

1 Wednesday, 30 September 2026 2 (10.00 am) 3 (Proceedings delayed) 4 (10.14 am) 5 THE CHAIR: Thank you. Yes. 6 MR DAWSON: Good morning, sir. The first witness this 7 morning is Lynn Smith. 8 THE CHAIR: Thank you. 9 MS LYNN SMITH (affirmed) 10 Questions by COUNSEL TO THE INQUIRY 11 MR DAWSON: Good morning. You are Lynn Smith? 12 A. I am. 13 Q. And I understand that you are the chief officer for 14 acute services at NHS Tayside; is that correct? 15 A. That's correct. 16 Q. Did you contribute to the compilation of a Rule 8 17 statement that was produced to the Inquiry on behalf of 18 NHS Tayside? 19 A. Yes. 20 Q. Could we have a look, please, at NHST-04944. Is that 21 the front page of the statement to which you 22 contributed? 23 A. Yes. 24 Q. Could we look at page 273, please. And do you 25 understand it to be the case that the document was Page 1	1 A. Yes. 2 Q. One of the things you tell us about is that in 2006 you 3 had a role as a clinical team manager within the 4 critical care directorate, where you tell us that you 5 had managerial responsibility for service delivery at 6 Stracathro Ambulatory and Diagnostic Treatment Service 7 and Renal Services; is that correct? 8 A. Yes. 9 Q. Could you tell us what a clinical team manager is? 10 A. So that's someone who has the day-to-day operational 11 management responsibility for the delivery of the 12 services, working with the clinical leads and the senior 13 nurses and the front line teams. 14 Q. So if I could imagine in a particular department there 15 would be -- we've heard already about the clinical 16 lead -- 17 A. Yes. 18 Q. -- you would be someone who would be the head person 19 within a department for a particular clinical 20 speciality, would that be right? 21 A. Yes. 22 Q. And then you'd be working alongside that person to help 23 support the clinical service by providing 24 an administrative service to them, is that right? 25 A. Yes. Page 3
1 signed on that page by Dr James Cotton the executive 2 medical director of NHS Tayside? 3 A. Yes. 4 Q. And as far as you're concerned, in particular in 5 relation to the matters which you helped with, are the 6 contents of the written statement true? 7 A. Yes. 8 Q. Thank you. You have provided to us a history of your 9 various involvements in various different roles over 10 the years within NHS Tayside? 11 A. Yes. 12 Q. And I think is it correct to say that you joined 13 NHS Tayside in December 1993? 14 A. Yes. 15 Q. And you've held various roles in various different 16 aspects of NHS Tayside's operation moving from various 17 different departments; is that correct? 18 A. Yes. 19 Q. So you've gained -- I think your role is 20 an administrative rather than a clinical one; is that 21 correct? 22 A. Yes. 23 Q. So you've amassed over the years, I think, a lot of 24 experience of the way in which different aspects of 25 NHS Tayside's work functions, is that right? Page 2	1 Q. And then you tell us that in 2009 you took up a role as 2 clinical services manager for specialist services, 3 oncology, haematology and renal, with responsibility to 4 effectively manage the delivery of quality services 5 whilst optimising available resources aligned to local 6 regional and national strategy. So the role we 7 discussed before that was a clinical team manager role? 8 A. Yes. 9 Q. By 2009 you become something called a clinical services 10 manager. 11 A. Yes. 12 Q. What does that mean? 13 A. So the service manager is probably the next level 14 within, I guess the hierarchical structure, where you 15 have a larger range of services that you have 16 responsibility for. So in 2009 in that specialist 17 services role there was 12 different specialties that 18 I was then providing that managerial support role for. 19 Q. Right, so it's a similar job, but it's a higher scale. 20 You're responsible for more -- 21 A. (Overspeaking) Yes, a larger group, yes. 22 Q. Understood. So, if I could just try to piece this 23 together because these are terms we're not familiar with 24 but you'll be extremely familiar with. So in 2006 25 you're working within a critical care directorate, as Page 4

1 I understand it. 2 A. Yes. 3 Q. We talked a moment ago about there being a team. How 4 big a directorate, what sort of range of activity would 5 it cover? 6 A. So in -- 7 Q. If you could perhaps compare it to what we're interested 8 in which is neurosurgery. Is a directorate equivalent 9 to the neurosurgery team, for example, or is it bigger 10 or smaller? 11 A. So the neurosurgery team would be one specialty. So if 12 I think about the clinical service manager role with 13 that grouping, there's 12 individual specialties within 14 that grouping and neurosurgery is one of those. So 15 there will be various size of specialties depending 16 on -- so for example, neurosurgery would have had four 17 consultants with, you know, an 18-bedded ward, whereas 18 plastic surgery may have 10 consultants with a 30-bedded 19 ward, for example, depending on the level of demand, 20 activity, et cetera that would go through the area. So 21 each of the specialties may be different sizes depending 22 on the workload and the demand within that specialty. 23 Q. So you were in the critical care directorate. We've 24 heard something called a neurosciences directorate that 25 existed at a certain point in time. Is that the same Page 5	1 Q. So you have something called "specialist services". 2 What sort of grouping is that called? Does that have 3 a title in the same way as the other one was called 4 a directorate, does specialist services -- 5 A. (Overspeaking) The structure had -- I guess it's the 6 nomenclature around it, we'd changed into clinical care 7 groups from directorates at that point, so specialist 8 services was a care group that held a range of 9 specialties within it. 10 Q. Right, okay. So I think you've given us some 11 information that suggests that the word "directorate" 12 fell out of use at a certain point and that became 13 a clinical care group. 14 A. Yes. 15 Q. But is specialist services at the directorate level or 16 is it at the level above that? 17 A. It would've been -- it's similar to a directorate in the 18 sense that it has a range of services in it, but again, 19 it's just the change in how the organisation termed the 20 grouping of services. 21 Q. Understood. So broadly speaking, so we have a number of 22 teams, and each team involves a particular specialty, is 23 that right? 24 A. Yes. 25 Q. And as we've established already, that clinical would Page 7
1 sort of thing, the same sort of size? 2 A. The critical care directorate at that time in 2006, it 3 included a range of services. So there would have been 4 theatres, intensive care facilities, renal services and 5 then we had the Stracathro ambulatory centre. So I had 6 Stracathro and the renal elements of that directorate 7 within the team manager role and then there 8 would've been a team manager for theatres and a team 9 manager for perhaps intensive care facilities. So 10 again, it was a range of services within a directorate, 11 with an overarching title. 12 Q. I see, so let's try and make sure we have this. So we 13 have a directorate and within that there are a number of 14 services. Each service has its own team, is that right? 15 A. Yes. 16 Q. And in each team, you would have a clinical team with 17 doctors and nurses? 18 A. Yes. 19 Q. And you would also have a team manager, such as the role 20 you had in 2006, is that right? 21 A. Yes. 22 Q. Then, moving to the role you had in 2009, effectively 23 we're moving up in the structure by one level, is that 24 right? 25 A. Yes. Page 6	1 have clinical staff, doctors and nurses? 2 A. Yes. 3 Q. But also have administrative staff, like yourself? 4 A. Yes. 5 Q. And then above that, we would have a sort of overarching 6 group which would contain a number of teams, a number of 7 specialties within it, is that right? 8 A. Yes. 9 Q. And an example of that sort of thing would be specialist 10 services? 11 A. Yes. 12 Q. And specialist services, I think, is the group in which 13 we would find neurosurgery, is that right? 14 A. Yes. 15 Q. And so there would be -- effectively, we've talked 16 already about the fact that there would be leaders 17 within the group, so there would be the clinical lead 18 and the managers who are in that group and presumably 19 a lead nurse, is that right, within the group? 20 A. Yes. So within the care group supporting those 21 overarching 12 services, there was a clinical service 22 manager, a clinical group director and then a lead 23 nurse. 24 Q. Understood and then when we get to the level further up, 25 the specialists level, presumably there would be a team Page 8

1 of people working within that as well but effectively 2 operating above a number of teams below? 3 A. Yes, so above specialist services sat within the 4 surgical division which had a general manager with 5 an associate medical director, an associate nursing 6 director and that would have had specialist services 7 with perhaps surgical services, theatre services, 8 critical care, all under the banner, I guess, of 9 surgical division. 10 Q. Okay, so within the specialist services grouping, who 11 would the main leaders be within specialist services? 12 A. So the clinical care group director, the clinical 13 service manager and the lead nurse would have -- would 14 be the senior staff -- 15 Q. Understood. 16 A. -- supporting the specialty teams below. 17 Q. So in the same way you'd have leaders within the 18 specialty teams, at the specialist services level you'd 19 have the clinical care group directorate on the clinical 20 side, yes? 21 A. Mm-hmm. 22 Q. And then you'd have a lead nurse and you'd have a lead 23 administrative person, if I can put it so bluntly? 24 A. Yes. 25 Q. I think in 2024 you took up your job as chief officer of Page 9	1 answered for us a number of questions relating to 2 a number of different aspects of the way in which 3 NHS Tayside services work now, but focusing also on what 4 we call the relevant period between 1995 and 2015, is 5 that right? 6 A. Yes. 7 Q. And one aspect of the way that you appear to have 8 approached answering the questions which, as 9 I understand it, is different from others is I think 10 you've gone and spoken to some people who either do work 11 or did work within those services to help you give the 12 Inquiry the information that we asked for, is that 13 right? 14 A. I think our team, we've looked at, yes, information 15 within the neurosurgery services and obviously if there 16 were information there for people that still worked 17 within that area, then we would have tried to gather 18 that and gleaned that from them, yes. 19 Q. So whereas for others, it appears to be largely 20 a paper-based exercise, my reading -- please tell me if 21 I have this wrong -- but my reading is that you and your 22 team, when you were answering the questions that were 23 put to you which covered a number of different areas but 24 it was really mostly about the way that the neurosurgery 25 service worked, you have uncovered certain document Page 11
1 Acute Services, is that right? 2 A. Yes. 3 Q. And am I right in thinking that we're going up another 4 level when we talk about Acute Services, is that right? 5 A. Yes. 6 Q. We learned yesterday from Dr Cotton, I think, that Acute 7 Services is effectively one of the major operational 8 blocks of NHS Tayside, is that right? 9 A. Yes. 10 Q. And it is the operational block that deals broadly with 11 hospital care, is that right? 12 A. Yes. 13 Q. So whereas one of the other blocks might be primary care 14 or general practice or something, Acute Services is 15 where we look when we're interested in looking at the 16 hospital organisation, is that right? 17 A. Yes, that's right. 18 Q. So the various different levels we've identified. 19 I have been trying to track this against your career 20 progression as you've moved up through the different 21 levels. 22 A. Yes. 23 Q. But is that broadly the structure that we're looking at? 24 A. Yes. 25 Q. Thank you. I was wondering if you could tell us, you've Page 10	1 material, is that right? 2 A. Yes. 3 Q. That you used, but also, I think you went and spoke to 4 some people who had personal experience of the 5 neurosurgery service to try and enhance the evidence 6 that you provided, is that right? 7 A. Yes. 8 Q. One of the things that remains a slight mystery is who 9 those people are. Could you tell us who the people are 10 upon whom you relied to help provide the evidence that 11 you've given us? 12 A. So I guess in terms of pulling the information together 13 I would have delegated that to my operational team to 14 then go and work with the neurosurgery team to gather 15 all of the information that was available there, and 16 they have then linked in, I guess, with the clinical 17 team that are there at the moment, including, you know, 18 the consultant staff or any of the nursing staff who are 19 still working within the unit now and would have worked 20 over that period to, I guess, understand to be able to 21 try and support some of the response to some of the 22 issues and questions that were raised. 23 Q. Excellent. I'm not in any way trying to be critical, 24 I'm actually noticing that this is a particularly 25 helpful way of doing things because one of the issues Page 12

1 that we've had with others who have gone about it on 2 a more paper-based exercise is that they've found, in 3 various places, that there are gaps in the record and so 4 this exercise of going to speak to the people who might 5 actually have been working or have knowledge of how 6 systems worked seems to have been quite a helpful 7 exercise in that you've been able to tell us quite a lot 8 of detail and quite a lot more than others have been 9 able to. So I'm interested in understanding, when 10 you were speaking to the people about the neurosurgical 11 service, is it nurses that work currently within that 12 service that you were speaking to? 13 A. Yes, there were a number of staff that still worked 14 within the unit. 15 Q. And I think one of the things you did was you provided 16 in one of the appendices lists of people who worked at 17 the time we were looking at, 1995 to 2015, you were able 18 to identify a number of different people, and I think 19 that identifies that there are some nurses who perhaps 20 were in lower grades at the time who are still there, is 21 that right? 22 A. Yes. 23 Q. And are these the people that you spoke to in order to 24 get the information about how the service worked? 25 A. I didn't personally speak to them. Page 13	1 able to help us further? 2 A. Yes. 3 Q. That's very helpful, thank you. Just bear with me 4 a second. You provided us with a good deal of 5 information about various different aspects of the 6 service, as I've said already, and you've told us about 7 the way in which various different roles were allocated 8 to people. One of the things you told us, which we 9 found out already from one of your colleagues, was 10 Mr Eljamel, you found out from your research, was the 11 neurosurgical clinical lead between 1997 and 2009, is 12 that right? 13 A. Yes. 14 Q. I think you may mention this in your evidence but we've 15 certainly seen it elsewhere that it was the norm for the 16 clinical lead jobs, I think generally but certainly 17 within neurosurgery, to rotate amongst the consultants. 18 Is that your understanding? 19 A. That would be my understanding from other specialties 20 that I have worked with, yes. It was a rotational post, 21 roughly three years. 22 Q. Three years, right. 23 A. Yes. 24 Q. So it appears that Mr Eljamel held that role for 25 12 years. Would that be unusual? Page 15
1 Q. Yes, your team? 2 A. But my team would have spoken to them, yes. 3 Q. Understood and I'm not asking for their names right now 4 but would you be able to provide the Inquiry with the 5 names of the individuals who assisted you with that? 6 A. Yes, we could do that. 7 Q. Because obviously you've helpfully -- or your team has 8 helpfully tried to glean that information but it may 9 well be that we would have more specific questions to 10 ask them about their recollection of events and that 11 would be incredibly helpful. 12 A. We can provide that information, yes. 13 Q. I understood it to be the case, from the analysis of all 14 the different information you provided us in the 15 appendices, that although there were nursing staff who 16 still work in the neurosurgical unit who did work in it 17 for at least part of the relevant period, there were no 18 other clinical staff who still work there now who worked 19 there then, is that right? 20 A. That's right. 21 Q. Right, so all of the doctors effectively have come and 22 gone -- 23 A. Yes. 24 Q. -- but there are still nurse who worked on the unit 25 at the time who have been able to help you and may be Page 14	1 A. Yes. 2 Q. Yes, and was there, in your research, either speaking to 3 people directly or the various papers that you managed 4 to uncover for us, was there any indication as to why he 5 had held that position for so long? 6 A. No. 7 Q. I think we did see, and I think you've produced to us -- 8 we discussed this with Mrs Watson -- that there was 9 a period early in Mr Eljamel's career where he was the 10 only full-time consultant, is that your understanding? 11 A. Yes. 12 Q. So effectively he became the clinical lead in 1997 and 13 then in 1997 one of the other consultants left and then 14 in 1998, Mr Varma who had been the lead in the 15 department, left -- 16 A. Yes. 17 Q. -- leaving him as the only consultant working there, is 18 that your understanding? 19 A. Yes, supported by a locum consultants I think at the 20 time, yes. 21 Q. Indeed, but given the fact that he was the only 22 full-time member of the consultancy staff within 23 neurosurgery, it would logically follow that he would be 24 the person who would be in charge? 25 A. Well, he would have taken on the clinical lead role, Page 16

1 yes. 2 Q. And in fact he had taken it on in 1997 before Mr Varma 3 left? 4 A. Yes. 5 Q. And then we understand from the evidence that you've 6 provided, is that he was joined by two other consultants 7 in 2000; I think that's right, is it? 8 A. That's correct, yes. 9 Q. Those were, was it Mr Ballantyne and Mr Mowle joined in 10 2000? 11 A. Yes. 12 Q. And indeed you tell us later on, in 2011 a fourth 13 consultant joined the team, who was Mr Lim, is that 14 right? 15 A. Yes, that is correct. 16 Q. Thank you. One of the roles -- we've touched on this 17 already but it was a role that I just wanted to ask you 18 a little bit more about -- was the role of the clinical 19 group director. Now, just to understand where that fits 20 in the hierarchy, as I understand it, the clinical group 21 director who would be relevant here would be the 22 clinical group director for specialist services, is that 23 right? 24 A. That's correct. 25 Q. I think you provide with us details of who held that Page 17	1 responsibilities like things like accessing equipment? 2 Would that be the escalation route, if you like? 3 A. Yes, so the clinical group director would be working 4 I guess with the service managers, et cetera, around 5 that operational delivery of services and how do we do 6 that and how do we do that safely, efficiently, 7 et cetera, and yes, they would then have that clinical 8 leadership or managerial line for individual medical 9 staff within that area. 10 Q. Understood, so they would bear both a professional 11 responsibility for doctors in the individual units but 12 also they would have a role in assisting the managers, 13 the administrative staff, with the way that things were 14 run, is that right? 15 A. Yes. 16 Q. And so would it be the case then that someone who was 17 a manager within, say, the neurosurgery team would, if 18 for example, the team needed new facilities or more 19 staff or something like that, would they escalate that 20 up via the clinical director? 21 A. Yeah, so I -- I guess as the service manager in that 22 area, if there was a need for more -- you know, if we'd 23 identified that the demand coming into the service was 24 such that there was a need for additional consultants, 25 or additional trainee posts or other staff, then we Page 19
1 post over various years. We've seen reference to 2 someone called Mr McLoughlin; did he hold that role at 3 a certain point? 4 A. Yes. 5 Q. We've seen him being involved in aspects of the later 6 career of Mr Eljamel, in particular relating to 7 provision made around his clinical supervision and 8 ultimate suspension. Could you tell us a little bit 9 about what the clinical group director's role, in terms 10 of their responsibilities for clinicians working 11 underneath them in the specialist units, would be? 12 A. So the clinical group director I think is having, again, 13 that overarching responsibility for the delivery of the 14 clinical services within the specialties that are 15 sitting within that care group, so providing that 16 clinical leadership role and support to those 17 specialties. 18 Q. So in terms of -- it may not be the right expression -- 19 but kind of line management, does that person sit above 20 the consultant's working in, say, the neurosurgical 21 team? 22 A. Yes. 23 Q. And what responsibilities would that person have, would 24 they have professional responsibilities for the doctors 25 in the neurosurgical team, would they have operational Page 18	1 would prepare that information into a paper or 2 a business case or, you know, over time those terms have 3 changed and we would work with the clinical leads of the 4 specialty teams to prepare all of that information. 5 Q. Understood. 6 A. And then work with the clinical group director to , 7 I guess, jointly present that paper through the line if 8 there's a requirement for it to be escalated for 9 approval in a different part of the system. 10 Q. I see and the escalation would go through the clinical 11 director, is that right? 12 A. Yes. 13 Q. Okay, so the clinical lead would then have 14 responsibilities of a similar nature, operational that 15 we've been talking about, so you, if you were the 16 manager within that particular neurosurgical department, 17 for example, you'd be working closely with the clinical 18 lead to try and develop plans as to what staff -- 19 A. Yes. 20 Q. -- and equipment you needed, is that right? 21 A. Yes. 22 Q. But also the clinical lead, in the same way as the 23 clinical director at the level above, would have 24 professional responsibilities relating to the people 25 that worked under them in their team? Page 20

5 (Pages 17 to 20)

1 A. I'm not sure I can answer that question around the 2 clinical lead having professional responsibilities. 3 I think some of my colleagues would be better placed in 4 terms of that medical line. 5 Q. Understood, but your perspective is that the clinical 6 lead would have an important role, as would the clinical 7 director at the level above -- 8 A. Yes. 9 Q. -- in operational matters, vis-à-vis the running of the 10 service? 11 A. Yes. 12 Q. And someone like you, or someone now who would be under 13 you in the hierarchy, would assist with the operational 14 aspects of that, ordering things and making plans and 15 working out how many staff were needed for the unit and 16 sort of thing? 17 A. Yes. 18 THE CHAIR: Can I just ask, on that point, if I'm right in 19 thinking that when it comes to establishing or fixing 20 a job plan, which as I understood it was done annually 21 for a consultant, that would be something in which the 22 clinical lead rather than the clinical group director 23 would be involved in? 24 A. I think that can vary. I think the clinical lead has 25 a role obviously in working with colleagues around Page 21	1 A. Yes. Yes. 2 Q. Okay, thank you. One other aspect that you've helpfully 3 helped us with is the other staffing that would be in 4 a team. 5 A. Yes. 6 Q. And you've helpfully explained to us, in great detail, 7 the various different roles that would be assumed by 8 others, including consultants who are not the clinical 9 lead, doctors at the level below that, if you like, 10 doctors in training -- 11 A. In training. 12 Q. -- and indeed, the various different types of nursing 13 staff that one would find. There are some aspects that 14 we've come across. One thing that we've come across in 15 relation to neurosurgery is something called an advanced 16 nurse practitioner. Is that something that you would 17 have been familiar with? 18 A. Yes. 19 Q. And presumably in roles that you've held in the past in 20 certain units that employ such people, you might have 21 had a role in recruiting or making plans for such 22 a person to come into the service? 23 A. Yes, so I was part of the team that looked at bringing 24 the advanced nurse practitioner roles into neurosurgery 25 through 2011, yes. Page 23
1 determining the job plan or agreeing the job plan, in 2 terms of ensuring that the entire service is able to be 3 delivered across the range of consultants that's there, 4 and then the job plan was signed off by the clinical 5 group director. So they both have a role in the job 6 planning process. 7 THE CHAIR: Okay, thank you. 8 MR DAWSON: Are you aware of there being any mechanisms by 9 which someone's performance in the role of clinical lead 10 would be measured? 11 A. No. 12 Q. You're not aware of any such mechanisms? 13 A. No, there isn't a formal mechanism for -- 14 Q. (Overspeaking) Would it, for example, not be the 15 responsibility of the clinical director at the level 16 above to assess that performance? 17 A. I think they would, as part of their annual review with 18 the individual, they would have had a discussion around 19 the role that they were playing within the department, 20 yes, but not necessarily something -- I guess, I have 21 got in my head would there have been something, you 22 know, formally written down? I don't think so. 23 Q. Right. So there would be some level of oversight but 24 there wouldn't be a constant monitoring of performance, 25 would that be fair? Page 22	1 Q. Right. And what role was it you were doing at the time 2 that -- 3 A. I was the clinical services manager. 4 Q. Right. And so you would have been involved in, at the 5 actual time that we're looking at here, the engagement 6 of the advanced nurse practitioners? 7 A. Yes. 8 Q. We've heard some evidence that -- I think a document 9 that you refer to as well, which we've looked at in 10 detail with Mrs Watson -- in 2013 in connection with his 11 clinical supervision, Mr Eljamel was critical of the use 12 of advanced nurse practitioners, in particular 13 suggesting that they were taking on perhaps more 14 responsibility than would be normal within the unit. Is 15 that something that you were familiar with at the time 16 or had an involvement in? 17 A. In terms of his view on the role? 18 Q. Yes, was that something you were aware of being brought 19 up or you had to deal with? 20 A. No, I wasn't aware of his view on the role. These posts 21 were brought into place because we were -- I think, as 22 we've heard previously so far -- trying to retain the 23 number of trainees within the department to keep the 24 department sustainable -- 25 Q. Yes. Page 24

1 A. -- was not feasible, and therefore we'd reviewed what 2 alternatives that we could look at to be able to provide 3 a sustainable service. And at that time the advanced 4 nurse practitioner role was developing across the UK. 5 There wasn't an advanced nurse practitioner in 6 neurosurgical services at the time but we had looked at 7 to see and done the research around that: would that be 8 a feasible option and could that work? And discussed 9 that with that the consultant and multi-disciplinary 10 team, who felt that that was a better way to put in 11 sustainable services for the 24-hour period, the 12 out-of-hours period and maintain the service delivery 13 model at that time. 14 Q. Understood. 15 A. So we piloted that, we were kind of a pilot site in 16 Scotland for that role and then that's been embedded in 17 practice and now it's "advanced practitioners" because 18 it can be physios or nurses within these neurosurgical 19 units. 20 Q. Right, so can you help orientate us. Did you say you 21 started in that role in 2011? 22 A. 2009. 23 Q. 2009, right. So can you help orientate us in time as to 24 when that move towards using advanced nurse 25 practitioners was being looked at? Page 25	1 fill that. And again, they're always on a short-term 2 basis. So we knew, at that point, that that was going 3 to be an ongoing challenge within neurosurgery training 4 and therefore we took the decision, after significant 5 review around how those roles would work, to bring in 6 that advanced nurse practitioner which is a kind of 7 nurse with an extended scope, to work within the unit. 8 Q. Yes, to take over some of the responsibilities that 9 would otherwise be filled by the trainee doctors? 10 A. Yes. 11 Q. When did that happen, when did the advanced nurse 12 practitioners actually arrive? 13 A. 2011. 14 Q. Did you say that there were two of them? 15 A. Yes. 16 Q. And the number of trainee doctors fell to four at that 17 point? 18 A. Yes, well, 2012 they fell to four. So over the period 19 of 2011, the nursing staff were building up their 20 skill-set, we gave them that 12-month period to develop 21 and get to the level that we were looking for them to be 22 at, then from 1 April 2012 -- or summer 2012, when the 23 new trainee rotas came in, we moved from six to four. 24 THE CHAIR: Who would be responsible for providing the 25 training for the incoming nurses over that period of Page 27
1 A. So, we were looking at it through the end of probably 2 around 2010 and then a proposal was put forward in early 3 2011 and I think the advanced nurse practitioners were 4 recruited around about April/May 2011 for an initial 5 12-month period to embed their training, and then the 6 plan in 2012 would be that we would remove -- so the 7 trainee numbers would go from six to four and it would 8 be four trainees plus two advanced nurse practitioners, 9 would be the sustainable, middle-grade trainee rota 10 moving forward. 11 Q. What was the reason why you had started to look at this? 12 You mentioned something about issues relating to trainee 13 doctors? 14 A. So I think across Scotland there were challenges in 15 being able to recruit into those trainee training 16 numbers and therefore, we had a number of years, 17 I think, where we were having to bring locums in to fill 18 the posts because if there was a number of six, 19 I think -- I'm going back a little bit now, but probably 20 a recollection on one year we maybe only received three 21 out of the six posts, therefore you've got three posts 22 to fill to maintain an appropriate rota within the unit. 23 And therefore we would have to go out and look for locum 24 appointments or locum specialty doctor appointments or 25 just different clinical fellows, other roles, to try and Page 26	1 time? 2 A. So it would have been partly the consultant team around 3 in the department. I think I remember that there wasn't 4 necessarily a formal EMP skills course at that point, so 5 we worked with the university to be able to develop that 6 skills course for the wider NHS Scotland. But it would 7 have been the MDT around within the neurosurgical 8 department. 9 THE CHAIR: Thank you. 10 MR DAWSON: In the job that you had at that time, you 11 weren't just covering neurosurgery, you were covering 12 a wider range of services, is that right? 13 A. Yes, 12 specialties. 14 Q. Right, based on the hierarchy that we talked about, 15 you're now in a role that has the 12 groups sitting 16 under it, is that right? 17 A. Which role? The service -- 18 Q. The role that you had at that particular time? 19 A. In the service manager's role -- 20 Q. Yes. 21 A. -- yes, there were 12 specialties within that group. 22 Q. So that was consistent with what we discussed earlier, 23 by you reaching a certain point and you had a number of 24 teams sitting under you, is that right? 25 A. Yes. Page 28

