clinical practice of one of the 17 Neurosurgeons as a precautionary measure following 18 receipt of the Royal College of Surgeons Invited Review 19 Report of the clinical practice of Professor Eljamel, 20 Consultant Neurosurgeon." 21 So you'll work out from that, doctor, where we are 22 in the timeline. This is around the time of the 23 suspension. 24 A. Yes. 25 Q. And it says: Page 203
1 you mention "vagal nerve stimulators". I'm not sure if 2 that's what I'm talking about, but we've heard the use 3 of nerve stimulation in functional neurosurgery was 4 a significant part of Mr Eljamel's surgery. Is that 5 covered in the list that you've given us there? 6 A. Without being a neurosurgical expert, Mr Dawson, that's 7 what I would interpret from a "vagal nerve stimulator", 8 being a nerve stimulator, yes. 9 Q. Thank you. Another aspect that I just wanted to ask you 10 about was, again, you'll be probably better placed than 11 me to answer this, even though you're not 12 a neurosurgeon. When it talks about "dural sealant", is 13 that something that would be used to close up the wound 14 after a craniotomy? 15 A. So, I could interpret that -- my last neurosurgical 16 training was in the mid-1990s, Mr Dawson, so I would 17 really need some expert advice around that, but I could 18 interpret that as being some form of sealant to seal the 19 dura, which is the membrane around the brain. So, yes. 20 Q. Okay. Well, although it's been a long time, you're at 21 an advantage over me, Dr Cotton, because I've had no 22 neurosurgical training, but was this list then compiled 23 by someone else? 24 A. It was compiled by the care group that has 25 responsibility for neurosurgery because it required Page 202	1 "This action has placed this service under 2 significant pressure and the remaining three Consultant 3 Neurosurgeons are experiencing major challenges in terms 4 of managing the emergency neurosurgical service as well 5 as achieving both the 12-week Treatment Time Guarantee 6 for elective demand and the 9-week Stage of Treatment 7 for outpatient provision. 8 "The emergent risks are particularly in relation to 9 outpatient targets and spinal surgery. 10 "A number of recommendations have been made and are 11 being progressed including ... 12 "Review of Professor Eljamel's spinal cases ... 13 "Meeting with patients known to have had incorrect 14 level spinal surgery ... 15 "Standard Operating Procedure for Intra-Operative 16 Establishment of Spinal Level ... 17 Scroll down, please: 18 "Standard Operating Procedure for pre-operative 19 marking ... 20 "Review of Consultant On-call arrangements ..." 21 And: 22 "GMC Referral." 23 And it tells us that: 24 "In June 2013, the General Manager, Specialist 25 Services Division and Clinical Director, Specialist Page 204

1 Services Division raised increasing concerns with the 2 Medical Director about the practice of 3 Professor Eljamel." 4 And then there's information about the Royal College 5 of Surgeons' report. If we can just scroll through 6 that, as we've seen much of that already. Keep going, 7 please. At the bottom, there is a risk assessment 8 indicated there. It says: 9 "Total of 5 confirmed cases of incorrect level 10 spinal surgery to date." 11 Just to pause there, incorrect level spinal surgery 12 in accordance with the documentation is a never event, 13 isn't it? 14 A. Yes. 15 Q. "A number of major risks have been identified in 16 relation to this situation and actions have been 17 implemented to manage and minimise these as far as 18 possible. 19 "A major concern is related to breach of 20 confidentiality resulting in adverse publicity and 21 reputational damage with lack of patient and public 22 confidence. Communications fully briefed. 23 "Incorrect Level Spinal Surgery. 24 "5 suspected incorrect level spinal surgery cases 25 were presented and considered during the Independent Page 205	1 out the principles that I make decisions around in terms 2 of patient safety and staff safety, so it's the 3 principle: first, do no harm. And that the surgeon in 4 case being suspended needs a different action to manage 5 the service, not consider whether that surgeon should be 6 suspended or not. I don't think -- they're two very 7 different things. And the options for managing the 8 service and the demand, because that has been impact on 9 clinical care -- but would be: can you bring a locum in, 10 can you work out with other health boards about 11 reallocation of patients across NHS Scotland? In 12 processes we would call "mutual aid". So there are 13 opportunities in there to ensure the safe running of the 14 service even when one member of staff is not there. 15 Q. Okay. You mentioned the principle "first, do not harm". 16 In this context does that mean, based on what you've 17 just told us, that the considerations around suspension 18 effectively need to put these issues aside in order to 19 prioritise the safety of patients? 20 A. So the first issue is that they'd identified and made 21 an assessment that the surgeon was not safe to be in the 22 workplace. The consequence of that needs to be fully 23 assessed, to be risk assessed, and then options put in 24 place to mitigate against those risks. And I think what 25 they outline in there is around prioritisation of the Page 207
1 Review process. 2 "4 cases have been confirmed as incorrect level 3 spinal surgery. 4 "A further case has been identified through the 5 complaints process and corrective surgery undertaken 6 with good outcome." 7 And so at this stage what's being identified, 8 doctor, is the dilemma, I think, that faces a unit or 9 an operational service, where it emerges that 10 an important figure in that requires to be suspended 11 because what happens is there is a dilemma to be faced 12 between the importance of patients being protected by 13 suspending the individual, verses the outcome for the 14 service in being deprived of that surgeon being able to 15 offer the service. Is that what's being defined in -- 16 that dilemma being defined in this piece of 17 correspondence? 18 A. That's how I read that document, yes. 19 Q. Would it be reasonable -- it would be the case, would it 20 not, that these sorts of considerations would always be 21 part of the downside, if you like, of suspending 22 a consultant, that there would be this knock-on effect 23 on the service? 24 A. So, no service, taking a member of staff out, always has 25 been effect elsewhere. I guess -- sorry, I have laid Page 206	1 emergency service, which would be right because that's 2 the highest risk thing that clinical teams would do and 3 then what would the impact be around the performance and 4 the waiting times for patients who have less urgent 5 care? And those two things have different solutions to 6 them. 7 Q. But the patient safety considerations should trump the 8 considerations of how it will affect the service, in 9 terms of working out whether someone should be 10 suspended; is that correct? 11 A. Yes. 12 Q. Patient safety consideration should trump considerations 13 of reputational damage? 14 A. Yes. 15 Q. Could I ask you a few questions about another area that 16 you've helped us with which we haven't looked at in 17 great detail. Could we go to the statement, please, at 18 paragraph 153. Go further up, please, to see the start 19 of this section, keep going. Yes, so you were asked 20 some questions here about a review of spinal cases from 21 2010 to 2013, which was a recommendation of the Royal 22 College of Surgeons' review. Do you remember that? 23 A. Yes, I do and I found this confusing actually. 24 Q. Well, perhaps you could elucidate why you found it 25 confusing? Page 208

1 A. So the language used is about undertaking "a review". 2 What I have taken from the evidence that I have seen is 3 individual cases were reviewed and individual patients 4 were seen by Mr Mowle. What I haven't seen is 5 a comprehensive report of that review and I think that, 6 if I was medical director, that is what I would be 7 expecting from that is, absolutely patients need to be 8 seen and appropriate treatment plan put in place, but 9 how do we understand the totality of what that 10 assessment has been? 11 Q. So we talked about there being a possibility of 12 an investigation at an earlier stage which we talked 13 about and I think your view was that that should have 14 continued in early 2014, is that right? 15 A. Yes. 16 Q. This appears to be something that was happening 17 separately from that, at a later stage, is that right? 18 A. Yes, or it could have been a component of 19 an investigation or an adjunct to an investigation of 20 informing if there had been a product from the review, 21 a single assessment from it. 22 Q. Understood, but your understanding, which is our 23 understanding at the moment as well, is that what 24 happened here was Mr Mowle, who was one of the 25 consultant neurosurgical colleagues of Mr Eljamel, Page 209	1 by December 2013, in particular in relation to probity? 2 A. Yes. So I think that links back to the question around 3 an investigation, which investigation would have 4 investigation into elements of the concerns which would 5 also be the clinical practice as well. And a look back 6 on a broader element to his clinical practice not just 7 spinal surgery, but recognising that the Royal College 8 of Surgeons had made this specific recommendation. So 9 I think there could have been a broader look back at his 10 practice and should have been. 11 Q. Mr Mowle was not an independent adjudicator of these 12 matters, was he? 13 A. Mr Mowle was a consultant surgeon within the department, 14 yes. So he was not independent in terms of outwith of 15 NHS Tayside. 16 Q. Yes. He had, in fact, been intimately involved in 17 matters -- he was, in fact, the supervisor of Mr Eljamel 18 in the period we discussed earlier. 19 A. Yes. 20 Q. And in fact because of the obligations that we 21 discussed, it may have been the case that there would be 22 questions related to how much he knew about Mr Eljamel's 23 practice and whether he should have picked up signs 24 relating to that, which he would have escalated through 25 the procedures that you mentioned already? Page 211