1 Q. So were these issues that you faced at that time, the 2 difficult decisions and having to change the staffing, 3 were these particular to neurosurgery? 4 A. That was a specific focus at that time in neurosurgery 5 as a small unit. I can't recollect that we were moving 6 that way at that point in that year but obviously, over 7 periods of time, the advanced nurse practitioner role is 8 now embedded across many specialties. 9 Q. Yes, but you were identifying the reason why you 10 undertook that work to try to see whether advanced nurse 11 practitioners would be the solution, was the difficulty 12 getting the trainee doctors, is that right? 13 A. The trainee numbers, yes. 14 Q. Was that in neurosurgery or was that a problem that 15 existed across the specialties for which you are 16 responsible? 17 A. There probably would have been -- I can't actually, if 18 I'm being honest, recollect that specific point in time 19 across those specialties, but I guess training numbers 20 add a challenge in different specialties at different 21 points. 22 Q. Yes, but in any event, you've told us that there was 23 a particular problem in neurosurgery at that time? 24 A. There was. 25 Q. And you have explained to us the solutions you were Page 29	1 to have weighed in working out what to do? 2 A. Yes, we would have had to look at that and say: why is 3 this -- you know, they would have had to have looked at 4 the evidence, was it working, what was the feedback from 5 the other consultants, from the other ward staff, from 6 our other departments that work with neurosurgery? We 7 would have had to do that if that was a concern that was 8 raised. 9 Q. Another aspect of the letter that I'm referring to, 10 again from 2013 that Mr Eljamel expressed some concerns 11 related to the way that the service had been provided in 12 the few years before that, related to the quality of the 13 doctor, the training doctors. In particular, he 14 mentioned specialist registrars and there being issues 15 with their ability to do certain things that he 16 certainly expected them to do. You're aware that that 17 was said in 2013? 18 A. Yes. 19 Q. Was that something that was drawn to your attention when 20 you were involved in the process of trying to find 21 solutions as to how the neurosurgical service could 22 function? 23 A. I think that was a general discussion that was happening 24 within the department, that perhaps in historical years 25 they had more senior trainees that were rotating into Page 31
1 trying to come up with. 2 A. Yes. 3 Q. And another aspect of -- you've told us, I think, that 4 you are aware, I think -- because I'm sure you refer to 5 the letter we looked at with Mrs Watson -- that 6 subsequent to this in 2013, Mr Eljamel, retrospectively 7 if you like, expressed some concern about the way that 8 this had been done but I think you've told us that that 9 was not something you were aware of at the time? 10 A. No. 11 Q. But you were intrinsically involved in looking into this 12 solution? 13 A. Yes. 14 Q. So if this had been raised with someone it would've been 15 raised with, amongst others, you? 16 A. If it was an issue within the department, yes, it would 17 be. I guess, as an individual clinician, if there were 18 concerns I would expect them to speak to the clinical 19 lead or the clinical group director if it's something 20 around their particular concerns around the role. 21 Q. But because of the fact that you were involved in trying 22 to come up with the solution, if one of the consultants 23 was saying: I don't like this solution, this doesn't 24 look good to me, that would necessarily have come to you 25 because it would have been something you would have had Page 30	1 Tayside and I'm not clear how actually the allocation of 2 all the trainees were made but in the -- kind of around 3 that time, there was probably a sense that they were 4 getting more junior trainees coming towards Tayside. 5 But those trainees rotate round over their years around 6 the four units. 7 Q. And that that was a concern across Tayside, that the 8 trainees were coming -- 9 A. (Overspeaking) I think the department were obviously 10 looking at that in terms of -- I guess it's the balance 11 of trainees that you have. If you have six posts, you 12 will expect to have some senior trainees plus some 13 junior trainees. If you only have three out of six 14 coming and, you know, there's less senior trainees then 15 that spread of, I guess, experience and skill mix in 16 terms of managing the service is more challenging. 17 Q. When we're talking about trainees, just to be clear, 18 because I think you provide information about the 19 numbers of trainees that were involved in the 20 neurosurgical department at different levels at 21 different times. So are we talking about what one might 22 describe as specialist neurosurgical trainees, or are we 23 talking about other doctors that might -- 24 A. (Overspeaking) No, the ST level. They're into 25 neurosurgical training at that point. Page 32

1 Q. Yes, so I think the information you have provided 2 suggest that there were doctors at below that level -- 3 A. Yes. 4 Q. -- that also work within neurosurgery, is that right? 5 A. Yes, there would have been more junior doctors that are 6 on their general rotation. So they will come into 7 neurosurgery just as part of their training. 8 Q. Yes. So before they get to the ST, which is the 9 specialist neurosurgical training? 10 A. Which is where they make the decision into the specialty 11 in which they will -- 12 Q. (Overspeaking) And I think my interpretation -- you'll 13 know the nomenclature better than me, but my 14 interpretation of what Mr Eljamel was complaining about 15 in 2013 was the quality of the specialist level, because 16 you mentioned specialist registrars. Would that be 17 right? 18 A. Yes, it was the ST level, yes. 19 Q. And again, you've helpfully told us about the position 20 with the advanced nurse practitioners but was it 21 something that was raised with you that there were 22 concerns about the quality of specifically the 23 neurosurgical trainees? 24 A. Not specifically with me, around the quality of the 25 trainees. I think, as I've said, that the department Page 33	1 training grades and junior staff as they work within the 2 department and therefore they have a responsibility for 3 their training programme and ensuring that they are 4 progressing and developing through that. And therefore 5 they will then have the oversight of those individuals 6 in terms of the care that they deliver. 7 Q. And I'm just focusing really on the word "direct", is 8 there particular significance to direct, in terms of does 9 there need to be a physical, one-to-one contact? 10 A. So my understanding would be that the consultant and 11 those trainees would be working together within the ward 12 or theatre environment. 13 Q. So physically together? 14 A. Physically together, yes. 15 Q. So the consultant would be doing various activities and 16 the trainee would be shadowing them effectively and 17 would be given certain responsibilities when they reach 18 a certain level; was that broadly how it worked? 19 A. Yes, that's my understanding. 20 Q. Again, as I asked you earlier with regard to systems 21 that existed for monitoring the role of the clinical 22 lead, were there systems that you were aware of for 23 monitoring the extent to which trainees were being 24 directly supervised in that way or whether they were 25 being left on their own to do things? Page 35
1 were probably recognising a drop in number of trainees 2 and then perhaps less senior trainees coming into the 3 department, but there was nothing referenced or 4 escalated to me in terms of the quality of the trainees 5 that we were receiving. 6 Q. Because to be fair, neurosurgery is a specialist 7 activity, isn't it? 8 A. Yes. 9 Q. So there might well be reason for people to think: we 10 need to have a very high level of trainee because what 11 we are doing is particularly difficult. Would that be 12 fair? 13 A. I think that would be difficult for me to comment on 14 from a medical perspective but my understanding would be 15 that you would move through the ST levels in all of your 16 training programmes. So as you move through the levels, 17 your experience and knowledge and skill-set will 18 increase until you are, I guess, qualified to work at 19 that consultant level. 20 Q. Thank you. You tell us in parts of the statement that 21 you've contributed, you talk at one stage about the 22 consultants being involved in direct supervision of 23 junior staff. What do you mean by "direct supervision"? 24 A. So my understanding of how the clinical areas work would 25 be that the consultant staff are responsible for those Page 34	1 A. I'm not aware of a formal process for that but the 2 trainees, I guess, would feed back to their programme 3 lead if there was concerns. 4 Q. Yes, we've talked to various people about the way in 5 which that works now, in NHS Tayside Education for 6 Scotland and that sort of thing, but at that time there 7 would have been similar systems -- 8 A. Yes. 9 Q. -- whereby the trainees would have had the opportunity 10 to feed back or indeed, be assessed as to their progress 11 themselves? 12 A. Yes. 13 Q. So if there were issues in that regard, there would have 14 been means by which that could have been looked at? 15 A. Could've been raised, yes. 16 Q. But you're not aware of there being any formal system, 17 someone within the unit checking that, if you like? 18 A. No. 19 Q. And another thing that you help us with, in terms of the 20 way the unit worked, you have told us about various 21 different meetings that would tend to form part of the 22 way that the operation of neurosurgery worked. In 23 particular, two types of meetings. I think you 24 mentioned there was a multi-disciplinary meeting which 25 I think involves neurosurgeons coming together with Page 36

1 other disciplines to discuss cases, is that right? 2 A. Yes. 3 Q. And another thing you tell us about, I think, is 4 something called mortality and morbidity meetings. 5 Again, that would be a forum in which there could be 6 discussion but more in relation to issues or concerns 7 that have arisen in cases, is that right? 8 A. Yes. 9 Q. Again, were there systems in place within the 10 neurosurgical unit to monitor the way in which those 11 meetings were functioning, for example, that they were 12 happening frequently enough, or that they were attended 13 by the right people? 14 A. The MDT meetings would take place weekly and review of 15 the patients and I think the morbidity and mortality 16 happened probably monthly in terms of the clinical 17 effectiveness data. I know that there were registers 18 for those meetings in terms of who was in attendance, 19 et cetera. I'm not aware that there were formal minutes 20 or notes of those specifically. 21 Q. We've discussed this with Dr Cotton yesterday. We've 22 seen some minutes, four minutes of meetings that took 23 place latterly in Mr Eljamel's career. 24 A. Okay. 25 Q. So it certainly looked like there were minutes of Page 37	1 A. That's my understanding, yes. 2 Q. Yes, thank you. Interestingly, it appears that 3 neurosciences was not just neurosurgery, it was a number 4 of different medical specialties which would require, 5 one would imagine, to interact and work with 6 neurosurgery on a regular basis, is that right? 7 A. Yes, "neuroscience" is the overarching term for those 8 range of services. 9 Q. Indeed, and we've heard already about the fact that at 10 this stage I think you told us at the beginning, this 11 would have been called a directorate of neurosciences at 12 this point? 13 A. Yes, I think so. 14 Q. And then that later on became, was it, a clinical 15 specialty or something? 16 A. So "neurosciences" as a term still existed but the 17 neurology service, neurosurgery service became 18 specialties within a clinical care group. 19 Q. And then you go on to tell us that something significant 20 happened in 1998, where it says: 21 "The Neuroscience department, including the 22 Neurosurgical service, was transferred from DRI to 23 Ninewells Hospital on 16 November 1998, one of the last 24 services to transfer from DRI prior to its closure ..." 25 So we've heard a little bit about this with Page 39
1 meetings. 2 A. Okay. 3 Q. Team meetings, those were, at that time. But in any 4 event these were, as you understood it, an important 5 part of the way in which the unit functioned, is that 6 right? 7 A. Yes. 8 Q. Could we have a look, please, at the statement at 9 paragraph 14.1, this is where you're telling us about the 10 way in which the service evolved over the relevant 11 period and you tell us: 12 "From 1995 to 1998, Neurosciences was located at the 13 [Dundee Royal Infirmary], which included the departments 14 of Neurosurgery, Neurology, Neurophysiology, 15 Neuroradiology and the Pain Clinic. 16 "From 1995 to 1998, the Neurosurgical ward had 17 a total of 27 beds, which included a high dependency 18 area and three paediatric beds. The Neurosurgical 19 theatre, which was housed in the same building, was 20 entirely dedicated to Neurosurgery and staffed at all 21 times by Neurosurgical theatre nurses." 22 So that was the position when we were in Dundee 23 Royal Infirmary, is that right? 24 A. Yes. 25 Q. So there were 27 beds dedicated to neurosurgery? Page 38	1 Mrs Watson, in the context of the advert that was sent 2 out for Mr Eljamel's consultant job, that even in 1995 3 when he started, it was anticipated that this was going 4 to happen. But I think what you're telling us here was 5 there was a gradual move of different services which was 6 associated with Dundee Royal Infirmary closing, is that 7 right? 8 A. Yes. 9 Q. And so in 1998, the neuroscience facilities moved across 10 and that was one of the last services to move? 11 A. Yes. 12 Q. So as you were able to find in your researches, was that 13 simply associated with the fact that Dundee Royal 14 Infirmary was being closed down, was an old building or 15 something like that? 16 A. Yes. 17 Q. And everything was being moved into the big hospital, if 18 you like? 19 A. All of the services were moved on to the Ninewells site, 20 yes. 21 Q. Thank you. At 14.4, you go on to tell us: 22 "The Neurosurgical service formed part of the 23 Neurosciences Department and was under the remit of the 24 Dundee Teaching Hospitals NHS Trust up until 25 1 April 1999. Responsibility then transferred to Page 40

1 Tayside University Hospitals NHS Trust, where it 2 remained until 1 April 2004." 3 We've covered that off with your colleague 4 Ms Dunning: 5 "Following the dissolution of that trust, 6 NHS Tayside was established as a unified Board assuming 7 operational responsibility for the Neurosurgical 8 service, which provided general neurosurgical services 9 for patients in Tayside and North-East Fife, covering 10 Perth Royal Infirmary as well as Stracathro Hospital, 11 and maintained close links with the neighbouring Fife 12 Acute Hospitals ..." 13 Now, one aspect of the materials we've looked at so 14 far suggested that, at times, Mr Eljamel may have 15 offered neurosurgical services in hospitals other than 16 Dundee Royal Infirmary and Ninewells. Can you help us 17 with understanding why, for example, he might have been 18 listed as offering services from Perth Royal Infirmary? 19 A. No, from the information I have and from the data I have 20 seen, I think there may have been a small number of 21 perhaps clinic appointments at Perth Royal Infirmary at 22 one point. But when I came in post 2009, all of the 23 services were delivered on the Ninewells site. 24 Q. So if it were the case he was delivering some sort of 25 service from Perth Royal Infirmary, that wouldn't have Page 41	1 this which I think can be contrasted with the way in 2 which you describe the neurosciences department before, 3 is that the previous service comprised a neuroradiology 4 component, whereas that is not part of the services 5 listed here. Is that right? 6 A. My thinking around that would have been the way the 7 services were set up within DRI at the time and the way 8 the services would be delivered within 9 Ninewells Hospital. So the neurosciences unit 10 encompasses all of those services within a set area and 11 then they would've accessed radiology services within 12 the radiology area in a different part of the hospital, 13 and the neuroradiology specialists would be based in 14 that and they would attend MDTs, et cetera, but they 15 wouldn't have necessarily have been based within that 16 department. 17 Q. Understood. 18 A. I'm thinking perhaps at DRI, there was an element of 19 neuroradiology specifically co-located with them, but 20 I'm not -- 21 Q. (Overspeaking) That's what it looks like from the 22 narrative. It would seem reasonable to assume that what 23 happened was, it wasn't as if neuroradiologists ceased 24 to exist or something? 25 A. No. No. Page 43
1 been a regular service, it might have been a requirement 2 arose in a particular case or something like that? 3 A. There was no regular service within Perth Royal 4 Infirmary. 5 Q. Yes, thank you. That's helpful. You go on to say, at 6 14.5, describing the new service: 7 "The Neurosciences Department, including the 8 Neurosurgical service, became part of the Specialist 9 Services Clinical Group in 1999 when the structure was 10 introduced. The Neurosciences Department encompassed 11 Neurosurgery, Neurology, Clinical Neurophysiology, 12 Chronic Pain Service, with the addition of 13 Neuropsychology and Neuropsychiatry. Following the 14 relocation of the department in 1998, from a dedicated 15 neurosurgical unit at DRI to Ninewells Hospital, 16 a dedicated Neurosurgical ward was established at 17 Ninewells Hospital, comprising 18 acute adult beds and 18 four high dependency beds. Neurosurgical intensive care 19 was provided within Ninewells General Intensive Therapy 20 Unit (ITU). Paediatric patients were looked after in 21 the Paediatric wards. A close liaison has also always 22 existed with the Brain Injury Rehabilitation Centre 23 based at the Royal Victoria Hospital in Dundee." 24 Now, so this is describing the new service the way 25 in which it existed within Ninewells. One aspect of Page 42	1 Q. Presumably there was a big radiology department in the 2 big hospital -- 3 A. Yes. Yes. 4 Q. -- and the neuroradiologists sat within that rather than 5 sitting alongside the neurosciences people, is that 6 a fair assessment? 7 A. Yes. 8 Q. I think the case is that also the number of beds 9 available to the neurosurgical ward has decreased, is 10 that right? 11 A. Yes. 12 Q. So it was 27 before and now it's 18, is that right? 13 A. Yes, with four high dependency beds. 14 Q. Yes, and the high dependency beds would be part of the 15 unit for what sorts of patients? 16 A. So patients that post-operatively or through emergencies 17 need more intensive care. So again, you know, more 18 increased nursing care and review and monitoring than 19 a general ward area. 20 Q. But they also, in other regards, relied upon the general 21 service of the hospital for the intensive therapy unit 22 and indeed the paediatric wards? 23 A. Yes. 24 Q. So again, that would presumably be part of a sharing 25 arrangement within a bigger hospital? Page 44

1 A. Yes. 2 Q. You wouldn't necessarily have your own dedicated area in 3 a smaller hospital that might be able to be 4 accommodated? 5 A. Yes. 6 Q. But there are sort of economies of scale here? 7 THE CHAIR: Would that mean the apparent reduction in the 8 number of beds as between the old and the new is perhaps 9 more apparent than real because the paediatric beds were 10 now part of a paediatric ward or wards, and the figure 11 for 27 in DRI included high dependency provision? 12 A. Not being around at the time, I'm not sure around that. 13 There would have been high dependency beds there, yes. 14 Not sure around paediatric beds. As part of the DRI 15 transfer, I would have imagined that there would've been 16 a review of the requirements and the bed requirements 17 were for the service as it stood and how it would be 18 delivered within the new hospital and therefore there 19 would've been an agreement around an 18-bedded unit for 20 elective care emergency and for high dependency. 21 So that modelling or work would have been done as 22 parts of the move of services from the DRI site to the 23 Ninewells site. 24 MR DAWSON: We've discussed, with a number of different 25 neurosurgeons, the various different departments or Page 45	1 Q. And I think you provided for us, you've done a search to 2 try and find as exhaustive a list as you could of 3 various people who used to work with Mr Eljamel and in 4 that, feature a number of anaesthetists. And are these 5 the ones that appear to be the ones who are doing that 6 role who regularly worked with him? 7 A. Yes. 8 Q. Understood. Let's have a quick look at 14.9, please, 9 I have various questions about this. We have touched on 10 some of this already, but the junior staff. I think you 11 mentioned already the way in which the junior doctor 12 numbers changed. One aspect I think you mentioned 13 already, clinical fellows, and in this you also mention 14 honorary and research fellows. Were these people that 15 you got in to try to deal with the shortfall in the 16 trainee doctors, is that right? 17 A. Yes. 18 Q. And are these people who are effectively at a training 19 sub-consultant level but predominantly work in the 20 university, is that right? 21 A. They can be a mix of people. So again, some of the 22 clinical fellows may be doing or have been doing some 23 research and this then provides them with some clinical 24 practice. Specialty doctors will be more that they're 25 still currently practising and come in to do a specific Page 47
1 other types of doctors one would tend to become involved 2 with and there seems to be a very, very long list but 3 one in particular would be anaesthesia in relation to 4 the surgery. Are we to assume that the anaesthesia 5 would be provided through a general anaesthesia 6 department -- 7 A. Yes. 8 Q. -- where there would be anaesthetists who perhaps would 9 come and go amongst different specialties, would that be 10 correct? 11 A. Yes, it would have been part of the larger department 12 within the hospital but I think there would be 13 individual anaesthetists who would specialise in 14 certain areas. So again, that continuity would have 15 been in place in terms of having a group of 16 anaesthetists who would have been particularly skilled 17 perhaps in neurosurgery and therefore would work 18 alongside the neurosurgeons. 19 Q. Thank you. So there would be some anaesthetists who 20 would specialise in certain areas, one of which might be 21 neuro-anaesthesia, if there is such a thing? 22 A. Yes, that's still the case today. We have a full 23 department but each anaesthetist has general skills but 24 they also have sub-specialty skills and they will 25 predominantly work with surgical colleagues. Page 46	1 role at below a consultant level. 2 Q. Right, but the clinical fellows, for example, are they 3 people who are predominantly based at the university 4 doing research or something but also can fit in to do 5 this role? 6 A. Yes, that's my understanding. 7 Q. So again, it would be logical that that would be a place 8 one would try to go to try and find additional people if 9 there were shortfalls, is that right? 10 A. Yes. 11 Q. You also tell us here that you don't have any 12 information about any of the locums that you mentioned. 13 Were records relating to who the locums were kept at one 14 time and no longer exist, or would that be something 15 that would just simply not be recorded within the sorts 16 of places you were looking for information? 17 A. I don't think that would have necessarily been recorded 18 as such within -- and again, it would have been based on 19 memory of the staff. I would have thought that the 20 recruitment documents may have been there but again, 21 they may not have been retained until this point because 22 the locums would have been recruited through a medical 23 staffing unit. 24 Q. Right, because you were able to provide with us a lot of 25 information but I think it's really more permanent Page 48

1 staff? 2 A. Yes. 3 Q. But you did have some access to information about some 4 of the more temporary staff, if you like, the clinical 5 fellows who came to work. Would they perhaps be ones 6 who stayed a bit longer? 7 A. Yes, so they probably would have had 12-month contracts 8 within the department maybe than perhaps someone for 9 maybe just six weeks. 10 Q. So in terms of engaging locums, how would that normally 11 work? How do you find locums and how long do they tend 12 to stay for? 13 A. So, I'm probably starting to step out of my expertise 14 area here, but we would link with our medical staffing 15 group and then locum adverts would go out within the 16 appropriate medium, whether that be recruitment agencies 17 or online, I guess, journals or documents to advertising 18 posts and availability within the department and then we 19 would expect to see applications come in. 20 Q. You mentioned the time period that you were involved in 21 looking at the way in which you might fill the gaps. 22 I think you said you arrived in the role you were doing 23 in 2009. 24 A. Yes. 25 Q. And this was looking at maybe slightly later than Page 49	1 the four neurosurgical units and they would then work as 2 one service through the managed service network that 3 would then set up the range of clinical standards to 4 then be able to ensure that all four neurosurgical units 5 were delivering care and services in the same way. 6 Q. I think that this was something we discussed to 7 a certain extent with your colleague, Ms Dunning, last 8 week because we asked a question about this, it was 9 question 20 in our list. The question was: what 10 questions, if any, were raised about the viability of 11 maintaining a neurosurgical unit within NHS Tayside in 12 the context of a restructuring of neurosurgical services 13 in Scotland over the relevant period? 14 And I think that's what you're telling us about, 15 that there was a period during which the viability of 16 delivering neurosurgical services via four units was 17 very much in question in Scotland, is that right? 18 A. Yes. 19 Q. And the culmination of that I think -- that was 20 a question that was answered by Ms Dunning for some 21 reason but it does seem to fall very much in the realm 22 of the questions that you otherwise answered about the 23 services. So I wonder if you might be able to help us 24 with it to a certain extent. 25 A. Yes. Page 51
1 2011, I think you mentioned? 2 A. Towards the end of 2010, we were starting to think there 3 were ongoing challenges and was there a different model 4 we could look to put in? 5 Q. Okay, one aspect of that which plays a role in your 6 explanation as to how neurosurgical services were 7 delivered was the development of something called the 8 "managed service network for neurosurgery". 9 A. Yes. 10 Q. Could you tell us broadly what the role of that was and 11 whether that was a service that you were using to try to 12 find these solutions? 13 A. So obviously, I was around at the time as the managed 14 service network was just being established. It was 15 established following a report from the implementation 16 group and I think there had been, prior to that for 17 a number of years, a review of whether we could sustain 18 four neurosurgical units across Scotland. I think the 19 output of that review and then the implementation group 20 was that was still a requirement for four units in 21 Scotland and that was around local access for 22 emergencies, so particularly from a north-east 23 perspective, and that there was a balance between having 24 that local access as well as a level of specialisation. 25 So I think the agreement was that we would retain Page 50	1 Q. I think I'm right in saying you produced to us a report 2 which was NHST-04433, which was a report really, 3 I think, telling us about the culmination of that 4 process and the creation of the managed service network 5 as a solution, is that right? 6 A. Yes, that's my understanding. Yes. 7 Q. Yes, but before that I think that there had been 8 obviously a process which had been gone through to try 9 to address the issues that existed. That was the 10 proposed solution but there had been questions raised 11 I think over years before that as to whether the four 12 units were still viable. 13 A. Yes. 14 Q. We provided you with a document which was actually 15 provided to us by the Scottish Government but was also 16 something which your colleague, Ms Dunning, referred to 17 in her evidence as something that she had discovered in 18 her research and it's a document from a slightly 19 earlier period from November 2007, in which there is 20 an ongoing discussion. It's a precursor, if you like, 21 of the MSN being formed. And in that, there is 22 a discussion about the services delivered by all of the 23 different units, the advantages and disadvantages, if 24 you like, of the maintaining the status quo, 25 geographical advantage of having four centres versus Page 52

1 problems that had been experienced with delivering the 2 services. 3 Can you help us with the period over which you 4 understand that those considerations and those 5 discussions were ongoing? 6 A. No, I can't. I have just -- I think the needs 7 assessment document was provided to me this morning. 8 It's the first time I've seen that. So, as I said, 9 I came into post in 2009 as the MSN was starting. So 10 I had a broad understanding of the -- I guess, the work 11 that had gone on before the implementation group report 12 in 2008, with its recommendations but I can't comment on 13 the length of time prior to that, where those 14 discussions were taking place. 15 Q. Right. And you had been there from 2009? 16 A. Yes. 17 Q. So that would be the first time you were plugging into 18 that? 19 A. Yes. 20 Q. I understand that. This is before that. 21 A. Yes. 22 Q. And it is at a different level, a different area from 23 what you were dealing with, I think? 24 A. Yes. 25 Q. Just for the sake of the record, that report is Page 53	1 this was something that was at least prevalent in the 2 discussions that you were having around the way that the 3 unit would work, as to whether or not there was a strong 4 impetus towards trying to retain the neurosurgical 5 service in Dundee? 6 A. I think by the time I'd come into post in 2009, the 7 implementation group report had been published and the 8 managed service network had been commenced. Therefore, 9 my understanding from that was that the four units had 10 been confirmed, would remain in place and then what we 11 were working towards was the development of core 12 standards that we would then be, you know, progress with 13 and then review against. 14 So in my understanding, the agreement had been -- 15 well, the review had taken place, there was agreement 16 that the four surgical units would remain and we were 17 moving forward with an overarching service network that 18 would look at: how do we try to ensure that we can 19 deliver across those four units in a standard way but 20 also how can we ensure that we have, you know, 21 appropriate recruitment and support for each other in 22 terms of trying to retain those four units. 23 Q. Thank you. So when you arrived, if you like, the policy 24 decision had been made? 25 A. Yes. Page 55
1 SG-00174. I won't ask you about the detail of it just 2 now. It may be that that's something we can take up 3 with other witnesses. As I say, it was produced to us 4 by the government in the first instance but helpfully 5 located by your colleague, Ms Dunning. One of the 6 aspects that is interesting about the report which you 7 might be able to help us with, was it says in the 8 report -- obviously there are contributions to the 9 report from people working within the different centres 10 and Mr Eljamel, for example, contributes certain 11 aspects, explaining information about how the Dundee 12 unit was working, and it does say in it that obviously, 13 there are two major centres, in Edinburgh and Glasgow, 14 and I think what's being contemplated is the possibility 15 of one or both of the other centres shutting and indeed, 16 there's discussion in it as to the possibility that 17 there could be a single centre-based model in Glasgow as 18 well. 19 But as regards the position with Dundee and 20 Aberdeen, it does say that neither Dundee nor Aberdeen 21 would support a move to reduce the number of centres 22 unless this achieved a single national centre of 23 excellence on a purpose-built, central site as had been 24 proposed in a previous 2003 report relating to this. 25 Are you able to help us with the extent to which Page 54	1 Q. You were moving forward with the implication of that new 2 system? 3 A. Yes. 4 Q. But it would appear that the discussion about this had 5 gone on for some years before but you weren't involved 6 in it? 7 A. No. 8 Q. Understood. You've also helped us with various aspects 9 of the way in which, if you like, day-to-day activity 10 within the neurosurgical unit would work. One of the 11 things, if we could look at, please, 19(c).2 of the 12 statement. Sorry, could we look at 19(e).3 first, 13 please. This is where you were telling us about the 14 number of sessions that would be offered for 15 neurosurgery at various different time periods and if we 16 just go to 19(e).2, please, you tell us there, that: 17 "In 1995, ten elective theatre sessions supported 18 continuous elective neurosurgical theatre activity 19 throughout the week. [The] model remained in place 20 until 2015 with the ten elective theatre sessions shared 21 between the four consultant neurosurgeons ..." 22 We've seen a little bit about this already, again, 23 emanating from the letter I mentioned a moment ago, 24 where Mr Eljamel was complaining at that time about the 25 fact that when Mr Lim had arrived in 2011, perhaps Page 56

1 slightly counter-intuitively, one would have thought 2 that was good news that another consultant was coming on 3 board, but he, in fact, seemed to be expressing at that 4 time that he had an issue with that because it meant 5 that the normal theatre sessions, which he had 6 traditionally offered on a Monday and a Thursday, were 7 now offered on a Monday presumably to make space for 8 Mr Lim on a Thursday and that that had caused him issues 9 with being able to keep up with the number of surgeries 10 he needed. In particular, as Mondays, as they are now, 11 were particularly affected by bank holidays. 12 Again, was that something that, in the time that you 13 were involved, that you were aware of there being 14 an issue about, Mr Eljamel having issues about the 15 number of sessions he was offered and his ability to 16 offer the number of surgeries that he required to? 17 A. No, I don't recollect specifically. I think, as a group 18 of four surgeons neurosurgeons, they have the ten 19 theatre sessions available to them and then, as a group, 20 would look how would be allocated across their week, 21 aligning with their outpatient clinic timetables, ward 22 time or any other additional things that they had. 23 So the decision around which day of the week someone 24 would take would have been a joint discussion between 25 the group of neurosurgeons, and I think obviously we Page 57	1 attitude, if he had expressed it? 2 A. I think it's difficult for me to comment on his views. 3 Q. But I mean from your perspective, the position was that 4 this was a development which was designed to try to 5 share the work more evenly? 6 A. So from my recollection around that time, we were 7 looking at a level of increasing demand coming into the 8 service. We'd identified that we had challenges within 9 that ST-level rota and therefore, we had proposed -- we 10 prepared a proposal for an additional consultant to help 11 with managing that demand and workload and also the 12 advanced nurse practitioners, in terms of helping that 13 day-to-day running of the service. So that, in my mind, 14 would have been -- or I would have thought would've been 15 a positive development for the service to have four 16 neurosurgeons in terms of a one-in-four on-call rather 17 than a one-in-three, four people to share the workload 18 and then the advanced nurse practitioners giving 19 a sustainable six-person, you know, trainee team. 20 THE CHAIR: Out of interest, would you expect the 21 consultants in -- the three consultants who were working 22 in the team to be consulted or indeed, be part of that 23 conversation before the proposal for the increase to 24 four? 25 A. Yes, very much so. Yes, I would have worked closely Page 59
1 moved from three to four neurosurgeons, therefore that 2 workload of three was moving to four people, and 3 obviously at the time, I'm thinking that we would've 4 looked to see ten theatre sessions per week would be 5 sufficient to meet the demand of the service and 6 therefore, then the theatre sessions are spread across, 7 with the expectation that the workload would be shared 8 between four people rather than three. 9 Q. Right, so again, you mentioned earlier issues about 10 getting trainee doctors, but was it difficult to get 11 consultant neurosurgeons as well? 12 A. Yes. 13 Q. So getting the fourth consultant neurosurgeon in 2011 14 must have been thought, by people in your position and 15 others, as being quite a significant achievement? 16 A. Yes. 17 Q. And your mindset, as I think you described, would be: 18 there is a certain workload here and that workload can 19 now and borne by four people rather than three? 20 A. Yes. 21 Q. And that would be deemed to be a good day, a success? 22 A. Yes. 23 Q. It didn't seem that Mr Eljamel looked at it that way in 24 the letter. Do you have any observations on that, in 25 terms of whether that would've been deemed to be an odd Page 58	1 with the clinical lead at the time. We would have been 2 identifying that there was increasing demand coming into 3 the service and I think some of the data around the time 4 shows that. I think at that time we also had -- spinal 5 work was shared between neurosurgery and orthopaedics at 6 that period in time and I remember there was 7 a diminishing number of orthopaedic surgeons, therefore 8 a lot of spinal referrals were coming towards the 9 neurosurgery service. 10 So that was a number of factors that were coming in 11 to that increasing demand and therefore our proposal was 12 put together on the basis of the existing workforce will 13 not be able to manage that workload and meet, I guess, 14 the forthcoming treatment guarantee times, et cetera. 15 Therefore, we need to put in a more robust workforce 16 model to support that. And as a supportive measure to 17 the consultants that were there trying to manage that 18 increasing demand. 19 THE CHAIR: Okay, I follow that. 20 MR DAWSON: I think you said the expectation, when you 21 brought in a fourth consultant or a fourth consultant 22 was brought in, would be that the workload would be 23 shared equally, what was a one-in-three would become 24 a one-in-four? 25 A. From an on-call perspective, yes, one-in-three would Page 60