1 undertook reviews of certain individual cases; is that 2 right? 3 A. Yes. 4 Q. So rather than it being a review in the sense of the 5 Royal College review, which looked at the overall 6 picture, it was looking very specifically at individual 7 spinal cases, is that right? 8 A. Yes. 9 Q. And it was restricted to spinal cases, is that right? 10 A. That's my understanding from that, yes. 11 Q. Would you think perhaps -- this is a suggestion -- that 12 that was related to the fact that the Royal College 13 report had suggested a review of spinal cases only? 14 A. Yes. 15 Q. But we do know also that, despite the fact that there 16 was an original consideration of the possibility that 17 Mr Eljamel might be suspended from spinal cases only, 18 the decision was taken by the requisite authorities that 19 he, in fact, should be suspended from all practice 20 in December 2013; do you recall that? 21 A. Yes, I do recall that. 22 Q. Was it clear to you from the paperwork why it was that 23 this review, therefore, looked at spinal cases only, 24 given the fact that the wider suspension was applied 25 because there were wider issues that had emerged Page 210	1 A. I think that's a fair assessment. 2 Q. In these sorts of circumstances, would you, as medical 3 director, have commissioned a consultant colleague of 4 the individual who had been suspended to undertake such 5 a review of patient cases? 6 A. I think I would have wanted some objectivity. Also 7 recognising the pressure that the department were under 8 as well of some objectivity from another neurosurgeon, 9 another health board, I think would have been much more 10 helpful. 11 Q. Well, indeed, because in the correspondence we just 12 looked at, we knew that there were ongoing effects of 13 Mr Eljamel's suspension and resignation on the service 14 which Mr Mowle would, in part, have been bearing? 15 A. Yeah, I agree, that would have been additional pressure. 16 This would have been additional pressure. 17 Q. And you identified earlier, with regard to the -- at 18 least an advantage of the Royal College invited review 19 mechanism, that one of its advantages was its 20 independence? 21 A. Yes. 22 Q. Dr Cotton, I asked you at the beginning of your evidence 23 whether you were part of a cover-up; do you remember 24 that? 25 A. You did, yes. Page 212

1 Q. And you said that you were not. 2 A. Yes. 3 Q. Do you still maintain that you are not? 4 A. Yes. 5 Q. Not continuing with an internal investigation into 6 Mr Eljamel when one could have done would be something 7 one might do as part of a cover up, wouldn't you agree? 8 A. That's one interpretation, yes. 9 Q. Not telling other agencies like the university, private 10 practice or the GMC about what was going on with 11 Mr Eljamel is also something one might do as part of 12 a cover-up, isn't it? 13 A. Again, that's an interpretation of that, yes. 14 Q. Ordering subsequent investigations into the Eljamel saga 15 which do not cover all of the matters which are 16 apparently relevant would again be something that one 17 might do as part of a cover-up? 18 A. Again, that's -- I refer to my previous statement that 19 could be an interpretation of that. 20 Q. Ordering investigations which do not take account of 21 patients' views or their testimony would be something 22 one might do to cover matters up? 23 A. Again I refer to what I have previously said, that could 24 be interpreted that way. 25 Q. Ordering investigations which are not independent might Page 213	1 A. Are you referring to the apology that was made? 2 Q. No, I'm relating to concessions about what went wrong 3 and the possibility that they may be interpreted as 4 unclear. That might be something one might do as part 5 of a cover up? 6 A. Again, you could interpret it that way. 7 Q. Issuing apologies which are not clear or comprehensive, 8 again, might be something that one might do as part of 9 a cover-up? 10 A. Are you referring to my apology, Mr Dawson? 11 Q. I am referring to that and other apologies that have 12 been given, yes. 13 A. So I think I have been clear that that apology probably 14 fell short and I have probably recognised that today. 15 Q. But issuing apologies might be something one might do as 16 part of a cover-up? 17 A. I think I have been clear already in my answer to 18 that, Mr Dawson. 19 Q. Dr Cotton, is this a cover-up? 20 A. No. 21 MR DAWSON: Sir, I have no further questions. At this 22 stage, Dr Cotton, I offer all the witnesses the 23 opportunity to add anything they may wish to add. So 24 I invite to you do so. 25 A. So, yes. I have reflected really deeply on this moment Page 215