1 become a one-in-four. 2 Q. Yes, what about elective procedures? 3 A. So I think in terms of, I guess, how clinical 4 specialties work, there will be general procedures that 5 all four surgeons I would expect would be able to 6 operate on and then there will be individual 7 sub-specialty areas that each surgeon will have and 8 maybe they will have that workload aligned with them. 9 Q. If a surgeon had a lot of sub-specialties such that 10 these were things that he or she did that others did 11 not, that would diminish their ability to share the 12 load, wouldn't it? 13 A. Yes. 14 THE CHAIR: Mr Dawson, I would normally take a break about 15 this time but I'm conscious not only of the timetable 16 today accommodating three witnesses, it may be that 17 you're not planning on going on much longer with the 18 witness. I'm rather in your hands as to whether it 19 would be convenient or indeed inconvenient to have 20 a break at this point? 21 MR DAWSON: I think if Ms Smith would be happy to continue, 22 it might be best for our timing to continue at this 23 stage? 24 A. I'm happy to continue, yes. 25 MR DAWSON: Thank you, sir. Page 61	1 interviews, a number of issues relating to the 2 consultant neurosurgeons' job plans were raised. The 3 RCS Review Team heard that the department had taken on 4 many degenerative spinal cases from Fife. This had 5 added to the surgeons' workload and changed their scope 6 of practice to being predominantly spinal work. 7 Consultant Neurosurgeons did not consider it feasible to 8 keep taking on patients from Fife without additional 9 support. The report concluded that workload had been 10 increased by NHS Tayside taking on more cases from 11 outside its established catchment area, including parts 12 of East and South Fife." 13 So a couple of questions about that. You mentioned 14 a moment ago that there was another source, I think, of 15 additional burden in what we would call the latter 16 period of Mr Eljamel's career, due to a lack of 17 availability of orthopaedic surgeons to take on 18 a certain burden of the work. So did that drive up the 19 number of spinal cases that the neurosurgeons needed to 20 do? 21 A. Yes, there was increased referral rate into the 22 neurosurgical service over that period and one of the 23 factors, as well as ageing population, et cetera, was 24 the fact that there was a change in the number of 25 orthopaedic consultants available to do spinal work, Page 63
1 You tell us about various different aspects of the 2 way that the unit would work and I would like to ask you 3 questions about the various different aspects. 19(c).2, 4 please. You tell us here, that: 5 "Until 2012, all Emergency referrals to the 6 Neurosurgical Team were recorded in a physical book 7 called the 'yellow book' which was carried by the 8 on-call registrar ... Following this, the Neurosurgical 9 unit adopted an excel spreadsheet referral system 10 containing referral data, which still runs to date ..." 11 Is the information about emergency referrals still 12 available from that period, or is that not something 13 that's available? 14 A. Yes, that's -- I -- 15 Q. So the yellow book? 16 A. Oh, the yellow book, I'm not aware that the yellow book 17 still exists. I think the understanding of how that 18 would have worked would have been gleaned from people 19 who have worked in the department over the period of 20 time. So I'm not aware of the yellow books still being 21 in existence. 22 Q. Okay. Could we have a look at 16(a).3, please. You are 23 telling us here about the way in which referrals worked 24 to the unit and one aspect that you say, is that: 25 "In the RCS report in 2013 ... during the course of Page 62	1 both in Tayside and Fife. 2 Q. Right, and this aspect of things seems to be connected 3 to that but it's an additional factor which is, is this 4 the reason why they were -- so were they taking on 5 additional cases because of a lack of orthopaedic 6 surgeons but also taking on additional cases from 7 a wider catchment area than would normally have been the 8 case? 9 A. So the catchment area for Tayside would be 10 North East Fife patients, but at that period in time, 11 I think what was happening was that Fife GPs, et cetera, 12 were referring into the Tayside service because of that 13 diminishing of, I guess, the surgeons available within 14 Fife to treat those types of cases. 15 Q. Right, so there was a diminishing number of orthopaedic 16 surgeons across the board? 17 A. Yes. 18 Q. And a diminishing number of surgeons who could do spinal 19 cases in Fife? 20 A. Yes. 21 Q. So there were two contributing factors, if you like, 22 which may have been interlinked, to some extent. 23 A. Yes. 24 Q. How would decisions around that sort of thing be taken? 25 Because we already heard from one your colleagues, Page 64

1 I think, that NHS Tayside generally covers the three 2 council areas in the Tayside area, but acute services 3 also covers North East Fife, is that right? 4 A. Yes. 5 Q. So that would be the norm, if you like, that 6 North East Fife would be covered and that patients would 7 come from there? 8 A. Yes. 9 Q. But what's being suggested here is that there are 10 patients coming from other parts of Fife and you've 11 explained to us why. Presumably, someone would have had 12 to have taken the decision that these referrals coming 13 from GPs or wherever else would be accepted at that 14 time, there would have to be some sort of policy 15 decision that that would happen? 16 A. So I'm not sure if there was a policy decision or if it 17 was as clear as that at the time. I think, as we were 18 seeing the referrals increase, we would then have 19 reviewed them around patients' postcodes, for example, 20 and then identified that we were seeing an increasing 21 referral from other parts of Fife. Then, I guess, more 22 senior colleagues would have had potentially discussions 23 with colleagues in Fife to understand why are those 24 referrals transitioning here rather than perhaps going 25 to Lothian, if that's where perhaps you have pathways. Page 65	1 them. But obviously what we were recognising was that 2 that increasing level demand, when we get underneath 3 what the reasons for that are, then we start to 4 understand and unpick that and then start to have that 5 different conversation with regional colleagues around 6 how we make -- if that's going to be a sustainable 7 pathway, how do we actually then appropriately resource 8 that. 9 Q. Just on the literal, physical level of having a patient 10 sitting in front of you from, say, South Fife, 11 a consultant would be obliged to deal with that because 12 they couldn't say: this is not our area? 13 A. No, they wouldn't have -- 14 Q. (Overspeaking) Someone else makes that decision? 15 A. At that point in time, they wouldn't have made that 16 decision. 17 Q. Understood. In relation to another aspect -- again, 18 sorry, I meant to ask you, this is something that came 19 up during the course of the Royal College of Surgeons' 20 review, when some people came and asked people about the 21 way in which the service was being run in 22 September 2013. Again, was this issue about there being 23 an increased burden in the two ways you've mentioned, 24 from the decreased orthopaedic service and from other 25 areas of Fife, something that you had been aware that Page 67
1 So again, it was kind of looking at -- I guess our 2 teams would have looked at that, and then started to 3 have a conversation with Fife colleagues around: we've 4 got an increasing workload coming this way, if that's 5 going to be an ongoing position, then how do we work 6 together to provide a wider regional service that's 7 appropriate and resourced? 8 Q. When you say "colleagues would have discussions", who 9 would the colleagues be that would make that sort of 10 decision? 11 A. Probably at that next level up from the general manager 12 area would have linked with general managers and perhaps 13 financial colleagues in Fife around patient numbers, and 14 pathways, et cetera. 15 Q. So for example, if you were in a clinic and you're 16 a neurosurgeon at this time and then you got a patient 17 who came in, effectively there's referral to you from 18 say South Fife, would you just have to take that patient 19 or would you say: hang on a second, this person should 20 be going to Lothian if there's an issue in south? 21 A. Yes, so I think at that point in time -- I think 22 probably things have moved on now in terms of being 23 a bit clearer around boundaries and accepting of 24 referrals, but probably at that point in time, referrals 25 would come in and be accepted and the surgeons would see Page 66	1 the neurosurgical team had noticed and were troubled 2 about? 3 A. I think we'd identified it, as we knew in terms of 4 I guess our waiting times for clinics and inpatients 5 were increasing and when we look at that, we can see 6 that we've got an increasing level of demand. The 7 consultant teams, in terms of reviewing referrals, 8 et cetera, would be -- we have our activity data that 9 tells us there's a shift in that activity. Yes, so we 10 were very aware of it at that point. 11 THE CHAIR: Would the hypothetical patient in South Fife 12 that we've been talking about ordinarily be referred, if 13 it was an issue regarding neurosurgical intervention, 14 would that patient ordinarily be expected to be referred 15 to the Lothian area, from their -- 16 A. I'm not clear at that point in time, back then what the 17 pathway would have been. 18 THE CHAIR: Because one thing is clear is that these four 19 centres, which don't include a Fife hospital. So should 20 I understand that historically the reason for this is 21 that there were degenerative spinal cases that were 22 being treated, not by neurosurgical input but by 23 orthopaedic input within Fife? 24 A. Yes. 25 THE CHAIR: And that was the -- Page 68

1 A. (Overspeaking) So the neurosurgical referrals that were 2 clear neurosurgical referrals in Fife would have gone to 3 Lothian. And then, as you say, historically what we 4 would have had is some degenerative spine would have 5 been dealt with by orthopaedic surgeons and some would 6 be dealt with by -- 7 THE CHAIR: We've come across that as a concept, yes. 8 A. Yes. 9 THE CHAIR: I see. So we're not looking at a difficulty in 10 the provision of neurosurgical services outwith Fife, 11 we're looking at this purely through the lens of 12 an orthopaedic issue, is that right? 13 A. Well, the spinal cases could be referred depending on 14 probably some clinical terminology around whether you 15 would refer to an orthopaedic or a neurosurgeon, but 16 that diminishing of orthopaedic surgeon I think then 17 meant there was a natural transition towards 18 neurosurgery for spinal. 19 THE CHAIR: Yes. All right, thank you. 20 MR DAWSON: I think you've provided us with quite a lot of 21 statistical information, very helpfully. That 22 statistical information appears to only relate to the 23 period 2011 to 2013. Is there a reason why it's only 24 confined that that period? 25 A. I think that's because that's what still remains Page 69	1 I think there may be reference to it in some of the 2 documents around -- there's the changes to our patient 3 administration systems over that period of time. 4 Q. Yes, and so the changes may have been made around the 5 same time to different systems but they were different 6 changes, if you like? 7 A. Yes. 8 Q. One other aspect -- we mentioned a moment ago, just on 9 referrals, the fact that certain surgeons would have 10 sub-specialities. We're aware of the fact Mr Eljamel 11 offered a number of sub-specialities and we talked about 12 the fact that that might account for the fact that he 13 retained a larger burden of the overall work, if you 14 like, because he was offering things that perhaps only 15 he could offer, or perhaps Mr Lim couldn't offer because 16 it was a speciality. How would referrals relating to 17 such work function? How would people know that 18 Mr Eljamel offered certain services and if they did know 19 that, presumably the referral would be to him directly 20 rather than to the neurosurgical department broadly? 21 A. I think at that point in time, the way the referral 22 management system worked was yes, there could be direct 23 referrals to an individual clinician, as well as general 24 referrals to the department. So yes, if our primary 25 care colleagues were aware of -- or internal colleagues Page 71
1 available within our business unit system. 2 Q. Understood, and we've heard about various other aspects 3 of various different systems disappearing for different 4 reasons. Are there reasons why the information from 5 before that, within the systems that you were looking 6 at, doesn't exist before 2011? 7 A. I'm not sure. I think it's purely the electronic system 8 that we have that's captured that only goes back to 9 2011, which is why that's what we've been able to 10 provide. 11 Q. We've heard a similar story in other areas, for example 12 in relation to the systems that were used for adverse 13 incident management -- 14 A. Yes. 15 Q. -- and for complaints. 16 A. Yes. 17 Q. And we've heard that those were separate systems and 18 they were combined together into the Datix system, which 19 I'm sure you're familiar with? 20 A. Yes. 21 Q. Are we talking about a different system here, where the 22 information you got was -- 23 A. (Overspeaking) Yes, so there would have been a patient 24 administration system that would capture our outpatient 25 information and our inpatient day case information. And Page 70	1 referrals, or emergency, they could, if they knew the 2 sub-speciality that Mr Eljamel practiced in, then those 3 referrals could have been made direct to him, yes. 4 Q. Because there's certain elements of the service which 5 appears that only he offered, or a smaller number of 6 people offered -- 7 A. Yes. 8 Q. -- and that's how that would work, people would know he 9 offered that and it would come to them? You tell us 10 about various activities that went on within the 11 neurosurgical department, including of course theatre 12 itself, but also other daily activities including ward 13 rounds and clinics and things like that. Could I just 14 ask in relation to the theatre time, you mention at one 15 point I think that although there was a dedicated 16 neurosurgical theatre, as I understand it, was it 17 possible that neurosurgery would be done in other 18 theatres at different times, for example, perhaps in 19 an emergency situation? 20 A. Yes, I think if there was a requirement for an emergency 21 procedure to go ahead within a timeline where 22 an elective procedure couldn't be stopped, then there 23 would be access to either the co-located theatre next 24 door to neurosurgery if it was free, or into one of the 25 other general surgical theatres. Page 72

1 Q. And you mention clinics. Are clinics opportunities for 2 doctors to meet with patients, not on the day of the 3 operation but otherwise, to have an appointment to 4 discuss their case? 5 A. Yes. 6 Q. And clinics within the neurosurgical context, I think, 7 could be either pre-operative clinics or post-operative 8 clinics, would that be fair? 9 A. Yes. 10 Q. Again, I have asked you this question a few times, but 11 are you aware of there being any systems related to the 12 way in which consultants offered clinics, in particular, 13 the way in which they would rely on junior staff to 14 attend their clinics on their behalf, or was that very 15 much the sort of thing that was left within the 16 discretionary responsibility of the consultant? 17 A. I think my understanding at the time that that would be 18 left within the discretion of the consultant at the 19 time. 20 Q. Yes, clinical judgment, I suppose, as to the best way to 21 do things? 22 A. Yes. 23 Q. Another aspect I was interested in, in a similar vein, 24 was whether there were any systems that you were aware 25 of which related to the oversight of the private work Page 73	1 statistics for different components of the way in which 2 practice went amongst the consultants, in response to 3 questions that we asked of you, is that right? 4 A. Yes. 5 Q. If I could go down a little bit further to the bottom 6 table, table 3, please. This is, I think, something 7 called "return to theatre data" which existed for the 8 various consultants who worked in the unit at the time, 9 is that right? 10 A. Yes. 11 Q. Is this statistical information which would normally 12 have been accumulated within the hospital? 13 A. Yes. 14 Q. And is it something that would be done for the 15 hospital's own purposes or was there some requirement to 16 provide it to some sort of audit? 17 A. I think it's part of that clinical review of practice 18 and we do monitor readmission rates, we do monitor 19 return to theatre, yes. 20 Q. Yes, and if one looks at this, one sees the return to 21 theatre, in the total number of cases, expressed as 22 a percentage over the period. 23 A. Yes. 24 Q. Who would be monitoring the column in the right, which 25 is the percentage, and at what point would someone Page 75
1 that was being done by consultants, in particular 2 whether there were any systems for verifying that 3 consultants would not do private work whilst on-call in 4 their NHS work? 5 A. I'm not aware of any systems. I think that consultants 6 were expected to note within their annual job plan if 7 they had undertaken private work but I think it was 8 quite clear that that -- you know, the terms and 9 conditions of their employment would be that they 10 wouldn't do that while delivering their NHS Tayside core 11 work. 12 Q. So again, would that largely be left as a matter for 13 their professional responsibility? 14 A. Yes. 15 Q. But presumably, given the importance of what it means to 16 be on-call, the expectation would be that they would not 17 be doing other work while they were on-call? 18 A. No, they need to be available. 19 Q. As I say, you've provided us with some very interesting 20 statistical information in various tables and there were 21 a couple of aspects of that that I just wanted to bring 22 up with you. Could we have a look, please, at 23 NHST-04945, page 48, please. So this is the statistical 24 information that I referred to a moment ago, from the 25 period April 2011 to December 2013. And you provided Page 74	1 think: well, that's cause for me to investigate further? 2 A. So I think that data would have looked at as part of the 3 clinical effectiveness sessions that the departments 4 would run. I would expect the clinical lead to be 5 reviewing that and there would be, within each 6 individual surgical specialty, what would be deemed 7 a reasonable rate or range as per, I guess, national 8 position of procedures undertaken. And if there was 9 anything that was deemed to be an outlier or a higher 10 rate, then there would be a discussion or a review of 11 that to understand the context, the circumstances, and 12 then is there anything we need to do to be able to 13 support. 14 Q. Who would be monitoring that within the clinical 15 effectiveness sessions? Would it be -- 16 A. So the clinical lead would be leading those clinical 17 effectiveness sessions, leading that, but there's 18 professional responsibility of the consultants that are 19 within that. 20 Q. Understood, so that would be something that would be 21 discussed amongst the consultants themselves. 22 A. Yes. 23 Q. Would there be anybody else monitoring that information? 24 A. I'm not clear. Potentially that information would be 25 discussed at appraisal, but I'm not clear. It's not my Page 76

1 area of expertise. 2 Q. Right, but in terms of, for example, as we discussed 3 earlier, the clinical director at the level above, would 4 that be something that they would be looking at? 5 A. Yes, and particularly if there were any concerns, then 6 you would expect the clinical lead to be having that 7 discussion with the clinical care group director. 8 Q. By this time, are you aware of the fact as to whether 9 there were sort of nationally recognised benchmarks, if 10 you like, as to what would be normal and what would be 11 perhaps, at least on the face of it, alarming? 12 A. Yes, I'm not cited specifically on that part, but 13 I guess, as part of the managed service network, part of 14 its remit, moving forward, was to have that annual 15 review of outcomes and this level of data would be 16 review through the managed service network. 17 Q. It was one of the purposes, I think, of the managed 18 service network, to provide benchmarking data, I think 19 it's called, is that right? 20 A. Yes. 21 Q. And that would be the sort of thing that benchmarks 22 would be provided for and these statistics would be 23 compared against them? 24 A. Yes, the managed service network would look at the 25 consultants across all four units and compare their Page 77	1 I guess, activity and waiting list positions, to be able 2 to understand is there anything that any of his 3 colleagues could help support with. And then I would've 4 expected that conversation to happen and then, you know, 5 if there were some procedures that could've been picked 6 up by colleagues, then that would've happened to enable 7 all patients to have as early access to their care as 8 possible. 9 Q. That's very helpful. So in the sense that if it did end 10 up being the case that he was bearing an inequitable 11 amount of the burden because of the particular services 12 that he offered that others didn't, what you would've 13 expected would have been that he would've had a forum in 14 which he could have brought that up? 15 A. Yes. 16 Q. And then others perhaps could have taken on -- I don't 17 mean it disparagingly -- routine work, in order to try 18 to rebalance the situation? 19 A. Yes. 20 Q. Because I think the position was that in terms of 21 theatre sessions, they all had an equal amount of time 22 in the week? 23 A. Yes, they had one full day per week and then 24 a one-in-four on Friday. 25 Q. So if Mr Eljamel was doing more, which I think the Page 79
1 data, yes. 2 Q. Thank you. You provided also to us, helpfully, a number 3 of pieces of statistical information about the number of 4 procedures that each of the consultants was undertaking 5 over this period and I think you explained your 6 expectation, at least for certain parts of the work, 7 there would be a redistribution of it. It does appear 8 that, over the piece, that Mr Eljamel was doing a lot 9 more, or certainly more surgery than anyone else. Is it 10 likely that that's accounted for by the fact that he had 11 more sub-specialities and therefore he had to, as we 12 discussed earlier, keep more on his plate. And to what 13 extent would you have expected, in those circumstances, 14 that that might be offset by others taking on more of 15 what I might describe as the routine work? 16 A. I think it's difficult for me to comment specifically on 17 because I wasn't part of, I guess, those consultant 18 conversations around how they were to manage the 19 workload. But my thinking would be that it may well be 20 that Mr Eljamel had, you know, those direct referrals 21 coming into him and maybe that was a higher level of 22 referral to him as an individual than some of his 23 colleagues. But in terms of how we would look -- or 24 I would have looked with the clinical lead around the 25 service would have been looking at the level of, Page 78	1 statistics for the period we looked at show, then that 2 basically meant in his session, which was the same as 3 everybody else's, he had to do more surgeries? 4 A. I guess that could be an interpretation. I think my 5 expectation would be that he would be doing the number 6 of surgeries that he was able to do within the theatre 7 day that he had. There could've been a discussion as 8 a group that, if he had more patients that were waiting 9 and some of his patients had less or lower wait times, 10 could that theatre be reassigned to him to allow him to 11 reduce that waiting list while they then worked together 12 to see how do we put in a more sustainable service. 13 So that team approach to things would have been, 14 I guess, what my expectations of the consultant 15 team at the time would do. 16 Q. But if the statistics show he was doing more and he was 17 doing more in the same session time -- 18 A. Yes. 19 Q. -- that means he must have been doing more surgeries in 20 a session? 21 A. He was doing more, yes. 22 Q. He could have discussed that with his colleagues and 23 said: you're going to have to take a bit more of my 24 routine work because I have too many surgeries to do in 25 my session; that's a possibility? Page 80

1 A. Yes. 2 Q. One technical point -- you tell us at one stage in the 3 information you provided that, I think where trainees 4 would be doing things, what they would be doing would be 5 included within the statistics for the consultant whose 6 patient that was; is that correct? 7 A. Yes. 8 Q. I won't go into the details of the actual numbers but 9 there is a period, as you may be aware, when Mr Eljamel 10 was under clinical supervision in 2013? 11 A. Yes. 12 Q. And in that period there are statistics -- his clinical 13 supervisor was Mr Mowle. 14 A. Yes. 15 Q. And in that period, there are statistics provided for 16 both Mr Mowle and Mr Eljamel. Now, over that period, if 17 someone, in fact was taking control of the situation as 18 the clinical supervisor, would the statistics normally 19 have started to be showing on their column rather than 20 their colleagues' column, or would they have remained 21 with the colleague who was the original consultant? 22 A. So my understanding would have been that the data and 23 the patient activity would align to the consultant 24 undertaking the procedure. 25 Q. Right, so even if someone was being supervised by Page 81	1 our participants wish to put through Counsel to the 2 Inquiry. So Ms Miller will take you back to the witness 3 room and we'll resume again shortly. Thank you. 4 A. Okay, thank you. 5 (11.49 am) 6 (A short break) 7 (12.01 pm) 8 THE CHAIR: Have a seat, thank you. 9 MR DAWSON: No further questions. Thank you very much, 10 Ms Smith. 11 THE CHAIR: Ms Smith, you'll have gathered that is the end 12 of your evidence session. There are no further 13 questions and just before you step down from the witness 14 stand, I hope you'll allow me to thank you for coming 15 into the hearing suite today, for sharing your evidence 16 with us and your reflections and insights on the matters 17 that you were asked about. 18 I think I picked up that you also made an offer to 19 look at some further material, information, and we can 20 no doubt pick up administratively how that will be dealt 21 with in due course with the board's legal 22 representatives. Can I also thank you for your 23 contribution to the statement which you spoke to and 24 indeed the involvement of those who assisted you in that 25 process and in the looking at documentation to support Page 83
1 someone else, if they were doing the surgery, if you 2 like, that would show up for them? 3 A. Yes, that's my understanding. 4 Q. Even though, technically, the lead person for that 5 patient would be the clinical supervisor, is that right? 6 A. From a consultant perspective, that would be my 7 understanding. I wouldn't have thought the data would 8 shift to the person providing supervision. 9 Q. Understood, that's very helpful, thank you. Those are 10 my questions. At this stage, Ms Smith, I offer all 11 witnesses the opportunity to say anything they would 12 like to add to the evidence they've already given. So 13 I'd invite to you do that? 14 A. Okay, thank you. I think just really just what I want 15 to say is obviously recognise the impact that the events 16 have had on the patients and their families and that 17 within my role as chief officer in Acute Services now 18 that any findings or improvements, recommended by the 19 Inquiry in time, will definitely be -- I will commit to 20 implementing them and embedding them within all our 21 areas within Acute Services. 22 MR DAWSON: Thank you. 23 THE CHAIR: Thank you very much indeed. We also normally 24 take a break at this point and the reason for that is 25 just to ensure that there are no further questions that Page 82	1 it. All of that is much appreciated. You're now free 2 to go. Thank you. 3 A. Okay, thank you. 4 (The witness withdrew) 5 THE CHAIR: Now... 6 MR DAWSON: So the next witness for today is Jane Duncan. 7 I don't know whether we need to have a short break to 8 allow Ms Duncan to come in? 9 THE CHAIR: I think we might need to do that briefly, just 10 to ensure she's ready to go. Thank you. 11 (12.03 pm) 12 (A short break) 13 (12.12 pm) 14 MR DAWSON: Sir, the next witness is Jane Duncan. 15 THE CHAIR: Thank you. 16 MRS JANE DUNCAN (affirmed) 17 Questions by COUNSEL TO THE INQUIRY 18 MR DAWSON: Hello. You are Jane Duncan? 19 A. I am, yes. 20 Q. I understand that you used to hold the position of 21 director of communications and engagement at 22 NHS Tayside; is that correct? 23 A. That's right. 24 Q. Did you contribute to a witness statement that was 25 provided by NHS Tayside to this Inquiry? Page 84

1 A. I did. 2 Q. Could we have a look at NHST-04944, please. Is this the 3 first page of the statement to which you contributed? 4 A. It is, yes. 5 Q. Could we go to page 273, please. And do you understand 6 that this statement was signed by Dr James Cotton who is 7 the executive medical director of the health board? 8 A. Yes. 9 Q. As far as you're concerned, in particular in relation to 10 matters which you contributed, are the contents of this 11 statement true? 12 A. Yes. 13 Q. You have helpfully provided to us some information about 14 your past employment history in the statement, in 15 particular at paragraph 2.7. Could we go there, please. 16 I think you tell us you joined NHS Tayside in 2002 as 17 a corporate communications manager, is that right? 18 A. That's right. 19 Q. And then you moved on to the role of head of corporate 20 communications for NHS Tayside in 2011 and that you were 21 subsequently appointed director of communications and 22 engagement in May 2019; is that correct? 23 A. That's all correct. 24 Q. Before that, you had a background in journalism, is that 25 right? Page 85	1 public communications was done. 2 I progressed to becoming a senior communications 3 manager, so that was a slightly elevated post in terms 4 of that I took a bit of line management responsibility 5 for the other communications managers. In all of that 6 time the functions stay predominantly the same, until we 7 get to the point around 2011 and I am made head of 8 corporate communications. The former head had moved on, 9 and at this time, this is where more of the social media 10 is actually -- there's been an exponential increase in 11 terms of that, the platforms that we can use. 12 So therefore we still have the internal and external 13 communications functions being brought together in one 14 team, however those functions are slightly changing in 15 terms of the evolving communications landscape at that 16 time. 17 Do you want me to go on? 18 Q. Yes, please. 19 A. Okay. So as the head of corporate communications, 20 that's a service manager level job. I reported into the 21 executive team through the board secretary. She was the 22 executive lead for the communications and obviously 23 reported to the chief executive. In that time there was 24 an increase, in the landscape again, in terms of public 25 engagement and some statutory duties came on board in Page 87
1 A. That's right. 2 Q. I wonder if you could tell us, from the period 2002 3 during the course of your communications and engagement 4 roles, if you could tell us broadly what your 5 responsibilities have been? 6 A. So from the initial recruitment into our corporate 7 communications manager that was at the time, I think 8 you've heard from other witnesses, that the board was 9 becoming unified and the trusts were merging into the 10 board. So this was a new team that was being 11 established at that time to bring all the communications 12 function in-house. At the time, the trusts that were in 13 place had separate internal and external communication 14 functions, and indeed the external communications 15 functions for two of the trusts were provided by a PR 16 company. 17 So therefore this was in the attempt to align with 18 unification of the boards, to bring an in-house team 19 together that would provide both the internal and 20 external communications functions. So internal being 21 for all staff, bearing in mind that that was about to 22 become the board and all the trusts would then have this 23 one identity and the one employer. And the external, 24 predominantly in 2002, that was around a press office 25 function because that was the main channels in which the Page 86	1 terms of involving patients in some of the service 2 redesign and decisions that we're making and that was 3 becoming much more of a prevalent function. 4 It, first of all, existed as a stand -- well, to the 5 side function, not quite a standalone; we did align and 6 work together. However, those two functions were then 7 brought together and that is where the director of 8 communications engagement, that was a new post for the 9 organisation. It was borne at the time when NHS Tayside 10 was exiting special measures actually and as part of 11 that function, as part of that period in which we were 12 in effect being managed by the Scottish Government in 13 2018/19, it was felt to be under the interim chief 14 executive and chair, that this was a role that was going 15 to -- a strategic role that would be very important in 16 moving the organisation beyond those special measures 17 and escalation. 18 Q. So in particular in relation to the aspects which you've 19 mentioned in 2019, even just looking at the job titles, 20 the communications role had always been part of what you 21 had done but then the engagement part came into it. Is 22 that what you're describing there, there would have been 23 the change in? 24 A. Absolutely, that was the difference, that that director 25 level post brought. Page 88