1 be something one might do in a cover-up? 2 A. That could be interpreted that way. 3 Q. Destroying records and asserting that they had been 4 destroyed as part of routine retention policies when you 5 don't know if that is the case would be something one 6 might do in a cover-up, do you agree? 7 A. You could interpret it that way. 8 Q. Deferring to colleagues and not taking responsibility 9 for things that you should do would be something, again, 10 that one might do as part of a cover-up? 11 A. Again, you could interpret it that way. 12 Q. Deferring to people who no longer work at the 13 organisation would be something one might do as part of 14 a cover-up? 15 A. Are you referencing my referring to other colleagues, 16 Mr Dawson? 17 Q. Yes. 18 A. Yes, so I have been clear about my -- why I deferred to 19 other colleagues, because of the lack of evidence 20 available to be able to answer that question and wanting 21 to assist the Inquiry as best as possible in providing 22 the best answers to you. 23 Q. Okay. Issuing unclear concessions about what went wrong 24 might be something one would do as part of a cover up, 25 do you agree? Page 214	1 and as you might know, Mr Dawson, I have met some of the 2 patients and heard stories and not as a doctor but as 3 a human being, they've been very difficult. They're 4 probably the worst stories I have ever heard, 5 clinically, in my 30-year professional career. And yes, 6 that's been incredibly difficult to hear, not just about 7 the impact that it's had on them as individual people 8 but their families and the ongoing trauma that that 9 causes them. 10 They're angry, they're right to be angry and they 11 should be angry and I'd probably just like to say that, 12 as a doctor, as a medical director I will do my best to 13 assist this Inquiry and try to answer the questions to 14 the best of my ability, but also to put systems and 15 processes in place to ensure that we've learnt from 16 this. And I think I have described some of that today. 17 So I think that's probably all I have got to say, 18 Mr Dawson. 19 MR DAWSON: Thank you, Dr Cotton. 20 THE CHAIR: Dr Cotton, thank you. We take another break at 21 this point briefly, that's just to ensure that there 22 aren't any further questions that our participants may 23 wish to have put through counsel. So if you can go with 24 Ms Miller in the meantime. We'll resume again shortly. 25 Thank you. Page 216

1 (4.21 pm) 2 (A short break) 3 (4.36 pm) 4 THE CHAIR: Thank you, doctor. Mr Dawson. 5 MR DAWSON: Thank you. Briefly, Dr Cotton. You gave some 6 evidence earlier, helping us with scenarios that may 7 have resulted in different sequence of events taking 8 place at various difference times in the past when there 9 were warnings, so there's evidence of there being 10 warning signs about Mr Eljamel's practice. In 11 particular, we talked about various different points in 12 time, we kind of went back in time, I think, and we 13 talked about the possibility, in December 2012 that 14 a different course might have been taken at that time. 15 And you told us, I think at that stage, that there could 16 have been a warning sign at that time. This was, of 17 course, at the time when the wrong-site surgery was made 18 by the medical professional to the chief executive. 19 You said, I think, at that time that that would have 20 afforded an opportunity for there to be a risk 21 assessment -- 22 A. Yes. 23 Q. -- of what should best be done, is that right? 24 A. Yes. 25 Q. We then talked about whether, in fact, we could extend Page 217	1 depending on the information that was available at the 2 time? 3 A. Correct. 4 Q. It might, for example, have involved ultimately 5 Mr Eljamel stopping being a surgeon completely in 6 certain circumstances, which you couldn't comment on, 7 theoretically? 8 A. Yes. 9 Q. It might have involved other courses such as Mr Eljamel 10 being offered further training or support, for example? 11 A. Remedial training would be an option. 12 Q. It might have involved an assessment of what pressures 13 had resulted in the possibility of a bad outcome for 14 a particular patient that might be able to be addressed, 15 including workforce pressures, lack of information, all 16 that sort of thing; that could all have been assessed? 17 A. Yes. 18 Q. But when you talked earlier about "it could and should 19 have happened", what you were talking about was what 20 could and should have happened was that he was suspended 21 pending that risk assessment taking place, is that 22 right? 23 A. So an intervention to be put in place to ensure that 24 patients were safe. 25 Q. Yes. And -- Page 219