1 Q. So does engagement, in that regard, mean patient 2 engagement? 3 A. It means public engagement. So, patient engagement, as 4 you've probably heard through other witnesses, tends to 5 happen through the line. So there's the clinical 6 engagement and the face-to-face and at the ward or 7 bedside, in terms of complaints and concerns, et cetera. 8 The public aspect, it was more around the public 9 engagement and that's involving members of the public 10 and people with lived experience and expertise in terms 11 of being a patient, I guess, having their voices heard. 12 Through some of the service changes that we have to 13 make and this obviously is very important and we're at 14 a critical juncture again which we're about to enter 15 a period of reform for, in the NHS. And so it was to 16 have the public voices heard in terms of more to do with 17 service transformation and redesign. 18 Q. So does the engagement function you're involved in and 19 you distinguish that from individual, clinical patient 20 interaction -- 21 A. Yes. 22 Q. -- yours is really more dealing with the public at 23 large -- 24 A. Absolutely. 25 Q. -- rather than dealing with individuals? Page 89	1 emanated from because there's the Patient Rights 2 (Scotland) Act 2011, for example, which enhanced 3 patients' rights to do certain things. Was that the 4 genesis of that or was it something different? 5 A. It was through the Healthcare Improvement Scotland team. 6 So actually, it emanated there, from -- I can't remember 7 the name of the organisation. It was an organisation 8 that was within Healthcare Improvement Scotland and it 9 dealt with patient voices and this was to -- the 10 Scottish Government have brought it much more to the 11 fore and a higher profile in terms of making that 12 a statutory duty. I think it's in the public sector 13 duty. I would have to check. I will check the actual 14 legislation. 15 Q. Okay, thank you. The other thing that you mentioned 16 there as being a significant background to that 17 evolution of the role or expansion of the role was the 18 fact that NHS Tayside was in special measures. I think 19 you've broadly told us already what that means. 20 Effectively, a situation where there are concerns on the 21 part of government, I think, about the way in which 22 a health board is being run and they can effectively 23 step in and take over. My understanding is there are 24 various different levels of control they can exert, is 25 that broadly correct? Page 91
1 A. Yes. 2 Q. We've heard some evidence from some of your colleagues 3 about a patient liaison team that came in, in 4 recent years. Does that sit in your function or 5 separately from your function? 6 A. No, that sits in the clinical governance and through the 7 clinical line also. And I think you've heard that 8 that's most recently been added into that line to work 9 alongside the complaints, the patient experience team. 10 So that has a new alignment there in terms of that, in 11 that clinical case, and it's still really the public 12 engagement function that I lead for. 13 Q. You mentioned I think, also in connection with the new 14 role that you took up in May 2019, that there'd been 15 some additional statutory responsible that had come 16 along with relation to patients. What did you 17 understand those to be? 18 A. So they are in terms of involving patients in service, 19 delivery. So we have a statutory duty around that to 20 involve patients in the public sector duties. So that 21 is one of the main -- there are, to be honest, not very 22 many statutory duties in terms of communications, 23 however this has brought it into the engagement and 24 there is a statutory duty around that. 25 Q. I was just wondering where the statutory duty had Page 90	1 A. Yes, that's right and we were escalated to level 5 and 2 the escalation levels are slightly different now, they 3 have different definitions around them. However, 4 level 5 is the highest and it was in effect under 5 ministerial control. 6 Q. What period had that gone for around that -- 7 A. 2018 to 2019. 8 Q. Right, and at that time, effectively, the board was 9 therefore under government control or increasing levels 10 of government control? 11 A. It went to a level 5, as I recall, in April 2018. 12 Q. 2018. 13 A. And there was an interim chair and chief executive 14 brought immediately in at that point. 15 Q. And what had been the background to that, in terms of 16 the concerns that had given rise to the government's 17 need to intervene? 18 A. Around financial matters, financial governance, and 19 other matters of governance in the board. 20 Q. And the reason I'm asking that is because there are 21 particular things that were happening in relation to 22 matters that we're looking at around that time, 23 including the commissioning of a report in relation to 24 matters to do with Mr Eljamel from NHS Lothian at that 25 point. And so sort of prevailing mood, if you like, is Page 92

1 of significance to us in that regard. 2 And I think you've explained that that was part of 3 the reason why your role was extended, is that right? 4 A. Yes, so the interim chair and chief executive introduced 5 a new structure across the executive team and this was 6 one of the roles that was in that new structure, and it 7 was that interim chief executive that had also been 8 involved in the commissioning of the Tracey Gillies 9 report as well at that time. 10 Q. I think we've already heard from your colleague who 11 you've mentioned, Ms Dunning, already about the way 12 decisions like that are made by the chief executive. 13 Effectively, there are certain roles that are prescribed 14 by government in terms of executive people sitting on 15 the board, but effectively, it's a matter for the chief 16 executive to decide what sort of policy initiatives and 17 plans they want to put in place and how they want to 18 organise their teams around that. 19 Presumably therefore, at that time, the need for 20 there to be a greater emphasis on engagement arose from 21 the fact that being in special measures inevitably gives 22 rise to concerns amongst the public and there was a need 23 to invest further, if I can put it that way, in that 24 activity to try and rebuild trust? 25 A. It was trust and confidence, yes. Page 93	1 Q. I see, when you say "under the corporate communications 2 function", did you say that it's not under the corporate 3 function? 4 A. It's not, no. 5 Q. Right, so it would be more for individual doctors or 6 whatever to be -- 7 A. (Overspeaking) Absolutely. 8 Q. Understood. 9 A. And through those other routes that you've explored 10 around complaints and concerns and other, just 11 lower-level resolutions, early resolutions at the ward 12 level and directly with staff. 13 Q. Understood. So what about communications with other 14 bodies rather than with patients or individual groups of 15 patients? For example, would you be involved in 16 communications with the Scottish Government? 17 A. Yes. 18 Q. What sorts of communications would involve you? 19 A. So, in my current -- in my enhanced role, or in my then 20 role? 21 Q. Well, let's pause for a second and ask about the 22 enhanced role because there are various different levels 23 and I'm trying to encapsulate them altogether, but it 24 may not be appropriate. Your current role, please? 25 A. So in my current role that's part of the function that's Page 95
1 Q. Understood. Over the period where you've been 2 responsible, up to I think including still the present 3 day, the communications that you have therefore are with 4 what sorts of bodies? For example, your communications 5 are with the press, for example? 6 A. They would be with the media, yes. 7 Q. And beyond that, your communications would be using 8 media but with the public at large, rather than 9 individual groups or individual patients; would that be 10 fair? 11 A. It could be with individual groups. The social media 12 platforms that are available to us afford us much more 13 opportunity to be able to communicate directly, so we 14 would maybe go into Facebook neighbourhood groups. 15 These are really good, well established way of 16 communicating with communities, and hearing from them. 17 And it's where our trialling WhatsApp groups at the 18 moment as well, in terms of for specific, it's one way, 19 in terms of -- not a dialogue but to get information out 20 into communities. So these platforms have afforded us 21 a much more direct engagement and dialogue with 22 communities and patients. 23 The individual patient communication is not so 24 much -- it would be under the corporate communications 25 function. Page 94	1 been added, in terms of that. External affairs -- 2 Q. (Overspeaking) What's the name of your current role? 3 A. Director of corporate affairs. 4 Q. Which we heard a little bit about from Ms Dunning last 5 week, I think. 6 A. Yes. So in the directorate of corporate affairs there's 7 an added element around external affairs and that's 8 around liaison with Scottish Government. At a higher 9 level, ministerial correspondence, co-ordination of 10 that, et cetera. But that would be through the office 11 of the chief executive and held there. It's not to say 12 that communications may not have a role in terms of 13 providing some advice or content or, you know, 14 particular information where we know that there is 15 a board position on something. So they would definitely 16 input, however it's not a leading role for them. 17 Q. So when you say you'd provide content, how does that 18 work? You would help with the wording that you might 19 wish to choose if you were the chief executive? 20 A. So if a request came into the office of the chief 21 executive and it was requesting an update on a matter to 22 do with a particular hospital, a service in a hospital, 23 it may be that we have already issued public lines 24 around that in terms of media. That's often how 25 requests come in, we hit the media first and then Page 96

1 Scottish Government ask for an up-to-date briefing. So 2 that's where the overlap would happen in terms of that 3 alignment. 4 In terms of the office of the chief executive, we 5 would be expected to go further and ask further 6 questions beyond just the lines that we have in place in 7 terms of those media lines. 8 Q. Understood. What about communication with other bodies, 9 what about the police, for example, do you communicate 10 with the police? 11 A. In neither role really, no. No, not directly. 12 Q. There would be others who would do that in specific 13 circumstances? 14 A. Absolutely, yes. 15 Q. And what about communications with regulatory bodies 16 like the General Medical Council, for example? 17 A. No, not directly. That's through the medical director 18 line. 19 Q. (Overspeaking) That would be for the responsible officer 20 type role? 21 A. Role, yes. 22 Q. Understood. What about communications with public 23 inquiries? 24 A. In terms of communications and engagement function, in 25 terms of the communications team? Page 97	1 organisation. They have corporate objectives which -- 2 these are updated annually and in terms of those 3 strategic aims and the corporate objectives, they of 4 course have to have good communications and engagement 5 around them and so that would be the alignment of that 6 strategic element into what the board would wish to 7 achieve for this one, the next year, three years, 8 five years. 9 Q. So the organisational goals would be set by the board? 10 A. The board set the strategic direction, yes. And the 11 corporate objectives, they are developed with the exec 12 and the non-executives. It's a joint endeavour around 13 corporate objectives. 14 Q. Yes, and in terms of making sure communications align 15 with corporate goals, those have already been set by the 16 board but what you might be able to do is to say: this 17 would be a better way of communicating something to make 18 sure it aligns with those goals which you have fixed? 19 A. Absolutely, or it might be obvious because the 20 corporate objectives are very strategic, there may be 21 strategic plans that are being developed and therefore, 22 if we have a strategic plan in how we wish to deliver, 23 for example, a new way of delivering mental health and 24 learning disabilities, there's a strategy that's 25 underway at the moment, that has to have -- the strategy Page 99
1 Q. Yes, what role would you have in that? 2 A. We'd offer input into the Rule 8, for example, that 3 I have and beyond that, anything that was requested or 4 allocated to me that would have thought I would be the 5 most appropriate person in which to provide the 6 information that was being requested. 7 Q. Okay. So should we see it as really an office that has 8 a function to assist with communications and there are 9 certain things that you would normally get involved in 10 but some things people could seek your assistance on if, 11 for example, they thought you would be able to add based 12 on your previous media communications or something like that, 13 you would be able to add to what they were saying? 14 A. The background to it, the context and then perhaps the 15 questions that they may wish to ask next, yes. 16 Q. Understood. In the paragraph that's up there, you say, 17 towards the end, that in this role, which is the role 18 that you just moved out very recently but you had held 19 since May 2019, it says you: 20 "... have strategic and leadership responsibilities 21 for the execution of internal and external 22 communications to align with organisational goals." 23 What do you mean by communications which "align with 24 organisational goals"? 25 A. So the board obviously sets the direction for the Page 98	1 must have a communications and engagement plan around it 2 to be able to fulfil what it wants to achieve. And that 3 has to be tailored to the strategic pieces of work that 4 the board are taking forward. 5 Q. Is that to try to achieve the maximum efficiency of the 6 communications in terms of, for example, that they are 7 clear as to what they are trying to express? 8 A. Yes. 9 Q. And one other aspect of the responsibilities of boards 10 that we've looked at is the importance of public 11 confidence. Is that something that you are involved in 12 trying to promote? 13 A. Absolutely. We try to have an approach in which our 14 staff voice is really strong in terms of -- 15 notwithstanding that there is a public inquiry into this 16 matter, they are delivering services and innovating and 17 redesigning services and delivering. And therefore, it 18 is incumbent on us to be able to show their endeavours 19 and their commitment and the things that they are doing 20 well in terms of trying to build public confidence in 21 the services. 22 Q. So does that mean, in the context of a public inquiry, 23 not answering the question that you're given but 24 answering it with the objective of trying to promote 25 what people are doing just now, even if the question for Page 100

1 example relates to something that happened in the past? 2 A. I'm not sure that I follow you. I think both can be in 3 parallel. We are obviously in a public inquiry 4 environment. We are endeavouring to answer the 5 questions in terms of what's been asked in the Rule 8. 6 However, there are communications and engagement plans 7 wrapped around strategies programmes of work that are 8 being delivered in the hospitals and in our communities 9 and that's what the communications and engagement team 10 are doing. 11 Q. I see, so you put those two things together. You talked 12 about dealing with the Public Inquiry and then trying to 13 promote good works that are going on at the moment. Do 14 those two things go hand-in-hand or are they separate 15 endeavours? 16 A. I think that we view -- the significance that we put on 17 the Public Inquiry has afforded, you know, quite a lot 18 of resource, a new function, support for staff in terms 19 of being able to respond to the Inquiry so the input 20 that we have and the significance that the board puts on 21 the Inquiry is significant. 22 The corporate communications and engagement function 23 will still tick over, it's not that we try to do one to 24 negate the other, if that's how I'm interpreting your 25 question. Page 101	1 day, involve reputational management? 2 A. It does. Most communications and engagement, head of 3 and directors, would involve an element of reputational 4 management, yes. 5 Q. Okay, and what do you take that to mean? 6 A. We know it's not always to try to play down things. The 7 reputational management is based around reputational 8 risk assessment around -- we know that there are 9 contentious issues, we know that there are things that 10 will go wrong in a board, and therefore it's the 11 assessment of how that is communicated, the reputation 12 management looks at. It is around the risk. So it's 13 not to not tell, it's to tell in the best way at the 14 right time to the right people. 15 Q. So rather than it involving the risk assessment you 16 talked about involving the possible outcome that you 17 wouldn't tell people things, it would be to try to work 18 out the best way to communicate the message at the right 19 time to the right people? 20 A. In terms of much of our work would be around that 21 stakeholder engagement and the right of people to know 22 ahead of, for example, a media statement, et cetera. 23 Q. And in circumstances where things have gone wrong and 24 the board wishes to issue an apology, is that something 25 that you would normally become involved in trying to Page 103
1 Q. Is there a public communications and engagement strategy 2 around your interactions or the board's interaction with 3 the Inquiry? 4 A. There is a board commitment in terms of the approach 5 that we have and that's around the transparency and the 6 openness and honesty. That's a commitment that the 7 board gave when the Public Inquiry was announced back in 8 2023. And that's something that the board is committed 9 to in terms of its approach. We don't have 10 a specific -- we have a specific communications and 11 engagement strategy around it, other than just -- other 12 than responding to the matters that we are being asked 13 to spend to through Rule 8 and Section 21. 14 Q. So the principle is transparency and openness? 15 A. Yes. 16 Q. Rather than something you mentioned a moment ago, which 17 is to try to promote what the board is doing at the 18 moment? 19 A. Yes, the board is not trying to use the more positive 20 things that are going on within our hospitals to try to 21 deviate from the significance of the Inquiry and the 22 core mandate of the Inquiry, what it's been set out to 23 do. 24 Q. Okay, thank you. Does your role -- the various 25 different levels that you've built up, up to the current Page 102	1 strategise and advise about? 2 A. For some elements, yes. Yes, it is a board -- it would 3 be a board -- on behalf of the board apology, but in 4 terms of that advisory to the board, the chief 5 executive, the chair, then that is part of my role. 6 Q. And as far as the strategy towards apologies are 7 concerned, or is concerned, is it important that 8 apologies are clear? 9 A. Yes. 10 Q. Is it important they are directed to the right people? 11 A. Yes. 12 Q. Is it important that they are comprehensive? 13 A. Yes. 14 Q. Is it important that they are accurate? 15 A. Yes. 16 Q. Is it important that they are genuine? 17 A. Yes, absolutely. 18 Q. And those would be the sorts of principles that would be 19 behind the strategy that we've put together as to how, 20 when and to whom to issue an apology, in the way that 21 you've described your role? 22 A. Yes. Yes. 23 Q. Understood. You have been -- some of your colleagues 24 that of we've spoken to have only been with NHS Tayside 25 for a relatively short time but you have been Page 104

1 with NHS Tayside, like at least one of your colleagues, for 2 quite a long time, including going back into the period, 3 what we're calling the "relevant period" that we're 4 looking at. Did your role ever involve you coming into 5 contact with any of the matters that we are concerned 6 with, broadly to do with the neurosurgical service and 7 concerns relating to Mr Eljamel in the period 8 between 1995 and 2015? 9 A. No. 10 Q. Were you involved in any of the communications 11 strategies around any of the things that happened 12 latterly in his career, for example in relation to the 13 ordering of the Royal College of Surgeons' report into 14 his practice in 2013? 15 A. No. 16 Q. Is that the sort of thing that you could have become 17 involved in? 18 A. Not in terms of Royal College report, no, that's an RO, 19 responsible officer. 20 Q. Because there might be questions that would arise in 21 that relating to the identity of people or organisations 22 to whom information about that should be communicated. 23 But that would be a clinical matter rather than 24 a communications matter, is that what you're saying? 25 A. Yes, I would expect them to have protocols around that, Page 105	1 report. 2 Q. And was that report published at the time to the general 3 public? 4 A. It was. There was a board paper that went on August 31, 5 in 2023 and that was the executive medical director's 6 report on the findings. So, yes, that was part of the 7 board open business. 8 Q. And so that meant it was released to the general public 9 through that medium? 10 A. Through the board papers and also available through our 11 website, alongside a statement. 12 Q. And were you responsible for the statement? 13 A. Yes, with the executive medical director, and the chief 14 executive. 15 Q. Right. What was the strategy around the release of that 16 report at that time? 17 A. The strategy was that it would be a public release and 18 it would go to the public board. It was a report that 19 had been undertaken, predominantly because of the 20 recommendations in the Scottish Government unresolved 21 concerns review, that had been the catalyst for quite 22 a number of the pieces of work that had been undertaken 23 in terms of the recommendations from the Scottish 24 Government. And that grew into, first of all, drawing 25 together the documentation that was available, and then Page 107
1 more regulatory or professional standards. 2 Q. Understood. So just because something involves some 3 level of communication, doesn't mean it automatically 4 involves you? 5 A. No. 6 Q. In particular, things that are more on the clinical 7 side, I think you've told us so far? 8 A. Yes. 9 Q. So, as far as any of the other matters that we've been 10 looking at are concerned, there are various reports that 11 were done. You've mentioned for example the Gillies 12 report in 2018. There were subsequent reports, there 13 was one done by the government, for example, in 2022 and 14 a due diligence report in 2023. Again, were you 15 involved in any of the communications or advising in 16 relation to anything to do with that? 17 A. Not in terms of the commissioning of them. Obviously 18 when the reports were to be responded to or were coming 19 at a board, for example, to be discussed at a board 20 meeting, we would be preparing the -- for example, in 21 the due diligence review, that was a proactive release 22 around the publication of the due diligence review, its 23 findings and what the executive medical director had 24 found. So there was an element of that in terms of that 25 public communication but that was when there was a final Page 106	1 the medical director then reviewing that documentation 2 to try to piece together, particularly around the period 3 of supervision -- I think you've covered that with the 4 executive medical director, but particularly around the 5 supervision arrangements. 6 So, yes. 7 Q. So do you mean, when you say "particularly", the message 8 that was to be communicated were related to the findings 9 around supervision? 10 A. I think the findings were in terms of for the patients, 11 111 patients that were identified as having been 12 operated on at that -- between the June and 13 the December, that was one of the main findings, yes. 14 There were obviously other findings around complaints 15 and concerns, fragmented, uncoordinated responses, 16 adverse events. 17 But in terms of -- I think they had probably been 18 surfaced in other reports into a greater or lesser 19 degree. The due diligence was the first time where the 20 executive medical director had concluded a position 21 around a board position around the supervision 22 arrangements. 23 Q. Right. So when you say "other aspects have been covered 24 by other reports", had those other reports been 25 publicised? Page 108

1 A. The Scottish Government report into unresolved concerns, 2 because that was not an NHS Tayside document, and 3 obviously it was relating to -- they had individual 4 patients involved, we would not be able -- we didn't 5 publish that. It wasn't ours to publish, if you see 6 what I mean. 7 Q. I took you to be saying that the reason why the focus 8 was on the supervision element of the conclusions that 9 were reached in the due diligence report was because 10 other elements had been focused on in other reports, but 11 had they been publicised? 12 A. Not from NHS Tayside. Obviously they had been shared 13 with NHS Tayside because they were recommendations for 14 NHS Tayside, but it was not a published document from 15 NHS Tayside, it was obviously a Scottish Government. 16 Q. But there were obviously other reports, the Gillies 17 report and the Royal College of Surgeons' report? 18 A. That had not entered the governance of the board, the 19 Gillies report, in terms of the -- 20 Q. Hadn't been? What do you mean "hadn't been"? 21 A. In terms of an action plan, it hadn't -- we'd expect, as 22 in the due diligence, the action plan would go through 23 board governance, so therefore it would have oversight, 24 there would be opportunities for non-execs to discuss 25 matters, and to be assured, ask questions, to be assured Page 109	1 was more in terms of the impact on patients particularly 2 around that supervision period. 3 Q. Was it your understanding that that was what the report 4 was focused on? 5 A. No, it had a terms of reference that looked at six or 6 seven matters, as I understand. 7 Q. But I'm just trying to work out why it is that you would 8 focus on one element for the publication aspect when it 9 looked at six or seven obviously important areas? 10 A. Yes. For the publication, it looked at -- it was 11 published, it looked at all the matters in it. In terms 12 of that -- the patient-facing aspect of it, the most -- 13 the key finding was around the inadequacy of the 14 supervision. 15 Q. Who decided that was the key finding? 16 A. The executive medical director. 17 Q. Okay, so you said, as far as the patient side was 18 concerned, it wasn't the patients who decided that? 19 A. No, the patients were -- I think you've asked this 20 question of Dr Cotton. The patients, as far as I can 21 understand, were not involved in the due diligence 22 review at all. 23 Q. Okay. One other aspect that we've discussed with some 24 of your colleagues already, I think you're responsible 25 for, is internal communications, is that right? Page 111
1 on matters, but that does not appear to have happened 2 with any of the previous reviews. 3 Q. And would that going through board governance process be 4 the sort of time where you might get involved, if there 5 were decisions around the possibility of communicating 6 some of the information? 7 A. Yes. 8 Q. It would make sense when everyone is sitting down 9 working out what does all this mean, one aspect of that 10 might be: should we be telling people about this? 11 A. Yes. 12 Q. But that didn't happen, so you weren't involved in that? 13 A. Are you talking specifically in -- 14 Q. (Overspeaking) The Gillies report, yes. 15 A. -- the Gillies report, yes. I wasn't involved. 16 Q. Going back to the due diligence report, again, I think 17 you've told us that the focus was on emphasising or 18 focusing on the supervision element, but I think there 19 were other matters that were covered by that report. 20 Was a positive decision taken not to focus on those 21 aspects? 22 A. It wasn't that they weren't focused on. I think, in 23 terms of the media statement that was released, it has 24 all the findings and it has the action plan, it has 25 who's responsible for taking those actions forward. It Page 110	1 A. Internal? 2 Q. Yes, internal to NHS Tayside? 3 A. NHS Tayside, yes. 4 Q. And we've discussed this with a few people about how 5 information, important information, is sent out into the 6 large workforce of NHS Tayside and we've heard things 7 for example to do with something called Vital Signs. 8 A. Yes. 9 Q. Is that an electronic mechanism by way important 10 information is conveyed to staff at NHS Tayside? 11 A. Yes, so that's one of the all staff communications, the 12 bulletins that we have, is called Vital Signs. 13 Q. Am I getting it right that that's within your sphere of 14 influence? 15 A. Yes, definitely. 16 Q. So that's an important part of the internal 17 communications systems and you're responsible for that, 18 correct? 19 A. Yes. 20 Q. Thank you. Can you tell me what systems exist for 21 auditing the extent to which recipients of important 22 internal communications like that read them? 23 A. Yes, so we have software now that is able to do that in 24 terms of how many times a particular bulletin has been 25 opened. So we have actually a piece of work ongoing at Page 112

1 the moment around what staff -- we recently published 2 a communication engagement strategy in April of this 3 year for the next three years. As part of that, we 4 asked staff: what do you like to see, what do you not 5 like, what works for you and what doesn't? And the 6 frequency of communications came back as one of the 7 things that was not working well, in terms of they felt 8 that they were having too much from the corporate 9 function. So therefore we have revised the frequency of 10 communications going to all members of staff and staff 11 are aware of what comes out every week now, in terms -- 12 it was probably a bit more ad hoc. 13 They know when a staff brief comes out. They know 14 there's an education and training and development 15 bulletin that comes out. Then the frequency of them. 16 And they know that Vital Signs is the one thing that is 17 actually is relevant to all staff. So we tend to put 18 content which -- well, we do put content that is 19 relevant to all staff, that Vital Signs is that. 20 As I said, we do now have insights that we can get 21 through the software that we use to distribute that in 22 terms of how many times that's been opened. 23 Q. Because one aspect that we discussed with the chief 24 executive, Ms Connor, was the reports that were done 25 into the destruction of the theatre logbooks and the Page 113	1 arrangements in terms of that cascade to their 2 particular areas. We do have functions, or channels 3 within the organisation -- I'm going to say the word 4 "huddle" here, but there are safety huddles in which 5 that's a whole system, all clinical staff, clinical 6 representatives from all the wards. It's for matters of 7 safe staffing and the running of the hospitals and the 8 community hospitals and the community services. And 9 they come together three times a day. 10 In that, I would expect, and we often do put 11 corporate communications within that, to make sure that 12 people know that there is a significant piece of 13 information that they should know. But it is -- there 14 is a responsibility on members of staff to put in place 15 what would work for their teams in terms of that ongoing 16 communication. 17 Q. And those are the managers that would be responsible for 18 that task? 19 A. Yes. 20 Q. And are there systems in place for auditing the extent 21 to which managers do that properly? 22 A. I would say no, there's not -- sorry. 23 Q. No, carry on. 24 A. There's not assurance loops, what we would call 25 assurance loops around that. Page 115
1 reports into that have various interviews with various 2 individuals who were involved in that and the broad 3 tenor of what they appeared to be saying was that they 4 receive lots and lots of emails and they had never read 5 the email that told them they shouldn't destroy things 6 that might be relevant to this Inquiry. 7 A. Yes. 8 Q. Is that something that troubles you? 9 A. Yes, which is why we have changed some of the way that 10 we have done and that has been before the publication of 11 the AAB report though. But, yes, it is incumbent for us 12 to make things as accessible and simple for staff who 13 obviously are at the front line, to be able to make 14 their jobs easier and for them to be well informed. We 15 have a staff governance standard that says staff must be 16 well informed and so therefore, that is a matter of real 17 importance for me. 18 Q. Okay, what systems exist for auditing the extent to 19 which recipients of -- or communications going to staff 20 are adequately or properly targeted to the people that 21 need to see them? 22 A. Yes, so we would expect -- we take responsibility -- 23 I take responsibility for the communications that are 24 going out to the 14,000 members of staff. Each of our 25 managers have a responsibility to put in place the Page 114	1 Q. Presumably that also logically extends to there being no 2 systems for auditing managers making sure that 3 communications are understood and implemented? 4 A. So there is in -- I can give you an example now and this 5 has been borne out of the AAB report and the do not 6 destroy notice and it is around what would happen if 7 a do not destroy notice was received into the 8 organisation now and so there is a compliance framework 9 and although it is specifically for the do not destroys, 10 it would be for any kind of legal or statutory, or 11 actually it could be translated to any piece of 12 information that we thought was so important. And it 13 works on an end-to-end assurance process in which 14 managers are and members of staff have to -- they must 15 sign templates that are provided to them, around their 16 understanding, around if team huddles have happened, 17 around if they've put in place specific actions that 18 that need to, that the communication is telling them to 19 do. 20 So that is one way that we've moved that on. We've 21 now got a framework in which we are able to do that, and 22 that is one thing that we were looking in terms of our 23 roll out beyond just do not destroy notices. 24 THE CHAIR: Is that a form of audit of the managers that you 25 said did not exist? This would be a development because Page 116