1 that further back because we were able to ascertain, 2 from the due diligence review, that there had been 3 a wrong-site surgery which had taken place in 2007 and 4 you were helping us with trying to work out what the 5 appropriate course at that stage would be. And I asked 6 you whether what could and should have happened was that 7 Mr Eljamel be stopped from operating at that stage. You 8 remember that? 9 A. Yes. 10 Q. And just to be clear about that, when you referred to 11 what could and should have happened, did you mean that 12 a similar risk assessment could and should have taken 13 place at that stage? 14 A. Yes, risk assessments are dynamic things that you would 15 do when presented with a new or changed risk. 16 Q. Yes, so I think we called them alarm bells, or warning 17 signs. 18 A. Yes. 19 Q. And in both those contexts, the alarm bell would be 20 information about a possible wrong-site surgery; is that 21 right? 22 A. Yes, a never event would be a signal, a strong signal in 23 the system to undertake a risk assessment. 24 Q. And the risk assessment, at that stage, could have 25 involved a number of different potential outcomes Page 218	1 A. Pending that assessment. 2 Q. Pending that assessment. 3 A. Or if that assessment had said: you can't demonstrate, 4 or can't seek assurances that patients are safe and you 5 need more time, what is it you need to do to keep it 6 safe. 7 Q. Yes. 8 A. And that might be a more restrictive -- until you 9 understand the situation better and becomes less 10 restrictive, or any other measures you've described to 11 me -- 12 Q. Understood. 13 A. -- to be put in place. 14 Q. And it wouldn't be possible for you to tell us what that 15 risk assessment would have involved because there would 16 be all sorts of factors. Effectively we'd be living in 17 a different reality because we would be investigating 18 things that we don't think were investigated at that 19 time, is that right? 20 A. I couldn't do that now. 21 Q. You couldn't, no, absolutely. 22 A. Not in hindsight, no. 23 Q. But someone might be able to try to piece together all 24 of the information, however you can't tell us what the 25 outcome of what that risk assessment would have been? Page 220

1 A. No. 2 Q. But what we can say is that in the circumstances where 3 the intervention to stop him operating, pending the risk 4 assessment, that would always have taken place in 5 a context on that hypothesis where there had been 6 a wrong-site surgery, is that right? 7 A. You would have assessed the clinical situation every 8 single time and what the risk was. 9 Q. But the reason that we were isolating that particular 10 event was because there was evidence of a wrong-site 11 surgery. 12 A. A wrong site surgery, yes. 13 Q. A wrong-site surgery is a never event, as we've said? 14 A. Yes. 15 Q. And as you've told us already, that risk assessment 16 would have properly been conducted in an environment 17 where patient safety would be the most important 18 consideration, is that right? 19 A. Patient safety should always be the most important 20 consideration. 21 MR DAWSON: Thank you very much indeed, Dr Cotton, for your 22 evidence. 23 THE CHAIR: Thank you. 24 Dr Cotton as you will have gathered that is now the 25 end of this session. There are no further questions Page 221	1 30 September 2026) 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 223
1 this afternoon. 2 Just before you step down, as I'll ask you to do 3 shortly, can I extend my thanks to you for attending the 4 hearing suite today and canvassing with us a number of 5 the very important issues that we've discussed over the 6 last few hours. I'm also grateful to you for the offer 7 at certain points in your evidence to facilitate the 8 undertaking of certain other documentary searches. No 9 doubt the nature and extent of that and the process by 10 which it's done can be canvassed in due course with the 11 representatives of the health board but I'm grateful for 12 that indication from you. 13 Finally I do appreciate, as I say to all witnesses, 14 where appropriate, the contribution that you've made to 15 the written statement which was prepared in advance of 16 your giving evidence, as well as the process by which 17 / 17 documents were associated with that. So, with those 18 thanks, I can now tell you you're free to go and 19 Miss Miller will show you where to go. 20 A. Thank you. 21 THE CHAIR: 10 o'clock. 22 MR DAWSON: Thank you, sir. 23 THE CHAIR: Thank you, everybody. 24 (4.43 pm) 25 (The hearing adjourned until 10.00 am on Wednesday, Page 222	1 INDEX 2 PAGE 3 DR JAMES COTTON (sworn)1 4 Questions by1 5 COUNSEL TO THE INQUIRY 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 Page 224

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