1 you're looking at seeing that the managers, who have 2 received the cascade if you like, are implementing 3 certain measures to ensure that that is -- 4 A. (Overspeaking) It runs from the board and the executive 5 team to the front line and then back up again in terms 6 of that assurance loop. 7 THE CHAIR: Right. 8 MR DAWSON: And there's an anticipated plan that that could 9 be rolled out for other types of documents rather than 10 do not destroy notices because presumably do not destroy 11 notices don't come along often? 12 A. No. 13 Q. What sort of other documents is it envisaged that the 14 system could be used for? 15 A. We've added it to our information governance policy and 16 also our records retention policy at the moment. It may 17 be for -- if we were to have, you know, if a regulatory 18 body came in and did an inspection, for example, and 19 there were matters that needed to be addressed 20 immediately, sometimes that's what happens when mental 21 welfare commission, for example, will use that. Then it 22 will be for those more -- the "must-dos", in terms of 23 an external body has come in and said that we must take 24 action. 25 Q. You were asked some questions and you answered them in Page 117	1 what he was apologising for, but you answered it? 2 A. James and I both worked on this, yes. 3 Q. Right, so you answered it because you helped him come up 4 with the wording of the apology in the first place? 5 A. And then ultimately, yes, and then the enquiry -- the 6 response to the media enquiry would go out through the 7 communications function. So there's one way in and one 8 way out in terms of media statements, yes. 9 Q. But you had helped him with the wording of what was said 10 on 10 September, is that right? 11 A. We had had a discussion, yes. Yes. 12 Q. So in the way that you described earlier -- 13 A. Absolutely. 14 Q. -- he can bring you in if he wants some help and because 15 it was a media thing, you came in and helped him with 16 the wording? 17 A. Yes. 18 Q. So can you help us with understanding the thinking 19 behind why it was that the apology was stated in those 20 terms? 21 A. So the apology, in terms of the knowing people have 22 experienced considerable distress, and we have added -- 23 I understand in many cases we've added to the trauma, 24 this was the first time that we were to make a public 25 statement in which since the -- actually, the Page 119
1 the statement. We've looked at these to an extent with 2 Dr Cotton already, but could we look, please, at page 70 3 of the statement. The board was asked a question about 4 this and another aspect of something that appeared in 5 the media around our preliminary hearing 6 in September 2025. Why were you given these questions 7 to answer? 8 A. I was given these questions because they had emanated 9 from a media enquiry. So a media enquiry had come in. 10 In fact, a number of media enquiries but the BBC one is 11 the one that has been produced here in terms of the 12 initial hearing and we were asked for a statement. So 13 it came in -- as may be the convention, it comes into the 14 communications office. It is then is flagged to the 15 executive or service lead, the person who would be in 16 charge of that, and then a media statement is prepared 17 on the back of that. 18 Q. Okay, because the questions weren't actually asking 19 about the media strategy, they were asking about what 20 the content of the statement actually meant? 21 A. Yes, so this -- as the statement was a media statement 22 in terms of the apology, then Dr Cotton and myself 23 discussed the media enquiry that came in and worked to 24 produce the apology. 25 Q. Okay, so basically this question was asking Dr Cotton Page 118	1 announcement of the public inquiry in 2023. The due 2 diligence had already made apologies around that 3 supervisory period and some other matters that were in 4 due diligence. This was in the understanding and 5 recognising that here we were in 2025 and still there 6 were unresolved concerns for patients that had also been 7 acknowledged in the due diligence, in Dr Johnston's 8 media statement as well. 9 And so, therefore, it was to also show that the 10 board was entering the Inquiry in as open and 11 transparent a way as possible with a commitment to 12 assisting the Inquiry in any way that it could. 13 Q. It doesn't say any of that in that passage, does it? 14 A. Not in that passage. I think the full statement goes on 15 to talk -- 16 Q. So you're talking about what other words meant, 17 I'm focusing on what these words meant. So you're 18 apologising sincerely for something, is that right? 19 A. Yes. 20 Q. And you're apologising, I think in the second sentence, 21 for aspects of the first sentence, is that right? 22 A. In terms of the trauma, yes, added to the trauma. 23 Q. So are you apologising for the fact that NHS Tayside 24 added to the trauma that had previously been experienced 25 by Mr Eljamel's patients by the way that they had gone Page 120

1 around handling complaints and concerns? 2 A. Yes. 3 Q. That's what the apology was for? 4 A. That was the intention of the apology. 5 Q. And that apology was limited in that way, it wasn't any 6 more extensive an apology? 7 A. No, because there had been previous apologies for other 8 matters, in terms of the due diligence review, there 9 were other -- 10 Q. I think we could probably spend the rest of the day 11 talking about the fact that there are various different 12 iterations at different times of things that were in the 13 due diligence report or not. This was an opportunity, 14 was it not, to state clearly what it was that 15 NHS Tayside was apologising for. And obviously, 16 I'm sure you would have imagined that the eyes and ears 17 of the affected patient group would be on this 18 statement, to try to understand what NHS Tayside 19 accepted and would apologise for at the start of the 20 Inquiry? 21 A. Yes. 22 Q. So a deliberate decision was made to limit the apology 23 in the way that we've just described? 24 A. Yes. 25 Q. You see, we looked for example yesterday with Dr Cotton, Page 121	1 including related to the question as to whether there 2 was clarity at the end of it as to what NHS Tayside 3 accepted and what they did not? 4 A. Yes. 5 Q. That's a matter of controversy. There are people, I can 6 assure you, who don't understand what it is the board 7 accepted and what they did not. But this was 8 an opportunity for you to make that position clear, is 9 that right? 10 A. Yes. 11 Q. Is that fair? 12 A. That's fair. 13 Q. And Dr Cotton has helpfully already explained that the 14 board does apologise for these matters and that that is 15 his position. 16 One aspect of what was included in the statement 17 that I wonder if I could ask you about. It says there 18 that there is an acceptance that the way in which 19 patients were engaged with is something that you wish to 20 reflect upon. Is that, therefore, an acceptance that, 21 effectively, your team didn't engage with patients 22 correctly? 23 A. I'm not sure the communications and engagement team has 24 had any part in terms of that direct engagement with 25 patients. Page 123
1 at paragraph 12.2, this is something you helpfully 2 provided us with. If we could just have a look at that. 3 And he helpfully told us that all of the things listed 4 there -- you provided this information for us, 5 helpfully -- all of the things listed there were things 6 that he now wished to apologise for on behalf of the 7 board. Why did they not appear in the apology at the 8 time? 9 A. I think I can only say that these were things that had 10 been apologised -- they had entered into the public 11 domain at the time of the due diligence review and the 12 executive medical director at that time had apologised. 13 Q. Right, so you thought it was unnecessary to apologise 14 again for something that had been apologised for again, 15 is that right? 16 A. I don't think we thought it unnecessary. We thought 17 that it perhaps was an oversight in terms of the board 18 accepted all of these actions in the due diligence 19 review. The board's position remains that they accept 20 all of those actions in the due diligence review. Yes, 21 it may have been a better idea to include them again, 22 given the passage of time between the 2023 due diligence 23 review and the hearings in 2025. 24 Q. And perhaps also given the fact that this Inquiry is 25 empowered with looking at the due diligence review, Page 122	1 Q. Right, so it's the engagement on the other side, if you 2 like, with the more clinical people? 3 A. Yes, it's anchored in the shortcomings and the failings 4 that were identified in the Scottish Government review 5 of unresolved concerns and also the due diligence 6 review. 7 Q. Thank you. You mentioned, on a few occasions, that 8 there were media statements that were released at 9 certain points when the due diligence report came out 10 and things like that. I don't think that those 11 statements have been provided to the Inquiry. Do you 12 still have records of those? 13 A. Absolutely, yes. 14 Q. Because it would be very interesting to us to be able to 15 see and understand what it was that was said at the 16 time. 17 A. Hmm. 18 MR DAWSON: Sir, those are my questions. 19 At this stage, Mrs Duncan, I offer all the witnesses 20 the opportunity to add anything they would like to add. 21 So I would invite to you do that. 22 A. Thank you. So, like a couple of my colleagues, I have 23 recently met with patients and their families and we had 24 actually met around a very specific issue, in an effort 25 to resolve that. That engagement with them resulted Page 124

1 actually in a very grounding experience for the 2 executives in terms of the patients shared their 3 experiences, the experiences of their families. And 4 I would reflect that some of the patients feel worse for 5 their families and that was very difficult to hear. And 6 also the impact that it's still having on them every 7 day. And as I said, that's had quite a significant 8 impact on the executives that were in attendance and it 9 has, notwithstanding the Inquiry and its role and its 10 job, however, just the support that we'd like to 11 support -- that we provide to patients going forward in 12 that much more meaningful kind of way. So what I would 13 say is that we will assist the Inquiry in any way we can 14 to help patients get the answers. And I would 15 personally commit to assisting the Inquiry further to 16 that end as well. 17 Q. Thank you. Just on that, if I may. The episode that 18 you've relayed to us, I think would you agree that that 19 demonstrates the importance of effective patient 20 engagement, in particular for those who are on the 21 executive side -- 22 A. Yes. 23 Q. -- who may not necessarily have that patient engagement. 24 It can be a very powerful tool? 25 A. Yes. Yes. Page 125	1 A. Okay, thank you. 2 (The witness withdrew) 3 THE CHAIR: Now, we're obviously a bit after the normal 4 timetable. We'll aim to sit again at 2.05 but if it 5 proves difficult we'll just have to take things as they 6 come. But let's aim for that meantime. 7 MR DAWSON: Thank you, sir. 8 THE CHAIR: Thank you. 9 (1.16 pm) 10 (The short adjournment) 11 (2.10 pm) 12 THE CHAIR: Good afternoon. 13 MR DAWSON: Good afternoon, sir. The next witness is 14 Caroline Lamb. 15 THE CHAIR: Thank you. 16 MS CAROLINE LAMB (affirmed) 17 Questions by COUNSEL TO THE INQUIRY 18 MR DAWSON: Thank you, sir. You are Caroline Lamb? 19 A. I am. 20 Q. I understand that you are the former director general 21 for health and social care within the Scottish 22 Government, is that correct? 23 A. That's correct, yes. 24 Q. Did you complete a witness statement for this Inquiry on 25 behalf of the Scottish Government after the government Page 127
1 Q. Thank you. 2 THE CHAIR: Thank you. Mrs Duncan, we have another short 3 break at this point. The reason for that is just to 4 ensure that there aren't any further questions that may 5 wish to be put through counsel on behalf of the 6 participants to the Inquiry. So if you go with 7 Ms Miller, we'll be ready to resume in a few moments' 8 time. 9 (1.09 pm) 10 (A short break) 11 (1.15 pm) 12 MR DAWSON: No further questions, sir. Thank you, 13 Mrs Duncan. 14 THE CHAIR: Mrs Duncan, you will have appreciated that there 15 are no further questions. That means that your evidence 16 session is now at an end. 17 Can I thank you for coming into the hearing suite 18 today, for sharing that evidence with us, and also 19 I think I detected the offer to provide some further 20 information which we can deal with administratively in 21 due course. Thank you also for your contribution to the 22 statement. I don't underestimate the amount of work 23 involved in putting things like that together. So to 24 you and those who assisted with that, I thank you also. 25 You're free to go. Page 126	1 had received a Rule 8 request from us? 2 A. That's correct. 3 Q. Could we have a look, please, at SG-00217. Is that the 4 front page of your statement? 5 A. It is, yes. 6 Q. Could we go to page 74, please, and although it's 7 covered over by something that says "cat C", does your 8 signature appear there on the last page of the main 9 copy? 10 A. It does. 11 Q. And the statement is dated 9 March 2026; is that 12 correct? 13 A. That's correct. 14 Q. And as far as you're concerned, are the contents of this 15 statement true and accurate? 16 A. So during the course of preparing to give evidence 17 today, I have identified a small number of inaccuracies 18 in that statement which have been notified to the 19 Inquiry. So subject to those things that were indicated 20 to the Inquiry last week, I believe, I'm content to 21 adopt that statement, yes. 22 Q. Thank you very much. Sir, we have a note from Ms Lamb 23 of various matters that have been found in preparation 24 for her giving evidence today that were slight 25 inaccuracies. Insofar as those are material Page 128

1 inaccuracies we'll try and cover them today, but the 2 plan otherwise is for there to be administrative changes 3 made at later stages to more minor changes such as 4 document referencing and the like. 5 THE CHAIR: Very well, thank you. 6 MR DAWSON: I understand, Ms Lamb, that you were, as I said, 7 the former director general for health and social care 8 within the Scottish Government; is that correct? 9 A. That's correct. 10 Q. And I also understand that you've recently retired from 11 the role; is that correct? 12 A. That's correct. 13 Q. And that, in fact, a replacement has been appointed very 14 recently; is that correct? 15 A. Yes. Yes. 16 Q. And who is that? 17 A. Christine McLaughlin has recently been announced as the 18 Director General and chief executive of NHS Scotland. 19 Q. Thank you which is precisely the same, the two roles 20 that you held simultaneously before? 21 A. Yes. 22 Q. When you prepared your statement you were preparing it 23 on behalf of the Scottish Government, is that right? 24 A. That's correct. 25 Q. And I think you explain in the statement that in doing Page 129	1 Government in matters with which this Inquiry is 2 concerned goes back to around 2013; is that correct? 3 A. Yes, that's my understanding, that Scottish Government 4 was first notified of these matters in December 2019. 5 Q. 2013. 6 A. Sorry, 2013. Apologies. 7 Q. And you took over the role that you formerly held in 8 2021, so that would mean -- would it be fair to say that 9 in material aspects that you've covered in your 10 statement thereafter, you did have a direct role in 11 matters, for example, in connection with the report 12 relating to unresolved concerns that was compiled on 13 behalf of the government in 2022; were you directly 14 involved in that? 15 A. I wasn't directly involved in that, but staff who were 16 part of my team within the directorate general were 17 directly involved in that, yes. 18 Q. Yes, and thereafter, you tell us about various other 19 activities that the Scottish Government were involved 20 in, meetings with MSPs and meetings with patients and 21 decision-making around the formation of this Inquiry and 22 other possible alternatives, and indeed, the Independent 23 Clinical Review which sits alongside it. So were those 24 matters you were directly involved in or again, were 25 they being dealt with by others within your office? Page 131
1 so, you assembled a team of other people who assisted 2 you with it, is that right? 3 A. That's correct. 4 Q. And these were people who had more experience in 5 relation to particular aspects because there was a wide 6 ambit of things that you were asked about? 7 A. Yes, there was a wide ambit of things and also much of 8 what happened pre-dates my time working with Scottish 9 Government. 10 Q. Yes. And as far as matters that are covered by the 11 statement are concerned, in a broad sense there are 12 a number of different time periods and areas that we're 13 talking about. Are the subject matters that you covered 14 things in which you did have personal experience, or are 15 you relying entirely on the assistance of other 16 colleagues to have put this statement together? 17 A. So in terms of those time periods, I became director 18 general and chief executive of NHS Scotland 19 in January 2021. So from that time, I have personal 20 experience and some recollection myself of matters that 21 were happening. Prior to that, I'm relying on 22 colleagues and also the documents that I have been able 23 to review. 24 Q. Thank you. So I think, broadly speaking, you tell us in 25 the statement that the involvement of the Scottish Page 130	1 A. They were being dealt with by other directors and staff 2 working to directors, but within the overall group of 3 directorates that I was director general for. 4 Q. I see. So they were -- effectively, there were people 5 that were dealing with this, it wasn't you directly but 6 these people sat underneath you, if you like. You were 7 the director general that oversaw their activities, 8 would that be correct? 9 A. That's correct. 10 Q. Thank you. I understand, from some other evidence that 11 we've had from other organisations, that you had 12 an involvement previously in NHS Education for Scotland, 13 is that right? 14 A. That's right. I was chief executive NHS Education for 15 Scotland first on an interim basis and then the 16 substantive post. 17 Q. In the documentation that we were provided by what's now 18 Public Services Delivery Scotland, was NHS Education for 19 Scotland, they tell us another individual who I think 20 was one of your predecessors in that role was someone 21 called Malcolm Wright, is that right? 22 A. That's correct. 23 Q. And Mr Wright went on to be the chief executive of 24 NHS Tayside, I think at a certain point, is that right? 25 A. That's correct. My recollection is Malcolm Wright was Page 132

1 appointed as interim chief executive by Scottish 2 Government. 3 Q. Yes, and we heard some evidence about that just this 4 morning in fact, and there is, within the documentation 5 that we've seen, something of a pattern of people 6 working within various agencies of the way in which 7 health services are delivered through the NHS Scotland, 8 of them moving around various different roles. Is that 9 something done deliberately by design, that people build 10 on experience they have and then move in a different 11 areas, or is it simply the result of people applying for 12 jobs that happen to come up and there's no particular 13 plan to it? 14 A. So I think that, first of all, it's absolutely the 15 result of people applying for jobs, that there is -- you 16 know, there is no -- with the exception of when interim 17 posts have to be appointed and the particular 18 circumstances you referred to around Malcolm Wright, 19 then all these jobs are advertised and competitively 20 recruited for. But, yes, it is absolutely the case that 21 I think people who move into jobs within the NHS in 22 Scotland will look at other opportunities that come up 23 and consider whether they have the skill-set that would 24 match those opportunities. 25 Q. And based on your wide experience of different jobs, the Page 133	1 and she described how she had come from outside the 2 Scottish system which I think, as you've said, she found 3 had certain benefits in her new role. But also that it 4 had taken her some time to get used to the Scottish 5 system. Was her appointment something that you had 6 involvement in? 7 A. I -- again, the appointment of the patient safety 8 commissioner was something that was dealt with within my 9 DG in terms of providing advice to ministers on that, 10 but it wasn't something that I had a direct involvement 11 in. 12 Q. One of the things that she explained to us was that 13 there had been a number of recruitment rounds, if you 14 like, before she was successful in the application 15 process. Is that something you had any involvement in 16 or have any knowledge in? I'm interested in knowing, in 17 particular, why it seemed to be so difficult to get 18 someone to fill that important role? 19 A. I do recall that there were some challenges in 20 fulfilling that role. However, I think I would need to 21 refresh my memory about the absolute detail on that. 22 Q. Okay, understood. You tell us in the statement that, as 23 director general for health and social care, you were 24 responsible for maintaining a high standard of care for 25 the people of Scotland and for providing support to Page 135
1 very senior position you held most recently, is that 2 something which you think is a good thing, in terms of 3 people being able to build on their skill-sets and take 4 them within NHS Scotland to move elsewhere or is it 5 something that results in a kind of insular way of 6 looking at things, do you think? 7 A. So I think that it's, from my most recently experience 8 as DG and chief executive, the view I would take is that 9 in order to get the best that we can for people in 10 Scotland we need a balance. So it is always helpful to 11 have people who have got good experience, who really 12 understand the Scottish system, the way it works, and 13 have that sort of background of what you might call 14 corporate knowledge. But at the same time, it's 15 important to have different views and different 16 experiences. And certainly, I can think of a number of 17 chief executives as an example who have come to Scotland 18 from other systems and they bring a really good 19 experience. Equally, we have recruited chief executives 20 from posts such as chief officers for health and social 21 care. So it's not always the case that there's 22 a straight route through and I think that is valuable to 23 the system as a whole. 24 Q. Right, we heard some evidence earlier, a few weeks ago 25 now, from the patient safety commissioner for Scotland Page 134	1 Scotland's health and social care professionals; is that 2 correct? 3 A. That's correct, yes. 4 Q. You tell us, as director general, you were a member of 5 something called the "Scottish Government's Corporate 6 Governance Board". Could you tell what you say that 7 board does? 8 A. Yes, the corporate governance board for Scottish 9 Government brings together director generals from across 10 government, together with the permanent secretary who is 11 the most senior civil servant in Scotland and also 12 non-executive members of Scottish Government. And the 13 board exists really to provide assurance around the way 14 in which Scottish Government is operating, particularly 15 with regard to risk management and with regard to the 16 production of its accounts, its annual financial 17 accounts, but also around matters such as staff 18 governance and ensuring that the civil service across 19 Scotland has the right people to be able to perform the 20 jobs that are required on behalf of ministers. 21 Q. I see, so that is -- it's a contribution you're making 22 as director general in the health sphere to the overall 23 clinical governance of the government, rather than 24 performing a specific health function, is that correct? 25 A. That's correct. Page 136

1 Q. Understood. In a number of documents and indeed, in 2 your own former title, one sees the phrase 3 "NHS Scotland" used. You've told us, I think, in the 4 statement about the evolution of the provision of 5 healthcare, the NHS (Scotland) Act 1978 and the 6 obligations that exist within government and indeed on 7 health boards which flow from that Act and other 8 legislative provisions. 9 When we see the term "NHS Scotland" of which you 10 were the chief executive, can you tell us what that 11 means? 12 A. Yes. So it's an interesting term because NHS Scotland 13 does not exist as a legal entity. "NHS Scotland" is 14 used as a term -- as almost an umbrella phrase to 15 describe the grouping of NHS boards who are charged with 16 discharging ministers' responsibility for health and 17 social care across Scotland. So, as chief executive of 18 NHS Scotland, essentially as chief executive of 19 an organisation that didn't have legal standing, my 20 relationship was in terms of being the principal 21 accountable officer for the health and social care 22 portfolio within Scottish Government and I delegate -- 23 delegated accountable officer responsibilities to the 24 individual chief executives of health boards. 25 Q. Right. We've heard from Ms Nicky Connor, who is the Page 137	1 cabinet secretary who is, in effect, acting as the 2 Scottish Ministers in that field, is that broadly 3 correct? 4 A. That's correct, yes. 5 Q. Thank you. As far as the use of the term "NHS Scotland" 6 is concerned, one of the things that you've helped us 7 with in your statement is you've told us that in various 8 different spheres, at various different times, one might 9 see guidance or direction or something like that issued 10 and one often sees that that's done in the name of 11 NHS Scotland. If one sees something like that, 12 NHS Scotland guidance on a particular area of healthcare 13 provision, should we really take that to mean that 14 that's guidance which emanates from the Scottish 15 Government? 16 A. Yes. 17 Q. So effectively, there are circumstances in which -- and 18 we may look at some of them in detail in due course -- 19 certain aspects of the operation of the healthcare 20 system exist within a framework whereby health boards 21 and individuals working within health boards have been 22 directed to do things in a certain way by the Scottish 23 Government. And that's called "NHS Scotland guidance", 24 is that broadly correct? 25 A. Yes, that's broadly correct, yes. Page 139
1 chief executive of NHS Tayside, who explained to us her 2 role as the accountable officer for that health board. 3 Do I take it then that, as the overall principal 4 accountable officer, you're a level up from her; would 5 that be the right way it look at it? 6 A. Yes, I think that's fair. I had overall accountability 7 for the portfolio that's delegated to me from the 8 permanent secretary and then, yes, I delegate those 9 responsibilities -- delegated those responsibilities to 10 individual chief executives. 11 Q. And in terms of looking upwards, you're obviously 12 accountable for what goes on below you but to someone 13 else above you. To whom are you accountable, or were 14 you? 15 A. So I am accountable -- in terms of my line management 16 was to the permanent secretary in Scottish Government. 17 However, I also, as director general for health and 18 social care, was the primary, principal advisor to the 19 Scottish Ministers, particularly the cabinet secretary 20 for health and social care. 21 Q. Right, and is the way that you described to the Scottish 22 Ministers, is that because the Scottish Ministers is 23 an entity that exists within law but, in the particular 24 circumstances of dealing with health and social care, 25 you're reporting on a daily basis to a particular Page 138	1 Q. Thank you. I'm interested in understanding how it is -- 2 how does it come to be that NHS Scotland or the Scottish 3 Government decides at any given time as to what sort of 4 guidance of that nature that it might issue? Because 5 sometimes one can see in the statement that you've 6 provided that it's issued, for example, in consequence 7 of there having been a recent piece of legislation and 8 therefore, presumably, the government thinks: well, 9 there's a new piece of legislation, people are going to 10 want to know how that should be implemented, so we'll 11 issue guidance. 12 But at other times, it seems less easy to understand 13 why, at a given moment, the government has decided to 14 issue particular guidance at that time. Could you give 15 us some indication as to how that works within 16 government? 17 A. Yes, so, as you have identified, there will be occasions 18 when particular bits of legislation come into force and 19 it's important that we issue guidance to help boards to 20 be able to comply with that legislation. 21 There are also bits of guidance that get issued 22 almost cyclically. So, for example, we would issue 23 guidance to NHS boards in relation to their planning and 24 their financial allocations in order to help them with 25 their annual planning cycles. Page 140

1 There may also be guidance that is issued as 2 a result of a particular issue emerging that ministers 3 feel it's important for us to respond to. There's also 4 guidance in relation to employment practices, would be 5 an example. So there's -- there are many different 6 routes through which there may be a decision taken to 7 actually issue guidance. 8 Q. Understood, and the decisions, in that regard, are 9 ultimately decisions for ministers, is that right, as to 10 when guidance would be issued? 11 A. That's correct, yes. 12 Q. Because we know -- one of the things that you've told us 13 about is that, in relation to the Eljamel matter, 14 certain information about concerns relating to 15 Mr Eljamel and the systems around him were brought to 16 the attention of the cabinet secretary for health who, 17 at that time, was Ms Freeman. And she appeared to get 18 interested in the subject and she took certain action as 19 a result of that. She convened meetings, she spoke to 20 health boards, she sought reassurance from them and then 21 ultimately, she ordered a report to be undertaken into 22 certain aspects of the matter. 23 Ultimately, in situations like that, or when one is 24 talking about guidance being issued more broadly, who 25 are the drivers behind that? Is it the minister that Page 141	1 A. Yes, that's correct as well. 2 Q. Thank you. You've provided with us a helpful summary of 3 the way in which responsibility for the provision of 4 healthcare in the NHS in Scotland has developed over 5 what we defined, in the letter that we sent to you, as 6 "the relevant period". And one particular aspect that 7 you've pointed out to us, because that relevant period 8 started in 1995, is that the relevant period straddles 9 the pre- and post-devolution position. 10 I think, broadly, what you've set out for us is that 11 in the period 1995 to 1999, there existed something 12 which I think is called "administrative devolution for 13 health", is that right? 14 A. That's correct, yes. 15 Q. In effect, as I understand it -- please correct me if 16 I'm getting this wrong, but I understand that what that 17 meant was that the Scottish healthcare system, Scottish 18 national health service was run not through the 19 Department of Health, although the UK Government -- it's 20 pre-devolution, so the UK Government ran the country, if 21 you like, but that it was run effectively through the 22 Scottish office and therefore, although there was not 23 devolution because it was run by a Scottish office 24 rather than a UK government, effectively that was 25 an administrative devolution arrangement; is that Page 143
1 decides: this is something I think I should get involved 2 in, or is it more from your side, if you like, from the 3 civil service side, to say: minister, I think this is 4 something that the government should take more of a role 5 in? 6 A. It can be both. It can absolutely be both. It can be 7 something that the minister is concerned about or it can 8 be something that officials believe needs to be 9 addressed and would therefore, offer advice to the 10 minister on how to address that. 11 Q. So action like that might be generated perhaps through 12 something being escalated ultimately to someone in your 13 position, or the position you used to hold, through the 14 system, saying: things aren't working here, it would be 15 useful to have the government's position on this. And 16 that ultimately could be something put to the minister 17 who would make a decision. Is that one route, is that 18 right? 19 A. Yes, that is correct. 20 Q. But equally, it may be that, as a result of something 21 coming to a minister's attention or something being 22 driven by a policy initiative that the government 23 particularly wants to pursue at a given time, that they 24 are the driver behind that and it comes almost in the 25 opposite direction, is that the way it works? Page 142	1 correct? 2 A. Yes, that's correct. 3 Q. And in 1999, there was a change, constitutionally, in 4 the way in which healthcare was administered and 5 healthcare was officially devolved into the competence 6 of the new Scottish Parliament when that came about? 7 A. Yes, that's correct. 8 Q. And so, although it might be perceived as an enormous 9 change, and it was an enormous change, in fact for 10 Scotland it might not have been as big a change as 11 perhaps the public perceived because there had already 12 been a form of devolution which had happened before 13 legal devolution, is that right? 14 A. Yes, I think that's fair comment, yeah. 15 Q. One aspect of something that we're particularly 16 interested in that you've helped us with in the 17 statement, that interestingly straddles that period, and 18 it may be something that you've -- not in position at 19 the time but others may have been able to help you with 20 it, is in relation to the creation, effectively, of 21 a system of clinical governance within hospitals. Now, 22 you've provided us with a number of pieces of 23 information and I think, our understanding at 24 least, was that clinical governance as a concept was 25 something that was in fact introduced before legal Page 144

1 devolution took place through the UK Government, is that 2 right? 3 A. Yes, that's correct. That's the MEL in 1998. 4 Q. That's right, November 1998. And then I think you've 5 also helpfully provided us with some documentation that 6 shows that that, as an initiative, was picked up by the 7 new Scottish Government in 1999, is that right? 8 A. Yes, that's right. There's further guidance issued in 9 1999 and indeed, in 2000 as well. 10 Q. Yes, and is your understanding that effectively that was 11 a relatively linear process and although there was 12 a change in responsibility for that system coming in, 13 was it, in effect, the position that what had been 14 planned before became what started to be implemented 15 afterwards? 16 A. Yes, absolutely. 17 Q. Thank you. And in that regard, to try to tie this into 18 a concept I was talking about earlier, it is the case 19 that clinical governance was something that came through 20 government, it wasn't something that health boards 21 decided to do off their own bat? 22 A. No, that's correct. 23 Q. And is clinical governance therefore, because of the way 24 that it came about, something for which government 25 retained a particular responsibility after that date, or Page 145	1 a need for there to be a change in the way in which 2 healthcare was delivered, in particular, there be a move 3 away from a reliance on individual clinicians adhering 4 to their professional responsibilities and a move 5 towards a system of oversight which was vested, I think, 6 in effectively chief executives of boards, is that 7 right? 8 A. That's correct. It was very much -- and I think the MEL 9 from 1998 describes the system of clinical governance as 10 being complementary and additional to the 11 responsibilities of individual clinicians. So it didn't 12 remove the responsibility from individual clinicians, 13 but what it did was to set in place structures that were 14 intended to provide checks and balances against that 15 responsibility of individual clinicians. 16 Q. Thank you. And in the role that you held in overall 17 charge of the chief executives and the health boards, 18 was clinical governance something that was a regular 19 feature of the role that you performed? 20 A. Through my role as director general, I would rely on my 21 team to provide oversight of clinical governance -- of 22 governance arrangements, through both direct contact 23 with NHS boards and through our processes, for example, 24 through annual review mechanisms. So, yes, clinical 25 governance, along with financial governance, staff Page 147
1 was it effectively handed over to health boards and they 2 were told: get on with that? 3 A. So the MEL that issued in 1998 represented a shift with 4 responsibility for patient safety and quality moving 5 from being held by individual clinicians to being 6 a corporate responsibility and a shift from chief 7 executives being broadly responsible for use of 8 resources to being -- having a wider set of 9 responsibilities. That was -- absolutely, that was 10 issued in guidance from government and government has 11 continued to provide guidance around the ways in which 12 we expect clinical governance to be exercised, but the 13 responsibility for actually delivering against that 14 guidance sits with NHS boards. 15 Q. Yes, okay. So the initiative and the principles behind 16 it came from government and government retained 17 an interest in it? 18 A. That's correct. 19 Q. But, as we've heard in lots of other spheres, 20 operational matters, as far as how it worked on the 21 ground, if you like, were for the health boards, is that 22 right? 23 A. That's correct. 24 Q. And I think you've told us that the principle behind 25 this was due to the fact that there was thought to be Page 146	1 governance, and other areas of governance are also all 2 part of the blueprint for good governance that we issued 3 as government. So, yes, we had the responsibility for 4 setting the overall framework within which we expected 5 NHS boards to operate. 6 Q. Thank you. The blueprint for good governance, I think 7 we've heard from elsewhere, came in, in 2019, is that 8 right? 9 A. That's correct and it was updated following that. 10 Q. Thank you. And so the principles behind that were that 11 the government wanted to set down a scheme within which 12 they thought -- what they were prescribing, I think, 13 that health boards should run themselves, broadly 14 speaking, is that right? 15 A. That's correct, yes. 16 Q. And one of the things that we had heard, from previous 17 witnesses, was the way that that worked, broadly, was 18 that there were prescriptions around things like, for 19 example, the types and number of people from the 20 executive side that should sit on the board. But the 21 prescription didn't go into running every part of the 22 operation, that remained at the discretion of the chief 23 executive in order to set that up as he or she saw fit? 24 A. Yes, that's correct. 25 Q. And before 2019, before the blueprint, how did that Page 148

1 operate in that sense? To what extent did government 2 prescribe any aspect of clinical governance of health 3 boards? 4 A. So the government did prescribe some aspects, 5 particularly in relation -- and you've already 6 identified, the membership and how many members from the 7 executive and how many members of non-executives, but 8 also the government prescribed mandatory committees. So 9 there were a number of mandatory committees prescribed, 10 one of which was a clinical governance committee, one of 11 which was an audit committee, with those being 12 sub-committees of the full board and charged with 13 particular responsibilities around providing assurance 14 to the board on particular matters. 15 THE CHAIR: How did it go about prescribing that? Is that 16 by reference to directions that were issued? 17 A. Yes, so that would be within guidance issued by the 18 government, that prescribed the setting up of -- I don't 19 recall exactly which -- the number of the MEL that set 20 up clinical governance, but it's very clear that it 21 should have an equivalent status to the audit committee. 22 THE CHAIR: There was an acronym lurking in there, which 23 I may have missed, if you explained it earlier, and 24 I apologise, but what does M-E-L stand for? 25 A. So that was a management executive letter. So the Page 149	1 looking at circumstances, as you know, in which concerns 2 arose around the performance of a particular surgeon, 3 but beyond that, started to look into the systems which 4 surrounded that surgeon and the extent to which those 5 systems may have been wanting in certain ways. 6 As far as the annual review mechanism is concerned, 7 how granular would the government's review tend to 8 become? 9 A. So I can speak to the annual review process as it has 10 been in operation over the period of time during which 11 I was DG, but the standard approach to an annual review 12 would be that the minister and myself, as DG if I was 13 supporting the minister, would get briefing that covered 14 the performance of the health board, the financial 15 performance of the health board, any issues around staff 16 governance, any issues around whistleblowing, any issues 17 around information governance. And then what would 18 happen on the actual day would be that the minister 19 would meet with a number of groups. So classically, in 20 the morning, you would meet with the partnership forum 21 which is the staff side and management advisory group. 22 You'd meet with the area clinical forum which was 23 clinicians from across the health board area. You would 24 meet with a patient forum, so you'd meet with 25 representatives of patients, of carers, all intended at Page 151
1 acronyms associated with guidance have changed over 2 the years and with the progression from, as Mr Dawson 3 described, a sort of system administered in Scotland, to 4 a system run in Scotland. 5 MR DAWSON: So the MEL we were talking about earlier was the 6 one that was issued by the UK Government in 1998 -- 7 A. That's correct. 8 Q. -- which effectively started clinical governance, is 9 that right? 10 A. Yes. 11 Q. Thank you. You mentioned, I think a moment ago, that 12 there were maybe annual reviews of health boards done by 13 the government, was that right? 14 A. Yes. There has been, for a number of years, a system of 15 annual reviews, some of which are conducted by ministers 16 with health boards, which looks at their performance and 17 I suppose is an opportunity for ministers and indeed, 18 the public to challenge the performance of health 19 boards. 20 Q. Right. I'm interested in various different ways in 21 which government might have a role in the way that 22 health boards operate. And as far as those annual 23 reviews are concerned, what I'm particularly interested 24 in is trying to explore the granularity into which such 25 a review might go. Obviously, we're interested here in Page 150	1 enabling the information that we had on paper to be 2 triangulated against what we were hearing from 3 representatives in those meetings. And then there would 4 be an in-public session at which the chair and chief 5 executive of the NHS board would be asked to present on 6 the board's performance over the last year in any 7 particular issues. We normally would require boards to 8 provide -- to give people an opportunity to submit 9 questions in advance, so to invite members of the 10 public. Obviously there was a period during Covid when 11 all of the reviews had to be done online, but when -- 12 I think we still tried to facilitate questions being 13 submitted from members of the public. 14 And we also invited questions in the room as well. 15 So -- 16 Q. Understood. So it sounds like that that system had the 17 potential for things to be brought to government's 18 attention that were quite granular. For example, if 19 patients were able to come along and report there's 20 an issue of the nature reported here, that such things 21 could arise through those fora? 22 A. Absolutely, yes, and certainly my experience was that it 23 was often the case that in the meetings with patient and 24 carers, we would pick up on things that we wanted to go 25 back and ask -- follow up with the board afterwards as Page 152

1 well. 2 Q. And you obviously have spoken to the period for which 3 you were responsible. 4 A. Yes. 5 Q. Was there a particular point at which that system of 6 annual reviews came in that you can recall or had that 7 been the position for a significant period of time? 8 A. So, I'm not sure that I can answer that question. 9 I think that -- my understanding is that that process 10 had evolved but I can't -- I'm sure that we will be able 11 to provide you details about exactly how that process 12 evolved and when it -- and it continues to evolve as 13 well. 14 Q. You tell us in the statement, I think, that it would be 15 wrong to think that that was the only mechanism through 16 which these things -- there were other mechanisms and 17 you tell us about professional mechanisms involving the 18 chief medical officer and we'll get on to that in 19 a second. 20 But in terms of the other ways in which the health 21 boards are controlled, if I put it that way, or overseen 22 by government, one of the other ways in which I assume 23 there is a degree of control exercised is in the money 24 that's given to health boards in order to operate. 25 So you've set out, I think broadly speaking, the way Page 153	1 is applied to how much money is spent in English public 2 services, that they have to use the money for the same 3 things in the same proportions? That becomes a matter 4 for the Scottish Government to propose and for 5 parliament to ratify; is that correct? 6 A. That's correct. 7 Q. Understood. So then, that then becomes a decision for 8 the government, in a budget which has to go through 9 parliament as to how much money will be allocated to 10 healthcare, is that right? 11 A. That's correct, yes. 12 Q. And then, because there are different political 13 priorities, it's why certain things are paid for by the 14 state like prescriptions in Scotland and they're not 15 paid for in other places like England, is that right? 16 A. That's correct. 17 Q. And so then, you get to a point where your department, 18 as was, effectively has a budget for the year. How then 19 is it decided what money goes to which health board? 20 A. So the funding of health boards is -- it's calculated 21 according to a formula. So it's referred to -- another 22 acronym, it's referred to as "NRAC", which stands for 23 the national resource allocation -- I can't actually 24 remember what the "C" stands for, I have never actually 25 used those -- but it's the NRAC formula. And that is Page 155
1 in which money comes to the Scottish Government is that 2 there's a block grant allocation which comes to the 3 Scottish Government from the UK Government which is 4 calculated in accordance with the Barnett formula, is 5 that broadly correct? 6 A. That's correct, yes. 7 Q. I think now the position is that the Scottish Parliament 8 also has certain tax raising powers of its own, such 9 that it can generate a certain amount of money for 10 public services in Scotland itself, in addition to that; 11 is that right? 12 A. Yes, that's correct. 13 Q. And my understanding is that that effectively forms 14 a pot of money that is available to government to decide 15 how to run public services in Scotland; is that correct? 16 A. That's correct. 17 Q. And therefore, the decision-making around what it is 18 that the government spends money on, be it health or the 19 police or prisons, that that is entirely a matter for 20 the Scottish Government to determine; is that correct? 21 A. Yes. The Scottish Government will prepare a budget 22 which then has to be approved by parliament. 23 Q. Yes, but it's not as if, for example, because of the 24 fact that the amount of money that's available to the 25 Scottish Government to use is based on a formula which Page 154	1 based on population shares, but also takes into account 2 things like demographics within different areas. So 3 that is used to actually calculate -- and so all boards 4 have a target share based on NRAC. However, not all 5 boards receive their total NRAC funding and some receive 6 slightly more than their NRAC funding and that's because 7 as things change, particularly population shifting from 8 the west to the east in Scotland, we have a commitment, 9 in Scottish Government, to maintain boards sat within, 10 I think it's 0.8 per cent of their NRAC funding. 11 But that does mean that -- and that's based on 12 trying to make sure that we keep funding trajectories as 13 smooth as possible, to make it as easy as possible for 14 boards to manage within those formula. 15 Q. Okay. So, as far as the decision-making around what 16 that allocation is used for, is that prescribed by 17 government, to an extent, or is that a matter for the 18 health board to decide? 19 A. No, that's not a matter for -- sorry, once the money 20 gets to the -- 21 Q. (Overspeaking) Once the money is handed with the NRAC 22 with the adjustments, who then controls what that's 23 spent on? 24 A. So once the money is allocated to a health board, then 25 we would expect the health board to deploy that money to Page 156

1 deliver against ministerial priorities. So when 2 I referred earlier to some of the guidance that we 3 issue being planning guidance, that planning guidance 4 would generally set out what priorities are in terms of 5 NHS boards being able to deliver services. And NHS 6 boards are -- then need to plan to be able to deliver 7 against those priorities, against the resource that they 8 have that we're making available to them. 9 Q. So are those priorities you mention effectively 10 political priorities prescribed by the government? 11 A. Yes -- yes, they tend to be and they tend to be around 12 where -- targets around delivery of planned care, for 13 example. 14 Q. Yes, so a political priority might arise because there 15 are sick concerns about a particular disease or 16 something like that and therefore more money should be 17 spent on that, or research showed that a lot of people 18 required a particular type of health service in 19 a particular area and that would be prescribed by 20 government, is that right? 21 A. So that's getting down to quite a granular detail. On 22 the whole, those priorities are relatively high level. 23 Q. Okay. So what I'm particularly interested in is the 24 extent to which there would be any prescription by 25 government as to, for example, how much money should be Page 157	1 the confidence that you can deliver on our 2 responsibility, so we're going to take over, is that how 3 it works? 4 A. That's correct. 5 Q. And would it be normal that one would progress up the 6 levels to try to see if things can be dealt with in 7 a more informal way and the final option would only be 8 taken in extreme circumstances? 9 A. Yes, certainly the intention of the framework is to 10 provide the board with support and with additional 11 oversight to enable de-escalation down a framework 12 rather than further escalation up the framework. 13 Q. Understood. In paragraph 13.2 of the statement you set 14 out a concept which relates to this area, I think, 15 called "collaboration subject to direction". 16 Is that a phrase -- is that a term of art, if you 17 like, or is that a phrase you're using to try to 18 encapsulate the way in which the dynamic between 19 government and a health board works? 20 A. Yes, I think the way in which -- I think that phrase is 21 used to indicate that we do not expect to have to use 22 directions in many circumstances, that we expect that 23 NHS boards will co-operate with Scottish Government in 24 terms of delivering against ministerial priorities and 25 that we have other levers that we would use before Page 159
1 spent on the neurosurgical service that might be offered 2 in NHS Tayside. Would that be prescribed or would that 3 be a matter for the board to decide itself? 4 A. That would be a matter for the board to determine. 5 Q. Thank you. Another aspect that I'm interested in, in 6 this general theme of the extent to which the government 7 does or can control what a health board does, relates to 8 something we heard a little bit about this morning which 9 is the possibility that the government might do 10 something called imposing "special measures" on a health 11 board. Broadly speaking, how does that work? 12 A. So I appreciate that people refer to this as "special 13 measures", although that's not actually a term we 14 officially use. So we have an improvement and support 15 framework. Again, that's evolved over a period of time. 16 But there are essentially five levels on the framework. 17 The first two levels, levels 1 and 2, are informal 18 levels. Levels 3 and 4 involve there being more support 19 and oversight from Scottish Government. And level 5 is 20 a ministerial decision, to intervene directly. 21 Q. And the legal theory behind that is ultimately the 22 delivery of healthcare is the minister's responsibility 23 and so if there are circumstances in which, in those 24 extreme circumstances that one got to level 5, 25 effectively the ministers will be saying: we don't have Page 158	1 getting to the point of direction or indeed 2 intervention. 3 Q. Indeed, I suppose collaboration is where it starts and 4 then the extent of the intervention goes up and up as 5 necessary but the objective would be to try to limit the 6 amount of direction that was needed, is that fair? 7 A. That's correct. 8 Q. You also tell us, in the specific circumstances that 9 we're interested here, at paragraph 19.1 of the 10 statement, that the Scottish Government could 11 investigate even an individual surgeon within a health 12 board if they thought it necessary under their statutory 13 powers. And indeed, we talked earlier about Ms Freeman 14 taking certain actions relating to matters relating to 15 Mr Eljamel that came to light. Would that be an example 16 of a situation in which those statutory powers were 17 being exercised, balanced against the general principle 18 that it would be better to try to collaborate and allow 19 the health boards to operate themselves, but in certain 20 circumstances the government will take further steps 21 when it considers it necessary? 22 A. Yeah, so I think in the circumstance that you describe, 23 it wasn't necessary for Ms Freeman to issue any 24 direction around taking that action because it was 25 understood that she had that as a recourse to her should Page 160

1 she had wished. But, yes, it was not necessary for her 2 to go to the point of direction, she was able to 3 instruct and commission the work that she did. 4 Q. Because that wasn't a situation which Mr Eljamel was 5 still working or anything like that. But it was later 6 on. But in the circumstances where there were concerns 7 about even the work of an individual surgeon, in 8 accordance with the legal principles we've set out, 9 I think you tell us paragraph 19.1 the government could 10 theoretically intervene do something even on such 11 a granular scale, is that right? 12 A. That is correct, although it's extremely unlikely that 13 the government would do that, particularly given the 14 responsibility of other organisations for individual 15 clinicians particularly the General Medical Council. 16 Q. Yes, the government might also think about providing 17 direction so that other people could do something about 18 it, would that be correct? 19 A. Yes, that would be correct. 20 Q. Rather than intervening directly themselves? 21 A. Yes. Yes. 22 Q. In order to be able to make decisions about that broad 23 function, and deciding what they should do, whether they 24 should push things in a certain direction, give 25 directions, intervene, it's important that the Page 161	1 Healthcare Improvement Scotland, Mr Pearson, who 2 explained some of these roles and he explained precisely 3 what you've just set out, the possibility that 4 an inspection could be undertaken by that body and that 5 that might result -- or that might be a way in which 6 information could be passed to government which could 7 precipitate certain action. 8 One of the interesting features, I suppose, of the 9 matters that we're looking at is that Healthcare 10 Improvement Scotland never became involved in any 11 investigation or aspect of matters relating to 12 Mr Eljamel or even in the various investigations that 13 took place thereafter. Do you think that they should 14 have, given your understanding of what their function is 15 that you've just explained? 16 A. Yeah, I think there may well have been an opportunity 17 for Healthcare Improvement Scotland to be involved in 18 terms of their particular expertise, and the particular 19 expertise that they have within their organisation as 20 part of one of the reviews that was conducted by the 21 board. And also to bring some externality into it. The 22 main way in which Scottish Government is alerted to 23 issues by Healthcare Improvement Scotland relates either 24 from inspections, whether they're announced or 25 unannounced inspections, or also from what's called Page 163
1 government is provided with a certain level of 2 information about things that are going on and perhaps 3 things that are going wrong, is that right? 4 A. That's correct. 5 Q. And as far as the sort of thing that we're talking about 6 here is concerned, concerns around a particular unit or 7 the service, or the care being provided by a particular 8 surgeon, what would be the main mechanisms by which 9 information might be conveyed to government when 10 concerns of that nature arise? We talked about there 11 being an annual review, but are there other mechanisms, 12 perhaps mechanisms that would be more normal to use in 13 those sorts of circumstances? 14 A. Yes. So I think in terms of routine mechanisms, the 15 inspections that Healthcare Improvement Scotland conduct 16 would be an example of when concerns about a particular 17 unit, a particular part of a health board, or indeed 18 a hospital, are brought to the attention of ministers. 19 And again, there is a framework within which Healthcare 20 Improvement Scotland have the ability to escalate 21 concerns that they come across in their inspection 22 regime to ministers. So that's one option. 23 Q. Could I just ask you a couple of things about that 24 because that's of particular interest to us. We've 25 heard some evidence already from the chief executive of Page 162	1 their "responding to concerns procedures", whereby 2 individual clinicians can raise concerns with Healthcare 3 Improvement Scotland and Healthcare Improvement Scotland 4 will investigate those. 5 Q. But equally, as I understand it, as I think you were 6 explaining a moment ago, Healthcare Improvement Scotland 7 could be used as a vehicle whereby the government could 8 take an interest in something and they could effectively 9 be sent in, as the healthcare improvement experts, to 10 say: would you mind having a look at that, we're a bit 11 concerned about it, we know that you'll work out what's 12 going on and report back to us; it works that way too? 13 A. Yes, it does. 14 Q. Another way in which information of this nature might 15 flow to government is, as I understand it, through the 16 chief medical officer, is that right? 17 A. That's correct yes. 18 Q. Could you tell me broadly how the system might work such 19 that the chief medical officer could become involved in 20 concerns being raised about a unit or a surgeon or 21 something like that? 22 A. Yes, so the chief medical officer has a relationship 23 with all the executive medical directors, they meet on 24 a monthly basis in the Scottish Association of Medical 25 Directors group and that's an opportunity for medical Page 164

1 directors to raise any particular issues or concerns, to 2 seek support from their colleagues in terms of whether 3 other people have had similar issues, but also to seek 4 support from the chief medical officer. 5 I think in addition to that, the chief medical 6 officer tries, certainly currently, to ensure that the 7 relationships they have with medical directors are such 8 that medical directors feel that they can pick up the 9 phone if they've got an issue that is of concern. 10 Q. Okay. So where would one find defined the 11 responsibilities of the chief medical officer in that 12 regard and imagine if you were a medical director and 13 you were sitting with an issue like this in front of 14 you, and you were trying to think to yourself: is this 15 the sort of thing I should go to the chief medical 16 officer with? Is there somewhere that you can look to 17 try to get a sort of guidance as to what sorts of things 18 should be brought to his attention and what should not? 19 A. So I think I would have to ask the chief medical officer 20 exactly around that guidance. What I would say, though, 21 is that I think that certainly in my relationship with 22 chief executives and my colleague's, the chief medical 23 officer's relationship with his medical directors, the 24 chief nurse's relationship with executive nurse 25 directors, we are really clear in the nature of that Page 165	1 into something that's a bit more executive-controlled? 2 A. I think the chief medical officer would probably be the 3 best person to actually comment on what more might be 4 appropriate in that space. 5 Q. Okay. And I think you tell us also in the statement 6 that there are various different directorates in 7 government. Is it the case that the chief medical 8 officer sits in a different directorate from the medical 9 directorate that runs healthcare mostly? 10 A. So no, the -- my role was as director general and within 11 my director generalship -- I'm not entirely sure what 12 the word for that is -- there were, and are, a number of 13 directors. And the chief medical officer was one of 14 those to so the chief medical officer was part of the 15 team reporting to me and also providing me with advice 16 in relation to providing advice to ministers. 17 Q. Thank you. You've told us -- we've already had 18 a discussion, to an extent, about areas in which 19 government broadly took an interest, we talked about 20 clinical governance and the way in which that came in. 21 The position, I think, if we could look, please, at the 22 statement. You told us, at paragraph 9.4, you were 23 asked there about the government's involvement in broad 24 systems of clinical governance. And you said there: 25 "The Scottish Government has not issued guidance Page 167
1 collaborative working relationship that we need to try 2 and operate on the basis of no surprises. 3 Q. Does that relationship work more on the basis of the 4 sort of professional side of things, which, a moment ago 5 we were discussing as being something that was displaced 6 to an extent when the clinical governance regime came 7 in. Is it sort of doctor-to-doctor speaking there? 8 A. Yes, certainly in respect of that relationship with the 9 chief medical officer to other executive medical 10 directors, that would be -- that's a doctor-to-doctor 11 relationship, yes. 12 Q. Because we know that, although my understanding is it 13 doesn't necessarily have to work this way, a medical 14 director has certain responsibilities, they would tend 15 also to be the responsible officer which has certain 16 responsibilities, these are largely professional 17 responsibilities and therefore that involves, as 18 I understand it, to some extent, an obligation to confer 19 with the chief medical officer when that seems 20 necessary. 21 I'm just wondering whether there may be some scope 22 there for there being greater clarity around how that 23 system should work, in the same way as there was a need, 24 back in the late 1990s, the government thought to move 25 away from reliance on a professional regulation system Page 166	1 expressly concerning clinical governance, albeit the 2 requirements of good clinical governance are interwoven 3 with the requirements of good corporate governance." 4 Then you go on to talk about the blueprint we 5 discussed a moment ago. Based on what you have already 6 told us, I think that perhaps that might not be right, 7 what is said there, that there is, in fact, guidance 8 issued by government, in particular in the form of the 9 1998 UK Government MEL and indeed, another one that 10 I think you've mentioned which came in, I think at the 11 start of the devolution period in April 1999, is that 12 right? 13 A. Yeah, that's correct and that was one of the corrections 14 to the statement that we've issued, yes. 15 Q. Yes, absolutely. Thank you for that. And as far as 16 other aspects of the way in which governance might work 17 within a health board are concerned, is it the case 18 that -- or I should say in other mechanisms by which the 19 government might become involved in matters. You say, 20 at paragraph 10.11, that anyone can complain about 21 an issue they have -- we can look at if you need to. 22 Perhaps it might be easier to have 10.11 up. You tell 23 us there: 24 "The Scottish Government would not ordinarily expect 25 to have direct communication with NHS Tayside's Page 168

1 neurosurgical patients. The delivery of healthcare 2 services being a matter for NHS Tayside. However, 3 complaints may be made directly to the Scottish 4 Government by or on behalf of patients which may prompt 5 a direct response from Scottish Government." 6 And then you talk about that later. I was just 7 interested in understanding how, practically speaking, 8 that would work if someone wanted to come to you or the 9 minister and say: I have terrible trouble with what's 10 going on in the hospital, how would they do that? 11 A. So it is not unusual for patients to contact either me, 12 in the role of DG and chief executive, or indeed to 13 contact ministers with a complaint. And the process 14 that we adopt then is generally to refer them to the 15 health board who is responsible for their care, as 16 they're the organisation that can best deal with 17 a complaint. 18 We would also alert them to the fact that the 19 Scottish Public Services Ombudsman exists who can deal 20 with complaints that they feel haven't been resolved. 21 And also to support for people wanting to make 22 complaints about -- 23 Q. (Overspeaking) Thank you. So that shouldn't really be 24 viewed as a sort of separate complaints system that 25 exists by coming straight to government, but someone Page 169	1 "The Scottish Ministers are clear that when 2 a whistleblower raises a concern, this must be treated 3 with the utmost seriousness and thoroughly investigated. 4 Health Boards are expected to investigate concerns 5 fairly and appropriately and ensure that the individual 6 raising the concern does not suffer adverse 7 repercussions for doing so. In 2011 the Scottish 8 Government and NHS Scotland produced a 'Partnership 9 Information Network' (PIN) policy entitled 'Implementing 10 & Reviewing Whistleblowing Arrangements in NHS 11 Scotland' ... This Policy defines a minimum standard of 12 best employment practice and is designed to achieve 13 a consistent approach across NHS Scotland. It contains 14 a 'model policy', which sets out the minimum standards 15 that must be adhered to and is designed for use by any 16 worker looking to make a qualifying disclosure. The 17 model policy includes an assurance that a whistleblower 18 may contact the Scottish Government Health Directorate 19 directly." 20 So, first of all, you say here that this document 21 that was issued in 2011 contains a minimum standard of 22 best practice. How does that work? That doesn't seem 23 to fit together. Either it's a minimum standard, or 24 it's best practice. I'm really just trying to work out 25 what it's seeking to achieve. Is it saying to people, Page 171
1 could come with a complaint and you wouldn't just close 2 the door on them, you would direct them back in the 3 appropriate place in the system where that should be 4 raised? 5 A. That's correct, yes. 6 Q. So one might imagine that it would be as a result of the 7 failures of the local system that someone might be 8 coming to you in the first place and so if you're just 9 directing them back to the local system and there's not 10 much else you can do, does that really assist? 11 A. So whilst you might imagine that actually, and perhaps 12 it's due to the nature of having the title chief 13 executive of NHS Scotland, I certainly personally got 14 a lot of correspondence when people thought that I was 15 the best person to tackle that when clearly I'm not 16 because I don't hold the information, nor should I hold 17 the information that relates to individual care. So the 18 most appropriate mechanism was to direct people back to 19 the individual health board, but also to be clear about 20 other mechanisms to escalate that, for example the 21 Scottish Public Services Ombudsman. 22 Q. Thank you. Could we look at paragraph 12.3, please. In 23 fact can we look at 9.9 first. This is another area 24 that we asked you about, whistleblowing, and the extent 25 to which government has a role in that. You told us: Page 170	1 or the health board: this is the minimum you need to do, 2 or this is what you need to aim for? 3 A. So I think, at this point, it was setting out what was 4 the minimum that was expected in a way that was, I would 5 imagine, at this point, intended to assure a more 6 consistent approach across NHS Scotland. The 7 arrangements around whistleblowing have evolved quite 8 considerably since this point. 9 Q. And obviously this particular period is of interest to 10 us because we are looking at things, to an extent, 11 historically. We're aware of the fact that the Public 12 Interest Disclosure Act brought in certain provisions in 13 1998. I was interested in why it was that it was at 14 this point -- if you can help us with this because it's 15 before your time, why it was in 2011 that this was 16 something that the government thought would require 17 a policy, a paper to be introduced? 18 A. So, I'm not sure I can help you with that right now. 19 I know that -- yeah, I know that there were a number of 20 pre-existing arrangements around whistleblowing but 21 I don't think I'm in a position to provide you with the 22 detail right now. 23 Q. We've heard, in other contexts, that sometimes when more 24 general rules come about, that what existed before that, 25 the phrase that's often used is "local arrangements". Page 172

1 Is it the case that there was an attempt in 2011, for 2 the government to try to say, for whatever reason: we 3 think it would be a good idea to issue a standardised 4 set of guidelines here because we think this is 5 an important area, perhaps as a result of a minister 6 taking interest or there being some policy around this 7 area? Before that, can we take it to mean that there 8 were obligations in this regard but it would be left up 9 to local arrangements? 10 A. Yes, I think it would be fair to assume that producing 11 a PIN policy, which are policies that apply across 12 Scottish Government -- across NHS Scotland, sorry, was 13 absolutely intended to get away from local arrangements 14 and to provide is more consistent. 15 Q. So it tends to mean whatever the precise mechanism was, 16 is at that time, somebody thought: hang on a sec, this 17 whistleblowing process is an important one to the proper 18 administration of healthcare. It doesn't seem to be 19 working in a very co-ordinated way, so this would be the 20 sort of thing that government should invest its time in 21 trying to co-ordinate in a single policy, is that right? 22 A. That's right. 23 Q. Thank you. Could we go to 21.1, please. Again, this is 24 another area in which we asked you what the systems 25 would be and it's significant clinical event analysis, Page 173	1 we take it that before this what would have been in 2 place would have been local arrangements, by which 3 I mean something that was not co-ordinated by 4 a government policy designed for that purpose? 5 A. Yes, that's correct. 6 Q. Thank you. I wondered -- actually, I think you maybe 7 go on to talk about this, but we heard some evidence 8 from Mr Pearson that he was involved in some workaround 9 issues that had arisen in Ayrshire and Arran around that 10 time, which I think may have given rise to some of these 11 frameworks. So in this instance, I think that might be 12 the source of the inspiration, if you like, to introduce 13 this framework. Is that your understanding? 14 A. Yes, that's absolutely my understanding, yes. 15 Q. That's very helpful, thank you. Also I wondered about 16 the circumstances in which the government might become 17 involved in more specific matters in the healthcare. So 18 rather than the clinical governance side that would be 19 looking at complaint systems, adverse event management, 20 the extent to which government might become involved in 21 specific aspects of healthcare. And you've helped us 22 with this again in the statement, by telling us about 23 certain initiatives that existed from the government's 24 perspective and from other bodies in relation to the 25 field of neurosurgery specifically. Page 175
1 or adverse event analysis, again, something which, as 2 you'll know very well, goes on in hospital. It says: 3 The Scottish Government would not expect to have any 4 direct involvement in a SCEA or adverse event analysis, 5 including identifying, reviewing or decisions related to 6 an adverse event. These are local processes determined 7 by the Health Board within which the care is being 8 delivered. The Scottish Government sets the strategic 9 direction of the policy and issues guidance but has no 10 operational involvement in the management of adverse 11 event reviews." 12 And then, in the next paragraph: 13 "National oversight of adverse events is led by 14 Healthcare Improvement Scotland. The National Adverse 15 Event Framework developed by HIS ... in collaboration 16 with Health Boards, is the framework to which Health 17 Boards should be aligning their SCEA processes. The 18 Framework was first published in September 2013. The 19 Adverse Events Framework sets out the requirements of 20 NHS boards for reporting to external agencies." 21 So again, this is a circumstance in which, at 22 a certain point in time, actually 2013 is quite 23 an important point in time for us, the government, 24 through Healthcare Improvement Scotland, has seen fit to 25 issue guidance or a framework for this area. Again, can Page 174	1 So, one thing that you did was you drew our 2 attention to a document which I'd like to look at 3 please, which is SG-00173. So this was a document -- 4 you've told us about various things that happened in the 5 field of neurosurgery, but this was a document -- we 6 actually were shown this document by another group of 7 witnesses, but it's of particular interest to the 8 subject that I'm going to discuss with you. 9 This was a document called "Safe Neurosurgery" from 10 2000, a report from the Society of British Neurological 11 Surgeons. And you've drawn our attention to this as 12 being, not a government document but a document that was 13 introduced, I think, by an influential body in the field 14 of neurosurgery which was trying to promote best 15 practice in that field, is that right? 16 A. Yes, that's correct, yes. 17 Q. And I think you then tell us -- we'll go on to this -- 18 in the statement that there were, subsequent to this, 19 a number of stages through which the government got more 20 involved in issues concerning the way that neurosurgical 21 services were provided, but that this was an important 22 component of that; is that correct? 23 A. That's correct, yes. 24 Q. Yes, the government wasn't responsible for this -- 25 A. No. Page 176

1 Q. -- but it was something that was a foundational document 2 in the government's activity, I think? 3 A. Yes. 4 Q. So could we go, please, to page 10 of the report. And 5 it, in fact, tells us there that this was not the first 6 of these documents, that, in fact, something called 7 "Safe Neurosurgery" had been published some years before 8 in 1993 and that it provided a benchmark for development 9 over the ensuing six years and then it tells us that: 10 "Since then ..." 11 This is now 2000: 12 "... there has been significant progress although 13 many of the standards proposed have yet to be achieved." 14 So we're at a kind of interim phase here of moving 15 towards better neurosurgical services. If we go to 16 page 20, please, paragraph 3.2.4. It says: 17 "Whilst there has been significant progress in terms 18 of defining standards, achieving some of those 19 recommended in 1993 and monitoring performance against 20 them has not yet been sufficiently realised. The 21 progress that has been made is largely due to the fact 22 that 'Safe Neurosurgery 1993' set explicit standards 23 that were felt to be realistic as well as setting a set 24 of safe benchmarks based on the needs of the time." 25 So therefore, the context of any government Page 177	1 involved in the care, in relation to a specific and 2 often quite specialised conditions, in order to enable 3 them to share expertise, share knowledge, learn from 4 each other, and also to start to develop data that would 5 help an understanding of any variance in performance 6 across a group of clinicians, particularly when they're 7 dealing with conditions that are not common and 8 therefore there isn't a huge amount of data within any 9 one hospital or within any one NHS board area. 10 Q. And I think, you see the term floating about in this 11 document and others all the time, a term called 12 "benchmarking". So effectively the data allows people 13 to be able to work out: is that service working at 14 a high level, or a medium level, or are there concerns 15 about it? If you don't have the data, it's hard to 16 judge that; is that the theory? 17 A. That's correct, yes. 18 Q. Thank you, and I think you tell us later that a managed 19 clinical network comes in, in relation to neurosurgery 20 in Scotland in, I think 2010, is that right, around 21 about then? 22 A. I think 2009, 2010, something like that, yes. 23 Q. Thank you. If we could have a look, please, at page 41 24 of this document. It's SG-00173 I'm looking at. 25 Page 41, please. So this is just to understand what -- Page 179
1 involvement appears to be this developing pattern of 2 this professional association trying to provide, not 3 only just general, high-level things, but actually 4 a specific guide to how services should be delivered in 5 specific places; was that your understanding of what 6 this was doing? 7 A. Yes. My understanding is that this is a report that's 8 particularly designed to look at volumes required to 9 achieve safe patient care. 10 Q. Thank you. And if we could look at paragraph 10.10.2, 11 please, a bit further on. It says here -- there's 12 strategic reviews which had gone before, included 13 an acute services review from 1998 led by 14 Sir David Carter. I think that's something you refer to 15 in the report as well, which tells us that: 16 "... this review introduced the concept of Managed 17 Clinical Networks ... as the primary mechanism for 18 delivering specialised care across Scotland." 19 Now, later on, you tell us that something called 20 a managed clinical network came in, in relation to 21 neurosurgery, but I wonder if you could tell us more 22 broadly what the concept of managed clinical networks 23 was about, as you understand it? 24 A. Yes, so as I understand it, managed clinical networks 25 was a way of bringing together teams of clinicians Page 178	1 there's an appendix to this which, actually as I was 2 saying, specifically gives some information about what 3 that organisation thinks should be the case with regard 4 to neurosurgical units in terms of the way that it 5 should work. If we remember because we're going to have 6 to go over the page, we remember what the columns are, 7 the first is the "population" served by the centre, the 8 second is the "target for 2005", "current staff" and 9 "shortfall". So this is looking forward, to say: given 10 the size of the area you are covering, you should have, 11 in 2005, so five years from this point, this number of 12 consultants. And then it tells us the current number 13 and the shortfall. 14 So we'll go over the page, please. And we'll see 15 there that Dundee, in terms of the number of staff, the 16 target is to have six consultant staff, as I understand 17 it, they currently had three and there was a shortfall 18 of three; is that what that's telling us? 19 A. Yes, that's my understanding, yes. 20 Q. Right, and if we could go to page 44, please. Again, 21 we're going to have to go back to 43. This tells us, 22 for the different units "beds target", "beds 1999" and 23 "shortfall". And again, if we go over the page, it 24 tells us that in Dundee there were 24 beds -- the target 25 was 24, there were 20 and there was a shortfall of four, Page 180

1 is that right? 2 A. Yes, that's correct. So this is a report produced in 3 2000 that is looking forward to what they expect to be 4 the volumes in -- 5 THE CHAIR: Mr Dawson, is this the same neurosurgery report? 6 MR DAWSON: This is the same neurosurgery report, sir, yes. 7 Sir, that would be a convenient moment for a break. 8 THE CHAIR: Yes, surely. 9 Ms Lamb, we'll take a break now for 15 minutes and 10 resume again after that. 11 Just one housekeeping matter. Because you've 12 started your evidence, we ask you not to discuss it 13 during the break and we'll be back in quarter of 14 an hour. 15 A. Thank you. 16 (3.22 pm) 17 (A short break) 18 (3.35 pm) 19 THE CHAIR: Thank you. I think we're ready to resume. 20 Mr Dawson, within you're ready. 21 MR DAWSON: Ms Lamb, we were talking about documents that 22 you'd helpfully provided us in connection with the 23 neurosurgical services and you tell us a little bit more 24 about that in the statement. If we could go to the 25 statement at paragraph 10.11 on page 35, please. Sorry, Page 181	1 establish the Managed Service Network for Neurosurgery 2 (MSN) in 2009 ... The MSN was set up to ensure patients 3 have equal access to high quality Neurosurgical care in 4 Scotland. The Network supports the delivery and audit 5 of services ..." 6 As you told us before. So we won't go into the 7 details of the documents, but you provided us with some 8 documents, historic documents, that indicate in the 9 period between 2005 and the eventual decision set up to 10 the managed service network in 2009, from what you've 11 said there, there appear to have been real issues around 12 the viability of the four centres and specifically, the 13 decision was required by ministers to retain 14 NHS Tayside's unit. Is that your understanding? 15 A. Yes, that's correct. The report that I referred to, 16 particularly I think the care report, had suggested that 17 a single managed service for Scotland might be most 18 appropriate, given the volumes involved. 19 Q. Indeed. 20 A. But then in 2007, there was a national neurosurgery 21 needs assessment done and that recommended that actually 22 the same result could be achieved by setting up the 23 managed clinical network, which was then subsequently 24 set up. 25 Q. Yes, the result of which was the four centres were Page 183
1 10.12 on page 35. This is something we discussed 2 earlier. You tell us that: 3 Neurosurgery audits are undertaken by the Managed 4 Service Network for Neurosurgery ... Established in 5 2009 [as you told me] and constituted by colleagues from 6 across the NHS in Scotland, the MSN supports the 7 delivery and audit of services in the four Neurosurgical 8 Units nationally: Aberdeen, Dundee Glasgow, and 9 Edinburgh. The MSN is accountable to the Scottish 10 Ministers and reports to the CMO annually." 11 And then you also provide some information over the 12 page, at 11.1. We asked you about the questions of 13 restructuring and viability of the services and you told 14 us that: 15 "In relation to 'restructuring' and 'viability', the 16 Inquiry may find earlier national strategic reviews 17 conducted between 2005 and 2009 to be of assistance to 18 its investigations, including the National Framework for 19 Service Change in NHS Scotland (2005) ... National 20 Neurosurgery Needs Assessment for Scotland (2007) ... 21 and, Neurological Health Services (2009) ... (following 22 the Kerr Report) ... During this period, the viability 23 of retaining four neurosurgical centres in Scotland was 24 challenged. Following these reviews, the Scottish 25 Ministers determined to retain NHS Tayside's unit and Page 182	1 retained but built around that, was a sort of support 2 service which did a number of things, including 3 benchmarking and audit and that of thing. But it's 4 important, for our context, to understand that there 5 were live discussions in that four-year period at least 6 around whether the services could be retained. And 7 I think we won't look at it in detail, but there is 8 certainly evidence in some of these documents that the 9 questions were around largely whether the two smaller 10 centres could be retained, namely Dundee and Aberdeen, 11 or whether there could be some level of centralisation 12 of the service. I think also the possibility of having 13 a single unit based in Glasgow was discussed. Is that 14 broadly your understanding? 15 A. Yes, that's my understanding, yes. 16 Q. Given your experience of running the -- or being the 17 chief executive of the NHS in Scotland, are these sorts 18 of issues common, in the sense of the possibility that 19 there may need to be a re-organisation of services or 20 certain units may require to be shut down. And if 21 you've had experience of them, could you tell us what 22 your experiences of the way in which that can be 23 unsettling to the way that the service is provided? 24 A. Yes, so I think there are probably two aspects at play 25 here. So the first is where you're dealing with Page 184

1 a service that is -- has low volume in terms of patients 2 and there is, as you saw from the safe neurosurgery 3 report but it applies to some other specialties as well, 4 where there are relatively low volumes of patients 5 requiring to be dealt with, there is a recommended 6 number of procedures per year that clinicians need to be 7 doing. And I think the way I always express that is 8 I think if you and I were going into have a procedure 9 done, we would want somebody who was doing that 10 procedure regularly rather than somebody who was doing 11 it sort of very, very periodically. 12 And the way in which that has been addressed in 13 Scotland is two ways. So we have -- there are some 14 specialist services where there is only one centre in 15 Scotland, some of the transplant units would be 16 an example of that. Others where there are more than 17 one unit but we put in place the managed clinical 18 network arrangement around it. 19 I think that whenever there is any consideration of 20 changes to services, there are always concerns about 21 travel, about what that means for patients in terms of 22 accessing services, but there are also concerns from the 23 clinicians involved in relation to what that means for 24 them and their own service and also concerns about their 25 ability to attract trainees and indeed consultants if Page 185	1 level for the service to continue to be deemed to be 2 viable, is that right? 3 A. So I think, again, these are all nuanced in terms of 4 exactly what we're talking about here, but I think there 5 is well established evidence that services are safer and 6 provide higher quality when there is a volume going 7 through those services that enables all clinicians to 8 absolutely maintain their skills at the top of their 9 game. 10 THE CHAIR: So in the scenario you're describing with 11 a relatively small number of procedures, essentially 12 it's not a concern about a theatre being under used, 13 it's a concern about the services of the consultants 14 being under used, for the reasons you mentioned? 15 A. That's absolutely correct, yes. 16 MR DAWSON: Thank you. You've provided to us a lot of 17 information about the government's involvement with 18 Mr Eljamel over the years and I think you told us 19 earlier that the first time in which matters relating to 20 Mr Eljamel's practice appears to have come to the 21 attention of government was I think 19 December 2013, is 22 that right? 23 A. That's correct, yes. 24 Q. You also, helpfully, in response to a specific question 25 you were asked, provided us with some information about Page 187
1 they're not offering the full range of services. 2 So it is a difficult balance to achieve in terms of 3 being, you know, really clear about what's best in terms 4 of outcomes and balancing off those other factors. 5 I referred to two aspects because I think over the 6 last five, seven, eight years, Scotland has also, in 7 an area where there are high volumes, so you'll have 8 heard of our national treatment centres which are 9 focused on high throughput, for hips, knees, cataracts, 10 et cetera, and we had established -- Scotland has 11 established a number of national treatment centres and 12 the evidence emerging from the use of those centres is 13 that patients have expressed a willingness -- HIS did 14 some work to review patient experience around using them 15 and people were prepared to travel in terms of being 16 able to get their procedure more quickly. 17 So it is a really sensitive area and a difficult one 18 to strike the balance in. 19 Q. It seems to be multi-factorial, the decisions around 20 these things -- 21 A. It is. 22 Q. -- quite complicated. Did I understand you correctly to 23 say that one of the features that one would be looking 24 at, from a viability perspective, would be the number of 25 procedures being done would have to reach a certain Page 186	1 our question to do with whether Mr Eljamel had provided 2 an advisory service to the government at any stage. You 3 address this at paragraph 16 but I think, broadly 4 speaking, the answer was that you had managed to -- or 5 your colleagues had managed to ascertain that he had 6 played a minor role in contributing to certain 7 government projects. But I think the way you put it -- 8 it's at 16.4 -- is that the information that you have is 9 that the government is "not aware of Mr Eljamel acting 10 in any standalone advisory capacity". 11 So contributing to government projects or policy 12 development might be done by a very wide range of 13 different people. It might be, for example, that you 14 might be providing some statistics relating to our own 15 unit that would add to something. That, I think you're 16 trying to tell us, is quite different from being 17 a government advisor in any sort of formal sense? 18 A. Yes, that's absolutely the case. In terms of developing 19 any government policy document, there is generally 20 consultation with a very wide range of clinicians and 21 other interested parties. And that's very different to 22 actually being a standalone advisor. 23 Q. Understood. So if Mr Eljamel were to have claimed 24 anywhere that he was a government adviser, then that 25 would not be accurate, as far as the government is Page 188

1 concerned? 2 A. It wouldn't be accurate. 3 Q. Thank you. So you've told us about various aspects, if 4 we could look, please, page 17 of the statement. This 5 is where you've recreated a sort of timeline which 6 I think originally came from the opening statement that 7 the ministers provided to the Inquiry. If we just 8 scroll down a little bit, please. The 19 December date 9 is identified there. That was the first date on which 10 the Scottish Government became aware of things. I think 11 you tell us there that your understanding at the time 12 the statement was compiled, that that had been on the 13 basis of 55 patient complaints. This is one of the 14 areas I think where, going through the statement, you 15 realise that that might be inaccurate. What was the 16 actual position in that regard? 17 A. Yes, so my understanding from the documents provided in 18 evidence is that there had been four, four and then 19 eight. So -- sorry, three, three and then eight, so 20 15 complaints in total and that was three in, I think 21 2011, three in 2012, and then going up to eight in 2013. 22 I think the figure of 55 comes from a document from 23 NHS Tayside issued around about 2018. So that includes 24 complaints that had been received by NHS Tayside after 25 Mr Eljamel was suspended. Page 189	1 Royal College of Surgeons' report, in fact the numbers 2 were very slightly different from what you told us. It 3 was actually three in 2011, four in 2012 and by the time 4 that the report was commissioned, there had been eight 5 in 2013. So broadly 14, 15 seem to have been the 6 number. 7 But we've gone through, in this Inquiry, various 8 steps that were taken before this, including a complaint 9 being made by a patient of wrong-site surgery which, in 10 terms of the NHS Tayside procedures and guidance or 11 policy at the time, was what is called a never event, 12 something that should never happen. That happened 13 in December 2012. There was then a serious clinical 14 incident review that took place, which reported 15 in May 2013. There was then the Royal College of 16 Surgeons' invited review mechanism based on the 17 complaints, that I have said. That provided what we 18 understand was verbal feedback after a visit to Dundee 19 in September 2013. There was then an interim report 20 issued on 6 October 2013 and then the final report on 21 6 December. 22 My understanding, therefore from what you've told 23 us, is that none of that was intimated to government at 24 all? 25 A. That's correct, yes. Page 191
1 Q. So that number has just been imported from a different 2 place, effectively -- 3 A. (Overspeaking) It has and it's been picked up and then 4 carried through some of the -- 5 Q. (Overspeaking) Understood. So I think the information 6 that you had given us was that there were, by this time, 7 14 complaints in total? 8 A. Sorry, 14. 9 Q. In fact, we've been tracing this through other 10 mechanisms and one of the things we've been looking at, 11 which I think it's correct to say that the government 12 didn't appear to know about at the time -- please 13 correct me if I'm wrong -- was that there had been 14 an investigation through the Royal College of Surgeons' 15 invited review mechanism, which had taken place during 16 the course of 2013, and it was the culmination of that 17 reporting -- the date of the report was 18 6 December 2013 -- that the government was then told, on 19 19 December, that there were issues pertaining to 20 Mr Eljamel. Is that broadly your understanding? 21 A. That's correct and my understanding is that Scottish 22 Government was informed that Mr Eljamel had been 23 suspended and that that had happened prior to the 24 19 December. 25 Q. Indeed. I think, if I remember correctly, that in the Page 190	1 Q. And would that be the sort of thing that one would 2 expect to be intimated to government, given the 3 relationships that we've talked about already? 4 A. So certainly my experience over the last five and 5 a half years was that I would have been very surprised 6 if an invited review had been triggered without the 7 chief medical officer being advised that that was the 8 case. 9 Q. Right, and so it was for all the reasons we've discussed 10 before that the government would need to have certain 11 information, chief medical officer or perhaps others in 12 government, in order to work out whether this was the 13 sort of thing that they needed to get involved in and if 14 the information isn't provided, that function can't be 15 performed, is that right? 16 A. That's correct, yes. 17 Q. And just to be clear, in this sort of circumstance, we 18 talked about various different ways of information 19 coming to government, it would be most likely to be 20 through that medical director to chief medical officer 21 channel that one would expect this to be directed? 22 A. Yes, I would expect that to be the most likely route. 23 Q. I mean, it was the medical director that ordered the 24 invited review mechanism report, so he obviously knew 25 about it? Page 192

1 A. Yes. 2 Q. You've helpfully given us the correspondence relating to 3 this and have told us precisely how that was brought to 4 your attention and we have the documentation there. One 5 document that I'd like to look at, please, is SG-00155. 6 I think this is one where we need to go to the end of 7 the document and scroll back. So we have there, this is 8 an email dated 7 January 2014 which was sent by someone 9 on behalf of, I think it's Aileen Keel, is that right? 10 A. That's correct, yes. 11 Q. Who was Aileen Keel at this time in January 2014? 12 A. Aileen Keel was chief medical officer. That may have 13 been in an acting capacity. 14 Q. Okay, and this is an email being sent to someone, 15 I think, called John Connaghan, is that right? 16 A. Yes. 17 Q. And who was John Connaghan at this time? 18 A. So at that point, John Connaghan was probably director 19 of performance. 20 Q. Right, so this is a communication between the medical 21 officer side to someone working within the civil service 22 within the healthcare sphere, is that right? 23 A. That's correct, yes. 24 Q. Thank you. And so, on behalf of Dr Keel, it says: 25 "John. Page 193	1 Royal College of Surgeons. 2 Q. So that might be something that Dr Keel or Mr Connaghan 3 would be able to help us with in more detail as to what 4 they were talking about there? 5 A. Yes. 6 Q. We'll read on. It gives us more information: 7 "There are clearly wider implications from all of 8 this not least the TTG for spinal surgery, which as you 9 are aware has been extended to April 2014." 10 Could you help us with "TTG"? 11 A. Yes, TTG is the treatment time guarantee. 12 Q. Yes. So what Dr Keel, I think, is saying there is there 13 are certain guarantees which I think are in accordance 14 with the government policy, to try to get people 15 treatment within a certain prescribed time. And the 16 fact that a neurosurgeon is now going to be missing from 17 the service is going to cause pressure with regard to 18 those being met, is that right? 19 A. Yes, my understanding would be that the reason that 20 Aileen Keel was sending this to John Connaghan was in 21 John's role because, as director of performance, he 22 would be overall responsible for working with boards to 23 ensure that the TTG could be met. 24 Q. Understood: 25 "In terms of more local management, the Board are in Page 195
1 "I have just taken a call from Andy Russell in 2 Tayside about the suspension of a Neurosurgeon, Sam 3 Eljamel, over mismanaged spinal surgery operations. 4 I was aware of this issue through the Neurosurgery MSN, 5 but the detail only emerged in this morning's 6 conversation. 7 "In October 2013 two patients (1 a GP) on whom 8 Mr Eljamel had undertaken back surgery lodged 9 a complaint. A Significant Clinical Event Analysis ... 10 was undertaken jointly by the Medical Director and 11 Director of Nursing, and was followed by an assessment 12 by the Royal College of Surgeons of Edinburgh. This 13 identified 6 cases of 'wrong level' surgery (i.e. the 14 operation conducted at the wrong vertebral level), and 15 Mr Eljamel was suspended. 16 "There are additional potential probity issues 17 relating to Mr Eljamel, and a background of 18 neurosurgical team dysfunctionality. The RCSE report 19 has gone to the GMC." 20 There's reference there to there being background of 21 a neurosurgical team dysfunctionality. We'll read on 22 again in a moment because there is more information, but 23 is that something that you were able to glean any more 24 information about? 25 A. Not other than what I have read in the report from the Page 194	1 the process of undertaking a case note review of all 2 relevant patients. Of 150 in total 100 have been 3 reviewed to date and no additional 'wrong level' cases 4 have emerged. They are therefore reasonably confident 5 that this will be the final number. In terms of the 6 6 patients identified, 1 operation was undertaken in the 7 private sector and Fernbrae are investigating. Another 8 (elderly male) patient had revision surgery, developed 9 bronchopneumonia and died as a result. The Board has 10 been in close contact with the two original complainants 11 and the private sector patient for some months now. The 12 remaining two are meeting the Board this afternoon. 13 Dr Russell feels that the story is unlikely to be put 14 into the public domain at this stage, but clearly there 15 must be some risk of that happening. The Board have 16 developed reactive lines which they will share with 17 Comms Healthier today. 18 "Given the long-standing dysfunctionality in the 19 neurosurgical team, I suggested to Dr Russell that 20 concerns about Mr Eljamel might have been picked up 21 earlier, e.g. through the appraisal/revalidation process. 22 He agreed that this would need to be further 23 investigated at Board level. 24 "Suggest the following reactive line to take in the 25 event of Media queries ..." Page 196

1 And it goes on to set out the position of the 2 government in that regard. So again, it appears to have 3 been Dr Keel's reaction -- well, she seems to have been 4 aware of some level of existing dysfunctionality within 5 the neurosurgical team and therefore there had been some 6 suggestion this might have been picked up earlier. 7 Again, is that something that we have any more 8 information about in order to try to understand the 9 connection of the two, or would that be something we 10 would need to seek more detail about from others? 11 A. So I don't have any further information to add to that 12 and I haven't seen anything in the documents that I have 13 reviewed, but Aileen Keel may be able to help with you 14 that. 15 Q. Thank you very much. 16 THE CHAIR: Could I just ask a question which may result in 17 the same answer, Ms Lamb, but could we scroll back to 18 the first paragraph of that email, please? I noticed, 19 as that was read out that, there's a reference to 20 Ms Keel having become aware of this issue through the 21 neurosurgery MSN and I'm trying to understand the 22 context in which that might have happened and whether 23 one can draw any conclusions as to when that information 24 might have come her way and, if so, how. Now, obviously 25 I caveat by saying you're likely to say "I don't know", Page 197	1 A. So my understanding is that, having been informed of 2 a suspension, Scottish Government required reporting in 3 terms of how that suspension was being managed and 4 whether somebody was still suspended or what -- so my 5 understanding is that that's the mechanism by which we 6 would have been informed of his intention to retire. 7 I am not aware that we were informed of any pause or 8 stop to any internal investigation by NHS Tayside or 9 indeed any others at that point. 10 Q. I see, so it was connected with the ongoing monitoring 11 of the suspension which, logically, would come to an end 12 if he ceased working there and was going to require? 13 A. That's correct. 14 Q. I see, but the reporting around the ongoing 15 investigation was not something that featured in the 16 correspondence you have seen? 17 A. Not that I'm aware of. 18 Q. It certainly seemed to be something that was of interest 19 to Dr Keel in the email to Mr Connaghan and therefore, 20 would it be the sort of thing that, given its wider 21 responsibilities for healthcare in particular in this 22 apparently serious situation, the Scottish Government 23 would expect to have been kept apprised of? 24 A. I'm not sure that the Scottish Government would 25 necessarily have been expected to be kept apprised of Page 199
1 but is there an issue to be explored there? 2 A. So I don't know, I could only speculate. But the 3 managed service networks do have a reporting line into 4 the chief medical officer. So that -- but I think you 5 would have to ask Aileen Keel for the detail of that. 6 THE CHAIR: All right. 7 MR DAWSON: Thank you, sir. 8 If we could go back, then, to the statement, please, 9 page 17. A bit further down, thank you. You then take 10 us to 24 April, where another event, based on the 11 information that you have: 12 "The Scottish Government was informed that 13 Mr Eljamel had indicated his intention to retire on 14 31 May 2014. He also resigned as a member of the 15 General Medical Council ... at the end of the May 2014." 16 Now, I think there was indication there that was 17 communication that came to the Scottish Government 18 saying that there had been an indication of his 19 intention to retire. The email that we just looked at 20 suggests that there was some ongoing investigation into 21 matters more widely. Did the information that you have, 22 suggest that it had been intimated to the Scottish 23 Government by that time that NHS Tayside had decided to 24 stop the investigation that it was doing in connection 25 with Mr Eljamel's practice? Page 198	1 all the details. And indeed, there will be 2 confidentiality issues around that as well. But I'm not 3 aware that Scottish Government was made aware that 4 actually the investigation was not going forward. 5 Q. Okay. And I think you indicate there that it was being 6 suggested that he resigned as a member of the General 7 Medical Council at the end of May 2014. Now, I don't 8 think that -- effectively, if that's he referring to him 9 having his name removed from the medical register, we 10 understand that that, in fact, took place in 2015 and 11 that he resigned from his post effective from the end 12 of May 2014. But did the correspondence there suggest 13 that it was indicated that he was going to have his name 14 removed from the General Medical Council medical 15 register in 2014? 16 A. No, I don't think the correspondence did indicate that. 17 Q. No, so, in fact, perhaps was it actually talking about 18 his resignation from his role? 19 A. I think that's correct. 20 Q. Thank you, that's fine. There was, in fact, 21 an application around that time for him to have his name 22 removed voluntarily but that was refused and there was 23 a later application the following year. Could I have a 24 look please in the statement at paragraph 5.25, at 25 page 12, just while we're on the General Medical Page 200

1 Council. One thing that you mention there is that 2 there's no reciprocal -- this is do with the 3 relationship of government and the GMC. You tell us 4 there, that, at 5.24: 5 "It is for the GMC, as the independent statutory 6 regulator of the medical profession in the UK, to 7 determine how it meets its obligations in the exercise 8 of these powers." 9 And you tell us that, in that regard: 10 "The General Medical Council ... is independent of 11 the Scottish Government [and] has a statutory duty ... 12 to notify the Scottish Ministers that it is 13 investigation a registrant's fitness to practise." 14 You tell us that: 15 "There is no reciprocal operational duty placed upon 16 the Scottish Ministers to share [any] clinical 17 information with the GMC, albeit the GMC does have power 18 to require 'any person' to provide it with information 19 to assist with their investigations." 20 When you say there's no reciprocal duty, are you 21 just contrasting that with the fact that there's 22 a statutory duty on the GMC the other way round? 23 Because presumably, given its healthcare 24 responsibilities, if, for some reason, something of 25 concern about a doctor came to the Scottish Ministers' Page 201	1 government would do so? 2 A. Yes. 3 Q. Understood. You tell us, again, if we go back to 17, 4 please, in your helpful summary of the key events, you 5 tell us that there were other events. Go back to 17, 6 please. In particular, between 2014 and 2017, the 7 government was being sent a large amount of 8 correspondence by a particular patient. That was from 9 2014, was it, that that started? 10 A. So that is my understanding but I haven't been able to 11 identify, from Scottish Government records, the precise 12 number, date and our response to it. 13 Q. Okay, but in effect what happens after, there is 14 a sustained period in which a number -- really two main 15 prominent campaigners, I think. At this stage we're 16 talking about Mr Kelly and later on Ms Rose, are in 17 correspondence with government about various aspects of 18 things relating to their own individual situations but 19 wider concerns about the service and it appears that 20 that started, at least for Mr Kelly, in 2014; is that 21 your understanding? 22 A. That's correct. 23 Q. You tell us then, on 1 December 2016, that: 24 "The then Chief Medical Officer (Dr ... Calderwood) 25 met with the General Medical Council to discuss the Page 203
1 attention and it hadn't gone through other channels -- 2 which might seem unlikely, but there are reporting 3 mechanisms that come direct to government -- the 4 Scottish Ministers would, in practice, tell the GMC 5 about that, would they not? 6 A. So, yes, I think that this is -- this is about 7 contrasting and explaining that there isn't a reciprocal 8 duty. However, it would be extremely unusual for 9 Scottish Ministers to have clinical information and -- 10 but yes, in extremis, if there was a situation where 11 Scottish Ministers felt that there was information that 12 was available to them that hadn't been made available to 13 the GMC, then Scottish Ministers would have the power to 14 alert the GMC. 15 Q. Understood, but I think you're trying to contrast 16 that -- everyone would be working reciprocally in the 17 healthcare space, but as I think you say, it would be 18 very unlikely that this would come to the government's 19 attention, for example that a health board or 20 a responsible officer didn't know about it already, such 21 that the government would, in practice, rarely be 22 required to do that and you're just telling us there's 23 not a statutory duty there? 24 A. That's correct. 25 Q. But in extremis, as you say, they would do so, the Page 202	1 frustrations felt by former patients that Mr Eljamel had 2 been able to voluntarily remove himself from the 3 register prior to the conclusion of a fitness to 4 practise investigation." 5 Was it your understanding that there were concerns 6 being raised around that time by patients in 2016 that 7 that was not the correct process to have been followed 8 in Mr Eljamel's case, as far as the patients were 9 concerned, and that that then gave rise to concerns 10 about the possibility he would be able to practice 11 medicine elsewhere? 12 A. Yes, so my understanding from this is that the 13 correspondence that we had from patients would raise 14 a number of issues and, as I've explained earlier, quite 15 often those are for the health board concerned to 16 answer. But if there are areas of broader relevance, 17 then we would seek to do -- in this case, the chief 18 medical officer -- there is a correction to the date. 19 I know that's an administrative one, but -- 20 Q. It's okay. I think it's perhaps 7 October that should 21 be; is that right? 22 A. That's correct, yes. 23 Q. I was wondering, in this capacity, the chief medical 24 officer was raising this with the GMC. There are 25 various different aspects that she might have been Page 204

1 raising at this time, but given that context, there 2 might have been a suggestion that the GMC's course in 3 allowing him voluntarily to remove his name is something 4 that perhaps shouldn't have happened. Given that 5 healthcare regulation is a reserved matter, would that 6 technically be a matter that would have to be taken up 7 by the UK Government; is that correct? 8 A. Yes, that's correct. Healthcare regulation is reserved. 9 My understanding is that the CMO would have raised that 10 with the GMC as a concern, as something that the GMC may 11 want to consider. 12 Q. Thank you. You then tell us that on 5 September 2018, 13 the then Cabinet Secretary, Jeane Freeman, engaged in 14 some correspondence -- which you've helpfully sent us -- 15 with health boards, seeking some reassurances around 16 aspects of healthcare and that that action had been 17 prompted by something to do with the Eljamel affair. Is 18 that right? 19 A. That's my understanding, yes. 20 Q. And so I think what had happened is that there had been 21 a television documentary about Mr Eljamel and that this 22 is one of these means by which something might come to 23 the attention of a minister and it catch their 24 attention. And Ms Freeman's response to this, I think, 25 was to write to the health boards in order to try to Page 205	1 A. That is correct, yes. 2 Q. One interesting component of that -- and this changes, 3 as you've already alluded to -- later, is that her 4 reaction was to use the information she had about the 5 Eljamel affair to prompt action within the boards and 6 their systems rather than, it would appear at this time, 7 in doing something connected to investigations about 8 Mr Eljamel per se. Am I correct in that understanding? 9 A. Yes, although I believe she did, at the same time, ask 10 the chief medical officer for a briefing on the 11 particular circumstances around Eljamel and NHS Tayside. 12 Q. Indeed. Because around about this time, I think my 13 understanding is, separately from Ms Freeman's interest, 14 the ongoing correspondence by Mr Kelly and Mrs Rose, 15 there was, in fact, a further review into 16 Eljamel-related matters instigated by NHS Tayside. But 17 my understanding from the paperwork -- and please, again 18 correct me if I'm wrong -- that's not something 19 government were aware of happening? 20 A. That's correct, I presume you're referring to the review 21 that Tracey Gillies carried out? 22 Q. That's correct, the Gillies report. 23 A. Yes. 24 Q. So I think you tell us in the statement that, in fact, 25 the fact that the Gillies report had been commissioned Page 207
1 ascertain what systems they had in place for the proper 2 clinical governance and supervision of this type of 3 situation, is that right? 4 A. Yes, that's right. She wrote to health boards and she 5 also -- it's covered later, she also looked to set up 6 an event to share good practice. 7 Q. Indeed. But just at this stage, in 2018, you've again 8 helpfully given us the correspondence which is still 9 there, but her reaction though situation was, I'm kind 10 of imagining that what this did was to make her think: 11 hmm, this is an interesting situation that's caught my 12 attention, I wonder if that's going on elsewhere. And 13 she then approached the health boards for information 14 and reassurance that the systems were robust to 15 pre-event this sort of thing happened; is that broadly 16 what happened? 17 A. That's correct. 18 Q. And I think there was a meeting took place at which 19 there was a discussion about the policies and the 20 various different health boards and the culmination of 21 that was, I think, that she indicated to the health 22 boards that effectively these systems needed to be paid 23 attention to and indeed, there should be better sharing 24 of information between the health boards about how they 25 went about this sort of thing. Page 206	1 and undertaken in 2018-19, so around about this period 2 where Ms Freeman has an interest in matters, was 3 something that only came to the government's attention 4 as part of a later review that Ms Freeman instigated; is 5 that right? 6 A. That's correct. 7 Q. Again, it seems perhaps ironic that in circumstances 8 where Ms Freeman was getting involved in a situation 9 where she was discussing the arrangements for clinical 10 governance and supervision, she was encouraging health 11 boards to share information about it, that there was, in 12 fact, in relation to the very matter that had instigated 13 that process, a kind of sharing going on between two 14 different health boards, because Ms Gillies had been 15 asked to do this in her capacity as the chief medical 16 officer of NHS Lothian. Again, in those circumstances, 17 in particular where there had been an interest shown by 18 the minister in these matters, is it unusual that the 19 fact that that was happening wouldn't have been 20 intimated to the minister or to the government? 21 A. So, yes, I would say, based on my experience, in the 22 role -- and this pre-dates that -- but it would be 23 unusual for a health board to be taking steps to 24 understand a situation that had resolved and for them 25 not to share that with officials and indeed, with Page 208

1 ministers. 2 Q. Thank you. You tell us about this in detail and indeed 3 provide us with correspondence and a copy of the report, 4 Ms Freeman did, in fact, instigate a further 5 investigation herself. And that is what led to the 6 "Review of Unresolved and Outstanding Concerns regarding 7 Mr Eljamel", which I think was commissioned in 2021 but 8 the report was published in 2022, is that right? 9 A. That's correct, yes. 10 Q. Now, one aspect of this investigation is that it's 11 slightly difficult, in the Inquiry's interpretation of 12 events, to try to understand why it is and how it is 13 that that report was commissioned. In particular 14 because -- and one can see the terms of reference that 15 were agreed with Mrs Rose and Mr Kelly -- that their own 16 individual circumstances were very much bound up with 17 whatever review was going on at the time. Would it be 18 fair to interpret what was happening there as being, 19 first and foremost, an investigation into matters 20 relating to the individual cases of those two patients, 21 which was not primarily focused on wider, systemic 22 matters? 23 A. So I think that actually, the work Ms Freeman 24 commissioned was intended to cover both areas. So she 25 commissioned this having met with MSPs and having met Page 209	1 access to a number of documents from NHS Tayside, 2 including the Gillies report, the Royal College of 3 Surgeons' report, an analysis of complaints, and other 4 areas. So he had the submissions from and the 5 discussions with the two patients, the clinical 6 case notes review, but also a bundle of documents from 7 NHS Tayside. 8 Q. Okay. I think that's fair that there were other 9 documents made available to him, but they largely appear 10 to be the other reports. So therefore, what he's really 11 doing in trying to do this, he's not undertaking a wider 12 investigation of materials. He's gone to NHS Tayside, 13 he's obviously asked them: so what is this all about, 14 there are wider issues, what sort of things have you 15 managed to do? And he's provided then with other 16 reports and then he's able to comment on the content of 17 those other reports. But there doesn't appear to be 18 a wider investigation into matters which would involve 19 him actually having access to a wider range of material. 20 Is that fair? 21 A. That's fair. 22 Q. Yes. So it's limited in that sense, but there may have 23 been reasons as to why it was limited in that sense. 24 And it is correct to say that, at least the government's 25 position, is that there was an attempt to try to agree Page 211
1 with both Mr Kelly and Mrs Rose as well. And I think 2 she was keen to understand the full picture of what 3 those unresolved complaints and concerns were. So she 4 was keen to facilitate the two individuals getting 5 a better understanding of exactly what had happened in 6 their own cases, which is why the consultant 7 neurosurgeons reports were commission, but at the same 8 time, she asked Craig White to perform a review of the 9 response of NHS Tayside. 10 Q. As I understand it from the report -- in commissioning 11 Professor White, I think, to take the lead, I think, in 12 relation to this, my understanding is that the material 13 he had available to him, other than the access that the 14 patients had granted to their case notes for their 15 individual cases to be reviewed by the independent 16 neurosurgeons, was really just a bundle of papers that 17 the patients themselves had been able to put together 18 and that there didn't appear to be any wider 19 investigation into matters at that stage, other than 20 speaking with NHS Tayside and trying to understand their 21 position. Is that an accurate representation or was 22 there some wider review of material that isn't apparent 23 on the face of report? 24 A. So there was -- my understanding -- and I think it's 25 covered in my statement was that Craig White also had Page 210	1 with Mr Kelly and Mrs Rose, who had been the ones who 2 were at the forefront of trying to speak to government 3 about all of the things they were concerned about, there 4 was an attempt, as I understand it, to agree with them 5 a list of the things that they consider to be unresolved 6 concerns, is that right? 7 A. Yes, that is correct. 8 Q. I think also that, actually the report also narrates 9 that there were a number of aspects of the way that 10 things had been done that the patients were not 11 satisfied with. So it rather suggested that, although 12 its ambition had been to deal with unresolved concerns, 13 that perhaps it had not managed to meet its objective; 14 would that be fair? 15 A. Yes, I think that's correct. 16 Q. Thank you. One aspect of the report that I'd just like 17 to look at, please, just give me a second. If I could 18 look at the report at SG-00008, page 12, please. There 19 are some conclusions expressed here, I think within the 20 limitations of what Professor White was able to do, or 21 in fact, did. He says, at 49: 22 "NHS Tayside identified that there were several 23 areas in which their clinical governance processes were 24 not as effectively implemented they could have been. 25 These were identified and actioned internally and Page 212

1 outlined in NHS Tayside's response to the Scottish 2 Government in 2018." 3 In that regard, that appears to be reflecting, in 4 many ways, things that had been reflected on by 5 NHS Tayside arising, I think, from the conversation 6 Professor White had had with them, rather than any 7 independent assessment himself of whether what had 8 happened was correct or not, is that right? 9 A. Yes, that is correct. 10 Q. But in the next paragraph, there does appear to be 11 an indication of a view, which is: 12 "NHS Tayside acted reasonably in requesting 13 an external review by the Royal College of Surgeons. 14 They also took proportionate action when initial 15 concerns and complaints were raised in relation to 16 Professor Eljamel, though the effectiveness of this 17 process was weakened by the clinical governance process 18 deficiencies some of which were recognised by 19 NHS Tayside. They did not consider involvement of 20 support from Healthcare Improvement Scotland beyond the 21 existing engagement in national programmes of work 22 focused on the issues raised, including the national 23 openness and learning work commissioned following the 24 Scottish Government's engagement event relating to 25 learning following the issues raised by Page 213	1 government-related thing and it is of relevance to us. 2 Page 16, please, at paragraph 70. As I say, I think 3 there are a number of areas here where the individuals, 4 Mr Kelly and Mrs Rose's dissatisfaction with the outcome 5 of their individual views are highlighted. I won't go 6 into those just now but I'm sure we'll return to them on 7 another day. There are some recommended actions 8 reflective actions of government here, one of which is 9 that government should: 10 "Develop a process for the commissioning independent 11 clinical reviews that is standardised across the DG 12 Health and Social Care and is available for officials to 13 implement against agreed timescales and to take account 14 of specific issues arising in procuring independent 15 clinical advice." 16 Is this Professor White, because he's commissioned 17 the two independent clinical reviews for Mr Kelly and 18 Mrs Rose, is this him reflectively sitting down 19 afterwards and thinking: that could have worked better, 20 we should actually probably have a more standardised 21 procedure as to how we go about these things? Is that 22 what he's saying? 23 A. Yes, I think Professor White had identified that the 24 standard methodology, the standard terms and conditions 25 which Scottish Government uses to procure services, is Page 215
1 Professor Eljamel's practice." 2 So it did appear to be a judgment of his that they 3 took proportionate action when initial concerns and 4 complaints were raised and in relation to the external 5 review, that they acted reasonably in requesting 6 an external review by the Royal College of Surgeons. 7 So those do appear to be, if I read it correctly, 8 conclusions that he's reached. 9 It, I think, would be difficult for him properly to 10 have reached those conclusions based on the limitations 11 of the information he had available to him. In 12 particular, as I think we've discussed, that there were 13 matters that were, on one interpretation certainly, 14 should have resulted in more precipitative action in 15 relation to Mr Eljamel much earlier than was actually 16 taken in December 2013 and that, although requesting 17 an external review by the Royal College of Surgeons may 18 be a useful thing to do, there's no mention here of what 19 was done to protect patients in those circumstances. 20 Would it be fair to view this as an attempt to try and 21 summarise the position, but one which really absent 22 a much fuller investigation, perhaps should not have 23 reached these particular conclusions? 24 A. Yeah, I think that's fair comment. 25 Q. One aspect I'd just like to ask you which is a more Page 214	1 not particularly well suited to procuring the services 2 of clinicians to carry out this sort of work. And as 3 a result of that, there was work that took place in the 4 DG to work with procurement colleagues in Scottish 5 Government to actually agree a different process. 6 Q. Right, so that did happen then afterwards? 7 A. Yes. 8 Q. And did that relate to the specific matter about the way 9 in which people procured services? The reason 10 I'm interested in this, to be clear is, obviously 11 subsequent to this you've set out in great detail in the 12 report there were various considerations about various 13 different options with regard to further enquiry when 14 calls for a public inquiry started to be strengthened 15 and you've told us about the various different 16 considerations. 17 What we ended up with was this Public Inquiry and 18 a parallel process which might be deemed to be -- it is 19 in fact called the Independent Clinical Review, which is 20 a much bigger project, involving lots -- well, 21 effectively, an open-ended invitation to former patients 22 of Mr Eljamel to seek an independent, individualised 23 clinical review. And I'm wondering whether the 24 suggestion of Professor White at this stage was taken 25 far enough with regard to considering how the government Page 216

1 would go about setting up an independent clinical 2 review, like the one that exists currently? 3 A. So I don't think it was the intention -- I don't think 4 that the intention of Craig White was to think that far 5 ahead. I think what he was reflecting on was some of 6 the challenges that he'd experienced in terms of trying 7 to identify clinicians to do this work. 8 Q. I see, there was a more limited concern. Because in 9 relation to the eventual decision to set up two 10 processes that was taken by the minister in 2023, there 11 are a number of issues, some of which have been 12 encountered in our partnership with the Independent 13 Clinical Review, which might tend to suggest that the 14 process of setting up a review like that perhaps wasn't 15 fully thought through. 16 One example that I might be able to give, or maybe 17 two examples. My understanding, from the documentation 18 that's been provided, is that the expectation of the 19 then minister, Mr Matheson at that stage and his 20 advisors, was that in order -- there was a separation in 21 thinking between what a public inquiry would do and what 22 a set of independent clinical reviews would do and my 23 understanding of his rationale was that he felt, on 24 advice no doubt, that there was a place for a public 25 inquiry into the wider systemic issues, which is what Page 217	1 existing systems one can draw upon but there are also 2 statutory powers and regulations within which one works 3 and there are, importantly, statutory powers given to 4 the chair of an inquiry so that he can go about doing 5 his work in the way that he sees fit. 6 No such powers exist within the Independent Clinical 7 Review; is that your understanding? 8 A. Yes, that's my understanding. 9 Q. Therefore, I'm wondering whether there was consideration 10 in the way in which the Independent Clinical Review was 11 set up as to whether its lack of statutory framework and 12 powers would, in fact, inhibit the way in which it was, 13 in principle, intended to work? 14 A. So I think that at the time all of this was being 15 discussed, ministers were clear that they wanted to 16 achieve two outcomes; that they wanted individual 17 patients to have the opportunity to have their cases 18 examined by an independent expert and they wanted 19 a public inquiry -- and they wanted the systematic 20 issues around clinical governance and NHS Tayside's 21 response to be properly examined as well. And it may 22 well be the case that there was not sufficient thought 23 given to how those two things would interact. I'm not 24 sure whether there is experience in Scotland, or indeed 25 elsewhere in the UK, of trying to run those two things Page 219
1 we're looking at right now, but there was also a place 2 for individualised reviews for patients who'd expressed 3 what he considered a legitimate need for that. Is that 4 broadly the thinking? 5 A. Yes. 6 Q. In doing so, my understanding is that what was 7 anticipated was that the independent clinical review 8 would be able to take place and be concluded before the 9 public inquiry effectively got up and running because, 10 based on previous experience, Mr Matheson and others 11 within government knew full well that to set up a public 12 inquiry and all its apparatus takes a certain amount of 13 time. Was that, in terms of the timeframe and what 14 would happen in what order, the expectation as to what 15 would happen with the Independent Clinical Review? 16 A. So I'm not absolutely certain that that was laid out 17 from the start, but I am sure that ministers would have 18 felt it would be helpful to the Public Inquiry to have 19 that detail around the Independent Clinical Review. 20 Q. Okay, because there are, of course, a number of issues 21 that might have occurred to people about the Independent 22 Clinical Review that, if I may say so, appear not to 23 have done. For example, when one sets up a public 24 inquiry, there is an entire statutory apparatus within 25 which the inquiry works. Therefore, not only are there Page 218	1 alongside. 2 Q. Indeed. I'm interested -- I know, as we discussed at 3 the beginning, Ms Lamb, you're helpfully trying to 4 provide an overview based on your prior position as to 5 what happened here. At this point in the timeline, 6 frankly, things do get quite a lot more detailed. And 7 you've provided with us a lot of information about the 8 government's thinking, the ministers' thinking, there's 9 different ministers, in fact, in relation to a public 10 inquiry. And indeed, there's specific details of 11 discussions and mechanics and things going on behind the 12 scenes, things going on with patients, developments and 13 that sort of thing. I take it to be the case that those 14 details would be best discussed with other people that 15 were actually dealing with this on the ground. Would 16 that be the right assumption? Because I think it might 17 be difficult if we were to get into the details. 18 There's also the lateness of the hour, but if we were to 19 get into the details, it looks to me, from some of the 20 correspondence, that there were other officials -- 21 colleagues of yours, no doubt -- who were involved in 22 making decisions around this, and that it might be the 23 sort of thing that we would take forward with them in 24 a more detailed discussion at a later date, which we 25 would be perfectly happy to do? Page 220

1 A. Yes, I think that would be helpful. I think from my 2 perspective what I was able identify was that ministers 3 wanted to take that twin-track approach, if you like. 4 They wanted to have a way of resolving individual 5 patients' concerns about their clinical treatment and 6 understanding what had happened and they also wanted to 7 look at the systematic issues. And they were also very 8 much taking into account, in their considerations of the 9 best approach to that, the length of time that it would 10 take, and also the fact that the one person who I think 11 everybody would wish to see answers from, Mr Eljamel 12 himself, was unlikely to be -- was not going to be able 13 to be forced to appear under any structure. 14 Q. Yes, so these were the considerations around the various 15 different options that you've sent us, that there are 16 guidelines relating to the processes, one needs to think 17 about the pros and cons of the various different 18 options. You tell us that although we ended up with 19 an independent clinical review and a public inquiry 20 eventually, there had been consideration given to 21 something else, which you called an independent 22 commission, which I think was kind of running the two 23 processes together, as I understand it? 24 A. Correct. 25 Q. And I think ultimately that was rejected as it would be Page 221	1 cohort of people and I think the correspondence and the 2 minutes and things show that there was an increasing 3 momentum, if I could put it that way, in particular 4 political support from members of the Scottish 5 Parliament, around the need for this particular group to 6 have a particular inquiry in relation to the matters 7 that related to them, rather than the balance being 8 offset by more general public considerations. Is that 9 the way in which things evolved? 10 A. Yes, absolutely. I think that ministers were always 11 probably primarily concerned with the individuals 12 getting answers. 13 Q. Right. One other aspect of the thought process, 14 something quite important happened shortly before 15 Mr Matheson announced the Inquiry on 7 September 2023, 16 which was the publication in the month before of the due 17 diligence report which came from NHS Tayside. So it 18 looked at various matters. We looked in some detail 19 with the executive medical director at the contents of 20 that report yesterday. Overall, one of the aspects of 21 the evidence, again, at quite a high level that you've 22 been able to provide to us, it's quite difficult to 23 understand what it was about the due diligence report 24 that pushed Mr Matheson in the direction of a public 25 inquiry and an independent clinical review. Page 223
1 too confusing as to which function each one was to 2 serve. But at that sort of high level, the process of 3 the thought that was gone through was to try to weigh 4 up, I suppose in the public interest, what advantages 5 there would be of having these investigations and 6 investing the time and money in them, is that basically 7 the process that's going on? 8 A. That's correct, yes. 9 Q. Because one aspect that one can see, without getting 10 into too much of the detail, it's a sort of high-level 11 consideration that one sees, is one of the matters that 12 definitely appears to be part of thinking is to do with 13 the fact there was a possibility that this Inquiry would 14 end up looking at matters which had been covered by 15 other public inquiries and that there may not, 16 therefore, be the public interest in repeating the same 17 material, if I could put it that way? 18 A. Yes, so there was definitely a concern that, given other 19 inquiries such as the Infected Blood Inquiry as 20 an example, that yes, there could be duplication of 21 approach. 22 Q. Indeed. One other aspect of the thinking which appeared 23 to be important -- because against that, of course, one 24 would balance the need that it's not just in the 25 interests of all the public, but there's a particular Page 222	1 He makes it quite clear in his parliamentary 2 statement that it was the due diligence report, although 3 of course there had been this momentum in the background 4 that finally made him make up his mind there should be 5 a public inquiry and an independent clinical review. 6 However, the testimony that you have given on behalf of 7 the Scottish Government in the statement tends to imply 8 that there were certain things within the review that 9 had come to the government's attention that they didn't 10 already know about, related to the Eljamel affair. 11 It's been quite difficult to identify what those new 12 pieces of information might have been that the 13 government was not already aware of and I wondered if 14 you could help us with broadly trying to identify what 15 they were? 16 A. Yes, so I think broadly, the areas that ministers felt 17 that government was not properly informed about, one was 18 around the processes for supervising Mr Eljamel during 19 the period from when the RCS, Royal College of 20 Surgeons', invited review was initiated. I think 21 Professor White in his report points to the fact that 22 those supervision arrangements may have been inadequate 23 and then in the due diligence report Tayside confirmed 24 that those arrangements were not adequate. 25 I think the second was that NHS Tayside had not Page 224

1 responded to a process by which they could have 2 prevented Mr Eljamel from getting voluntarily erased 3 from the register. 4 The report drew attention to the fact that the board 5 hadn't been sort of up the centre of the responses to 6 previous reports and that there were things in previous 7 reports that hadn't been responded to. 8 There may have been other things as well but that's 9 off the top of my head. 10 Q. That's a helpful list of things. One might say that 11 some of those things had either been ventilated before 12 or indeed resolved before but that some of them do 13 appear to be new, at least as far as the government's 14 understanding was concerned. 15 One aspect that you do tell us about in the 16 statement I think was related to the suggestion that the 17 government's role in the whole Eljamel affair should be 18 subjected to scrutiny in a public inquiry as well. Was 19 that what you told us, that that was part of the 20 thinking? 21 A. So I think that that was part of ministers and I think 22 ministers have been clear that they will be keen to hear 23 the outcomes of this Inquiry and indeed the learning 24 that develops as you go through the process of the 25 Inquiry. Page 225	1 Q. I'm trying not to get too much involved in the detail 2 and go beyond what you have told us, because having seen 3 some of the documentation there are lots of details 4 here. But I'm just sticking to what it is that you've 5 been able to tell us at that relatively high level. 6 MR DAWSON: Sir, those are my questions for Ms Lamb. 7 As I've indicated there are a number matters of 8 detail and indeed a number of matters of detail that 9 have been raised with us by core participants but 10 my intention would be to suggest that those be matters 11 that are taken forward with others, given the fact that 12 Ms Lamb has helpfully helped us at a certain level but 13 those matters would be difficult I think for her to 14 answer productively. 15 THE CHAIR: Very well. 16 MR DAWSON: Ms Lamb, those are my questions but at this 17 stage I offer all of the witnesses the opportunity to 18 say what they would like in addition to their evidence, 19 so I invite you to do that. 20 A. Thank you very much. So I find myself in an interesting 21 position because I don't think I can say that I'm here 22 speaking on behalf of Scottish Government any longer, as 23 I've retired. However, I would like to offer my 24 sympathy to all the patients and the families who have 25 been affected by the actions of Mr Eljamel. And I know Page 227
1 Q. But the specific issue of whether the government's role 2 in the whole saga should be subject to scrutiny itself, 3 was that part of the thinking? Was that part of what 4 was expected would be part of this Inquiry? 5 A. I would need to go back and just check the documents to 6 see what was advised at what point. 7 Q. Just to be clear, my understanding is that in the 8 statement what you say is that the thinking was that 9 that would be part of it. 10 A. Yes. 11 Q. But that wasn't part of the way in which it was proposed 12 that this Inquiry would be set up when the Inquiry 13 started to effectively regulate its own Terms of 14 Reference. It wasn't part of it and it was something 15 that was added in to the process. So that would tend to 16 suggest that the scrutiny of the government's role 17 itself was not something that was part of the 18 government's thinking as to what would be part of the 19 process. In fact that arose from a public consultation 20 exercise that the Inquiry itself undertook. So if 21 I'm right in that, that would tend to suggested, would 22 it not, that the government suggesting it itself should 23 be scrutinised was not part of its thinking at the time? 24 A. So if you're correct in that, that would appear to be 25 the case. Page 226	1 that my colleagues in Scottish Government, and 2 particularly Christine McLoughlin who has taken over the 3 role that I previously held, will be watching the 4 progress of this Inquiry and will be looking to take 5 learning and implement changes that might result from 6 that. 7 MR DAWSON: Thank you. 8 THE CHAIR: Thank you very much. Ms Lamb, we take a break 9 at this point, a short break. The purpose of that is 10 just to ensure there aren't any further questions that 11 our participants might wish to have put to you. So if 12 you go with Ms Miller in the meantime, we'll be ready to 13 resume again shortly. 14 (4.36 pm) 15 (A short break) 16 (4.43 pm) 17 THE CHAIR: Have a seat. 18 MR DAWSON: Nothing further, sir. Thank you for your 19 evidence, Ms Lamb. 20 A. Thank you. 21 THE CHAIR: There you are, that will tell you that there are 22 no further questions for you to answer this afternoon. 23 Before you leave the hearing suite, can I just 24 extend my thanks to you for your attendance today, for 25 the evidence that you've given during the course of the Page 228

1 afternoon, and also for your contribution to the 2 statement at its relevant parts and the accumulation of 3 documents that you and those helping you would have been 4 involved in to enable that statement to be populated as 5 it has been. So for all of those reasons I extend the 6 Inquiry's thanks, and my personal thanks, and you're 7 free to go. 8 A. Thank you very much. 9 (The witness withdrew) 10 THE CHAIR: Anything further? 11 MR DAWSON: Nothing further, sir. 12 THE CHAIR: Thank you everybody. 10 o'clock tomorrow. 13 (4.45 pm) 14 (The hearing adjourned until 10.00 on Thursday, 15 1 October 2026) 16 17 18 19 20 21 22 23 24 25 Page 229	
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